

FOCUS[®]

The magazine of the Joint Center for Political and Economic Studies

LIFE OPTIONS FOR YOUNG MEN OF COLOR

The Dellums Commission

By Michael R. Wenger

When former congressman Ronald V. Dellums (D-CA) agreed to chair the Commission on Life Options for Young African American Males, he vowed that the Commission, which has become known as the Dellums Commission, would “not put out another report that will gather dust. The Commission will put together a document and a set of recommendations that will make a tangible difference.” Dellums has made a career of being a strong voice for the voiceless, and the Commission, which held its first meeting on March 7 of this year and met again in May and in July, is well on its way to putting the Dellums stamp on its work.

This effort is unique in focusing on policy, especially at the state level, that will address the needs of young African American males, and in framing the health issues of overrepresentation in the criminal justice system and in the school-to-prison pipeline. Dr. Gail Christopher, the Joint Center’s Vice President for Health, Women, and Families and Director of the Joint Center Health Policy Institute (HPI), made the decision to

— Continued on page 10

IN THIS ISSUE...

- 2 **Playfair**
- 3 **The Health Policy Institute**
An Overview
- 10 **Life Options for Young Men Of Color**
The Dellums Commission
- 12 **Infant Mortality:**
Re-envisioning the Problem and Its Resolution
- 14 **Medicaid on the Chopping Block:**
Dangerous Times for Health Care and Economic Stability
- 16 **Factors Affecting the Health of Men of Color**
in the United States

IN TRENDLETTER...

- 5 **Health Report**
The Sullivan Alliance Partners with the Joint Center To Increase Diversity in the Health Professions
- 7 **Economic Report**
Poor Health: A Barrier to Economic Advancement
- 9 **Political Report**
The Commission on Medicine, Genomics, and Health: Realigning Race and Science

In Memoriam
Eleanor Farrar
1925 - 2005
Senior Vice President
The Joint Center for Political and Economic Studies

Cold Comfort

The dog days of August, the period of sultry weather signaled in the late summer sky by the Dog Star, Sirius, are upon us in Washington. Traffic is light; news is sparse; the President is at the Texas White House avoiding the uninvited; and the Congress is in recess. Only a handful of residents and tourists is left to reflect on this summer's issues: health, the devastation of Hurricane Katrina (see our website), and John Roberts.

Judge John G. Roberts, Jr., along with his admirers in the administration and his pursuers on the Senate Judiciary Committee, is providing this year's summer political sport. He is President Bush's nominee to succeed Supreme Court Justice Sandra Day O'Connor.

Justice O'Connor was the Court's trailblazing first woman appointee, sweeping away more than two centuries of male exclusivity and myopia in the secretive, perpetually aging clique that permits only nine active members. Many on both sides of the national political aisle had hoped that she would be reappointed in the guise of a nominee similar in capability, intellect, philosophy and temperament, and identical in gender.

John G. Roberts, Jr., is not Sandra Day O'Connor. He is also not Ruth Bader Ginsberg, the other woman on the Court; Thurgood Marshall or Clarence Thomas, the two African Americans who have been appointed in the Court's history; or Alberto Gonzalez, the nation's Hispanic Attorney General, who many consider a likely candidate. Nor is he Native American, Asian American, or from any of the other underrepresented groups with a legitimate stake in the governing of this nation.

A Woman of the West, Justice O'Connor spent much of her career as an elected state legislator and came to the Court as a state appellate judge from a life far outside the Capital Beltway. Judge Roberts, a federal appellate judge, has spent his career in Washington either in the Federal government—including two stints in the Department of Justice and in the Office of Counsel to the President—or in one of the largest, oldest and most prestigious law firms in the nation's capital. He is a Washington insider.

Justice O'Connor is a centrist pro-business conservative whose views and votes on certain social issues before the Court have often been decisive. Judge Roberts' judicial record is not yet clear.

There is no guarantee in the record of John Roberts, private citizen and lawyer to the powerful, that he can be counted by social conservatives as a predictable vote. He has represented homeless Washingtonians, advocated for environmental protections, spent 25 hours assisting a convicted murderer with a death penalty appeal, and helped gay rights activists win a Supreme Court anti-discrimination case.

On the other hand centrists, progressives, and their fellows have their own cause for concern. There is an unsettling tone to Judge Roberts' writings as an assistant to the Attorney General, as a member of the Reagan White House Counsel's office, and in his later arguments as the first President Bush's Deputy Solicitor General on civil rights, voting rights, and the right of women to control their health and bodies.

These are not small matters. Judge Roberts' attitudes with respect to the Voting Rights Act of 1965 and concerning women's rights will require explanation and assessment. With, however, the limited judicial record available, every question is not likely to be fully answered nor every concern fully assuaged.

What we can gather from the record is this: he is a candidate of substantial credentials whose demeanor suggests a mind that is adept, disciplined, and—at the very least—not quite closed. The President could have done much, much worse.

That is cold comfort for some. In a republic, however, where one party holds the White House and both houses of the Congress, it is generally, although not always, a fair approximation of the will of those who elected them.

Thos. Playfair

As FOCUS went to press, we learned of the death of Chief Justice William H. Rehnquist and of the subsequent re-designation of Judge John G. Roberts to be Chief Justice of the United States. Albeit that John Roberts fits rather neatly into Justice Rehnquist's shoes, there remains the crucial selection of an Associate Justice to succeed Sandra Day.

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The Health Policy Institute

By Gail C. Christopher

An Overview

The mission of the Joint Center Health Policy Institute is “to ignite a ‘Fair Health’ movement that gives people of color the inalienable right to equal opportunity for healthy lives.” Persistent, seemingly intractable health disparities call for a galvanized, consolidated effort to mobilize diverse communities for action. Current controversies over how to reform Medicaid, the number of people without health insurance, the high cost of prescription drugs, and the race-specific labeling of certain drugs are among the issues that further illustrate the need for such a movement. Policy debates now raging over these and other issues consider only peripherally the concerns of communities of color. Raising the visibility of these concerns, as the Health Policy Institute is attempting to do through a range of collaborative activities and cutting-edge research, is essential to policy decisions that reflect the best interests of all of our citizens.

In recent years it has become increasingly clear that race continues to play an important role in the quality of health and health care that a person experiences in the United States. The data leave little room for argument. Racial and ethnic disparities include heart disease, stroke, cancer, diabetes, asthma, and excess infant mortality, which affect people of color in far greater percentages than they affect Caucasians. Recent studies have confirmed that health care professionals often provide disparate treatment based on a patient’s skin color and that the treatment accorded to people of color is generally inferior to the treatment accorded to Caucasians. The life expectancy of people of color significantly lags behind the life expectancy of Caucasians, with African Americans having an average life span seven years shorter than that of Caucasians.

As our scientific knowledge has advanced, it has become equally clear that inadequate health care is both a key factor fueling racial disparities in economic and educational achievement and a key outcome of those same disparities. Thus, although illness-specific research is important in moving us closer to high-

quality health for all, it is not enough. Good health means more than simply the absence of illness. Good health is produced by a range of factors that include genetic and biological processes, individual behaviors, and the social environment in which people live. All these factors affect a person’s ability to live a healthy life and all these factors need to be addressed if progress is to be achieved in reducing racial and ethnic health disparities.

It is in this context that the Joint Center for Political and Economic Studies has undertaken a substantial amount of ground-breaking research on health issues over the last decade. Among the topics it has addressed in recent years are reproductive behavior and teen pregnancy, HIV-AIDS, and gender-specific health issues. The Joint Center has issued a number of publications on this research, which are available from our website: www.jointcenter.org.

In 2003, with a grant from the W. K. Kellogg Foundation, the Joint Center formed the Health Policy Institute (HPI). HPI institutionalized the Joint Center’s leadership role in identifying key policies that negatively affect the health of African Americans and other minority groups, and in examining policy options that can reverse such effects. I arrived in early 2004 to direct HPI and subsequently to fill a new position at the Joint Center: Vice President for Health, Women and Families. My role is to give HPI a clear direction and to accelerate its progress both in making health more visible as a vital civil rights issue for the African American community and other communities of color, and in developing comprehensive strategies that will produce real change.

A “Fair Health” Movement

By framing HPI’s mission in terms of a “Fair Health” movement, my colleagues and I acknowledge the legacy of activism and coalition building that underpins racial, political, and economic progress, while at the same time shifting the focus away from the negative (health disparities) and toward the positive (desired outcomes and implied strategies for achiev-

ing these outcomes). HPI’s broad goal is “to help communities of color identify short- and long-term policy objectives and related activities” in seven key areas:

1. Identifying and addressing the economic, social, environmental, and behavioral determinants that can lead to improved health outcomes.
2. Increasing resource allocations for the prevention and effective treatment of chronic illness.
3. Informing the policy and practice of reducing infant mortality and improving child and maternal health.
4. Reducing risk factors and supporting healthy behaviors among children and youth.
5. Improving mental health and reducing factors that promote violence.
6. Optimizing access to, and the quality of, health care.
7. Creating conditions for healthy aging and improving the quality of life for seniors.

Through a variety of collaborations, HPI is aggressively pursuing this goal in all seven areas. An example is the recent forum on Medicaid cosponsored by HPI and the American Public Health Association. This forum unveiled research showing that Medicaid expenditures may actually provide counter-cyclical protection during downturns in the nation’s economy and that significant cuts in Medicaid expenditures may exacerbate economic downturns.

Reflecting these collaborative relationships, a prestigious 28-member national advisory committee, chaired by former congressman Louis Stokes, and three broadly representative commissions have been established. The Dellums Commission, chaired by former congressman Ronald V. Dellums, is analyzing the effect of several key public policies on the physical, emotional,

and social health of youth and their communities and will recommend actions aimed at reversing policies that limit the life paths of young men of color. The Commission on the Courage to Love, co-chaired by Dr. Ronald David, former Chief Medical Officer and Executive Vice President of the District of Columbia Health and Hospitals Public Benefit Corporation, and Dr. Barbara Nelson, Dean and Professor of Public Policy and Political Science at the UCLA School of Public Affairs, is attempting to answer this question: If relationships are primary, and all else is derivative, what then are the implications for care, research, and public policy that aim to reduce infant mortality? The Sullivan Alliance to Transform America's Health Professions, chaired by Dr. Louis W. Sullivan, former U.S. Secretary of Health and Human Services and President Emeritus of the Morehouse School of Medicine, and co-chaired by Dr. Lonnie R. Bristow, former President of the American Medical Association, grows out of two reports issued in 2004 that examine diversity in the health care professions, one by the Sullivan Commission on Diversity in the Healthcare Workforce and the other by an Institute of Medicine panel. The objective of the Alliance is to implement the recommendations of these reports and thus increase diversity in the health professions, in turn helping to reduce racial disparities in health status and health care.

Partners and Alliances

In addition to these three commissions, HPI has developed a number of other collaborative efforts to further its work in the seven key areas. An alliance with Winston-Salem State University of Health Sciences is helping to identify successful programs and policy models and their implications for Historically Black Colleges and Universities. An alliance with Children's Sentinel Nutrition Assessment Program is a national project to identify issues concerning food and nutrition and related policy initiatives that could help decrease health disparities among communities of color. Working with the National African American Drug Policy Coalition, HPI is seeking to identify ways of influencing and informing drug policy at both the state

and national levels, and then to produce initiatives that will influence health policy and reduce health disparities. The National Center for Health Behavioral Change and HPI are working together on research, information dissemination, and policy review to affect issues related to behavioral medicine and behavioral health change. HPI has allied itself with the National Dental Association to implement recommendations that were in HPI's oral health policy brief issued in 2004. HPI has commissioned the National Academy for Social Insurance to prepare two papers on the role of Medicare and other federal legislation, such as the Americans with Disabilities Act, in reducing racial disparities in health. And to produce a directory of community-based organizations concerned with racial disparities in health, HPI is working with the Poverty and Race Research Action Council.

Another important alliance developed by HPI is with Families-USA, a prominent advocate for health care consumers, especially those who are senior citizens or have low incomes. Before the 2004 presidential election, this alliance produced and widely distributed a document analyzing the positions of both President Bush and Senator Kerry on a range of key health issues. Now, in collaboration with the National Medical Association and the National Association of Latino Elected and Appointed Officials, HPI and Families-USA are developing training programs for elected officials, journalists, and others on key health issues.

Whereas the three commissions and these strategic alliances all promise positive and powerful future action toward achieving an equal opportunity for healthy lives for all Americans, regardless of race or ethnicity, HPI has already produced a number of publications that are proving valuable to organizations working in the field. With Policy Link, a California-based national organization involved with nonprofit research, communications, capacity building, and social advocacy, HPI has produced a set of four publications:

- *Community-Based Strategies for Improving Latino Health*
- *Breathing Easier: Community-Based Strategies to Prevent Asthma*

- *Building Stronger Communities for Better Health*

- *A Place for Healthier Living: Improving Access to Physical Activity and Healthy Foods*

HPI's other publications include:

- *Factors Affecting the Health of Men of Color in the United States*

- *Visible Differences: Improving the Oral Health of African American Males*

- *Health Care and the Medicaid Program: Knowledge and Perceptions of Black Elected Officials*

HPI is working with the International City Management Association and the National Association of Counties on what it intends as its signature project, "Place Matters." Consisting of both an annual print publication and an on-line web-based version of the print publication, as well as a "fair health" tool kit, "Place Matters" will profile relevant conditions and circumstances in counties with the highest percentage or highest number of people of color and will give county officials, community leaders, and legislators guidance on how to improve these conditions and circumstances. It will serve as an ongoing tool enabling counties to benchmark their progress toward the creation of conditions and circumstances in which all their residents have an equal opportunity to live healthy lives.

Change will not come easily or quickly. But by creating a "Fair Health" movement and reaching out to a wide range of collaborators, the Health Policy Institute has demonstrated its commitment to an intensive long-term effort that engages virtually every sector of society in promoting policies that will enable all of us to live healthy and fulfilling lives. □

Gail C. Christopher is vice president for Health, Women, and Families at the Joint Center and director of the Joint Center Health Policy Institute.

HEALTH REPORT

The Sullivan Alliance Partners with the Joint Center To Increase Diversity in the Health Professions

By Louis W. Sullivan, M.D.

The health care system of America today is in trouble. By many measures it is the most advanced in the world. Yet, significant disparities in health status, health care, and health outcomes persist among America's minority populations despite efforts to reduce those disparities. At the same time, the number and percentage of minorities in America are increasing, and they are predicted to surpass the country's "majority" population by 2050—a development that means the nation's problem of health disparities is going to get a lot worse unless something is done.

Three "Healthy People" reports from the U.S. Department of Health and Human Services—in 1979, 1990, and 2000—have documented and addressed the issue of health disparities in America. In addition to these large-scale federal initiatives, broad-based efforts have been made in the education, biomedical research, and health professions communities, supported by both private foundations and public funding, to assess and analyze health disparities, determine their causes, and find ways to mitigate the disproportionate mortality and morbidity suffered by America's minorities. Among those efforts, the 2002 landmark study by the Institute of Medicine (IOM), titled "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," stands out. The study found that a consistent body of research demonstrates significant variation in the use of medical procedures by race, even when insurance status, income, age, and severity of condition are comparable. One of the study's key recommendations

is that the nation needs more minority health care providers, for they are more likely to serve in minority and medically underserved communities, delivering needed medical care to those communities.

Diversity in the health professions is the subject of two important studies funded by the W. K. Kellogg Foundation, which has a long history of helping institutions and the health professions cope with the changing demographics of the U.S. population. In 2002, the Foundation supported a study by the Institute of Medicine to assess the institutional and policy-level strategies needed to achieve greater diversity among the nation's health professionals. Also in 2002, the Foundation issued a grant to the Duke University School of Medicine to organize and convene the Sullivan Commission on Diversity in the Healthcare Workforce.

The IOM's report was issued on February 5, 2004. Titled "In the Nation's Compelling Interest," it was produced by a committee of 15 leading representatives of the health professions under the chairmanship of Dr. Lonnie R. Bristow. In addition to assessing and describing the potential benefits of greater diversity among health professionals, the report evaluated strategies and made 25 recommendations for action in five areas:

1. Admissions policies and practices of health professions educational institutions.
2. Public (e.g., state and federal) sources of financial support for training in the health professions.
3. Diversity-related standards of the accrediting organizations for the health professions.
4. The "institutional climate" for diversity at health professions educational institutions.
5. The relationship between community benefit principles and diversity.

The report also focused on the 2003 U.S. Supreme Court decision in *Grutter v. Bollinger et al.*, where the majority found there to be substantial evidence that the quality of the educational experience in a university that has achieved a "critical mass" of diversity is significantly better than the quality of the educational experience in a university without significant diversity. The Court further found that America's need for better-educated leaders who are also more accustomed to interacting with a diverse world community, as well as a more diverse American society, is indeed a "compelling governmental interest."

The IOM report found that the Court reviewed evidence from an array of research to reach its decision. Of particular note was research by Gurin et al., who studied 11,000 students from diverse backgrounds in several hundred undergraduate colleges and universities across the country and found that the benefits of a diverse college experience were observed across all racial and ethnic groups, resulting in better quantitative and qualitative outcomes and a better educational experience overall.

Meanwhile, the Sullivan Commission—composed of 16 leaders in the fields of health, education, law, and business—proceeded with its work, which included holding six hearings around the country. The Commission's report was issued on September 20, 2004, with the title

“Missing Persons: Minorities in the Health Professions.” This report identified a number of strategies to make education and training in the health professions more attainable and affordable for minority students, presented 37 recommendations to remedy the lack of diversity among health professionals, and warned that failure to act quickly would only exacerbate the growing racial and ethnic differences between health care providers and the populations they serve. The report documented the “diversity gap,” finding that African Americans, Hispanic Americans, and Native Americans make up more than 25 percent of the U.S. population, but are only nine percent of the nation’s nurses, six percent of the nation’s physicians, and five percent of the nation’s dentists. With demographic projections showing that no racial or ethnic group will constitute a majority of America’s population by 2050, and with the (already low) proportion of minority students in the nation’s health professions remaining flat or declining, it would appear that unless diversity in the nation’s health professions dramatically increases, the communities served by these professions can anticipate major problems. The Commission concluded that swift, large-scale change is needed to preserve and enhance America’s health care system; the system needs to change, and change soon.

Together, the reports from the Institute of Medicine and the Sullivan Commission, including their 62 recommendations for action, offer the nation a comprehensive blueprint for achieving diversity and ensuring cultural competency among our nation’s health professionals. The reports created a groundswell of awareness and interest in moving forward. The need then was to harness the momentum created by the two reports and move to action, with initiatives that would enlist the participation and investment of health professionals, students, corporations, associations, business leaders, government officials, the academic community,

nonprofit and community-based organizations, and other stakeholders.

To address this need, the Sullivan Alliance to Transform America’s Health Professions was formed, bringing together members of the former Institute of Medicine Committee, members of the former Sullivan Commission, and other experts who are committed to ensuring that the recommendations are adopted and implemented and that they produce the desired results. I was elected chair and Dr. Lonnie R. Bristow was elected co-chair.

In January 2005, with a planning grant from the W. K. Kellogg Foundation, the Sullivan Alliance formed a partnership with the Health Policy Institute of the

African Americans, Hispanic Americans, and Native Americans make up more than 25 percent of the U.S. population, but are only nine percent of the nation’s nurses, six percent of the nation’s physicians, and five percent of the nation’s dentists.

Joint Center for Political and Economic Studies. The Alliance is committed to seeking a variety of investors and partners who support its mission. It is currently initiating, or has already initiated, relationships with several educational institutions, foundations, corporations, associations, and community groups. In addition, the IOM and Sullivan Commission reports have spawned initiatives by other organizations, which wish to support and extend the continuing work of the Alliance.

In September 2004, the Virginia-Nebraska Alliance was formed, bringing together into a consortium the two academic health science centers of Virginia Commonwealth University and the University of Nebraska, all of the five historically black colleges in Virginia (Hampton University, Norfolk State University, St. Paul’s College, Virginia State University, and Virginia Union University), and the J. Sargeant

Reynolds Community College. The goal of the Alliance is to significantly increase the success rate of students from the consortium’s undergraduate schools in gaining entry to, and in graduating from, a health professions program. In 2005, the first eight students from these colleges were enrolled in summer research and educational programs at the Virginia Commonwealth and University of Nebraska health science centers.

On January 31, 2005, at the National Press Club in Washington, D.C., the presidents of the American Medical Association, the National Medical Association, and the National Hispanic Medical Association announced their

formation of the Commission to End Health Care Disparities.

In its ongoing work, as in its mission, the Sullivan Alliance will focus on increasing racial and ethnic diversity in the health professions of medicine, dentistry, nursing, and psychology. This effort will reach and influence all segments of American society. More importantly, it will generate remedial actions that bring about changes in health care, health care institutions, educational institutions, educational and professional associations, corporations, and government. The Alliance will be a national leader in the effort to achieve diversity in the health professions. With its members’ energy, talents, depth of experience, and dedication to the task, it will undoubtedly succeed. □

Dr. Louis W. Sullivan is president emeritus of the Morehouse School of Medicine. He served as U.S. Secretary of Health and Human Services from 1989 to 1993.

ECONOMIC REPORT

Poor Health: A Barrier to Economic Advancement

By Margaret C. Simms

Much of the current policy dialogue about work and health focuses on the importance of employment-based health insurance, given that two-thirds of the insured get their coverage from on-the-job health insurance plans; however, it is also important to recognize that health status has an effect on the ability to get and keep employment.

Health Status: Disability

A chronic disease, a physical limitation, and mental illness can all affect a person's ability to work. Each of these conditions may constitute a disability in the workplace. The Census Bureau defines disability as "a long-lasting sensory, physical, mental, or emotional condition... [which] makes it difficult for a person to do activities such as walking, climbing stairs, dressing, bathing, learning, or remembering. It can impede a person from being able to go outside the home alone or to work at a job or business, and it includes persons with severe vision or hearing impairments." Not all disabilities limit work effort, but some do. Not all chronic health conditions are disabling, but some are.

The incidence of disability varies by race and ethnicity (Table 1). The Census Bureau estimates that in 2003 close to 20 million adults between the ages of 21 and 64 were disabled, or about 12 percent of the population in that age group. Approximately 38 percent of the disabled adults were employed, compared with 77.5 percent of the adults without a disability. African Americans were more likely to report disabilities than their white counterparts, whereas Hispanics were somewhat less likely to do so. Among both African Americans and Hispanics, women were slightly more likely to report disabilities than

men. The effect of disability on employment was greater for African Americans than for either whites or Hispanics. Disabled African Americans were only 40 percent as likely to be employed as were African Americans without disabilities. Among people with disabilities, African Americans, both male and female, and Hispanic females were the least likely to be employed, whereas white and Hispanic males were the most likely.

The incidence of disability also varies by income and is greater among low-income families, according to a 2004 report by the Urban Institute. The report also finds that these individuals are less likely to work and much more likely to draw on a range of public assistance programs, including Temporary Assistance to Needy Families and Social Security disability programs (Table 2).

Effect of Health on the Movement from Welfare to Work

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 changed the public assistance program then known as Aid to Families with Dependent Children (AFDC). What had been a long-term cash support system became short term, as the program's new name indicated: Temporary Assistance to Needy Families (TANF). During the economic boom years of the late 1990s, states made significant headway in moving TANF recipients from welfare to work, but many long-term recipients remained on the rolls. In an effort to identify the barriers that kept more welfare recipients from moving into the paid workforce, the federal government and others began to look at differences between "leavers" and "stayers." They found that one important determining factor was health.

A 55-month study by Mary Corcoran and others, the results of which were published in the journal *Women and Health in 2004*, examined the effect of health and other employment-limiting factors on work effort among current and former welfare recipients in Michigan. More than 70 percent of the sample reported physical limitations, many of which persisted for the duration of the study. African American women were no

Table 1: Incidence of Disability and Employment Status by Disability Status by Sex, Race, and Ethnicity for the U.S. Noninstitutional Population, Ages 21-64.

	Total Population	Disabled Population	Percent Disabled	Percent of Non-Disabled Employed	Percent of Disabled Employed
Total	165,180,683	19,871,681	12.0	77.5	37.8
African American Total	19,057,324	3,058,860	16.1	73.8	29.1
Male	8,524,446	1,341,512	15.7	76.6	30.0
Female	10,532,878	1,717,348	16.3	71.5	29.3
Hispanic Total	21,720,811	2,125,946	9.8	72.8	35.8
Male	11,194,986	1,041,788	9.3	84.6	41.8
Female	10,525,825	1,084,158	10.3	60.1	30.0
White Non-Hispanic Total	113,930,275	13,622,505	12.0	80.0	40.1
Male	56,176,625	6,815,352	12.1	86.5	44.1
Female	57,753,650	6,807,153	11.8	72.9	36.0

Source: U.S. Bureau of the Census, American Community Survey, 2003, <http://factfinder/servlet/>

more likely to report chronic or persistent health problems than were whites; persistent poor health had a negative effect on employment for both groups.

The findings from the Michigan study are consistent with studies of potential employment problems among TANF recipients conducted in six other states: Colorado, the District of Columbia, Illinois, Maryland, Missouri, and South Carolina. These studies are synthesized in a 2004 U.S. Department of Health and Human Services paper. Although the data are not segmented by race, African Americans ranged from 18.2 percent of the caseload (Colorado) to 96.1 percent (District of Columbia). An average of 21 percent of the subjects had physical health problems, and 30 percent had mental health problems. Both types of health problems had a negative effect on employment: subjects with health problems were about one-third as likely to be employed. After adjustments were made for other factors, poor physical health still had a significant negative effect on holding a job, but mental health problems did not.

Disability on the Job

Sometimes workers develop health problems on the job. African Americans and Hispanics (especially males) are more likely to be in jobs with high health hazards, so one might assume that they are more likely to have work-related health problems. A recent study using data from a 1992 survey, however, found that this was not the case for African Americans. Overall, African Americans in the sample were more likely to report disabilities than were whites and about as likely to report them as were Hispanics. But when asked if the disability was caused by a work-related injury or work condition, Hispanics were more likely than whites to say yes, whereas African Americans were not. The differences among racial groups were greatest for men, with nearly 56 percent of Hispanic men reporting job-related disabilities, compared with 50 percent of white men and 40 percent of African American men. Among women, about 25 percent of women in each racial/ethnic group said their disabilities were work related.

According to the 2004 Urban Institute study mentioned earlier, Social Security Administration (SSA) disability participants

cite fewer financial difficulties than do other low-income adults who have work limitations. The study claims that this smaller number of financial difficulties is due in part to the SSA disability participants' greater enrollment in an array of noncash programs, such as Section 8 housing, which makes special provisions for those in the SSA disability program.

Policy Recommendations

As the studies mentioned here indicate, limitations on people's ability to work puts a burden on the public sector. But if the policies and procedures of public assistance programs were reviewed and revised, the result might be better short-term support for individuals and stronger chances of their achieving more independence in the long run. For example, in their examination of health problems among TANF recipients, the authors of the Michigan study suggested two program changes that might improve these women's chances of successfully moving into the workforce. One proposal focuses on treatment, recommending that all TANF recipients and their children be systematically screened for physical and

mental health problems and subsequently referred for health services if necessary. Participation in treatment programs could then be counted as a work activity, allowing the recipient to be exempt from work requirements until the problem is corrected. The second proposal is to extend eligibility for health insurance coverage under Medicaid beyond the one-year transition period, since many of the women in the program will obtain jobs that do not provide employer-supported health insurance. One or both of these recommendations could be applied to recipients of some other public assistance programs as well, which would allow more people to be contributing members of the labor market. □

Margaret C. Simms is vice president for Governance and Economic Analysis at the Joint Center. For additional information: on Urban Institute studies, www.urban.org; on Social Security disability studies, www.ssa.gov/policy/docs/ssbv65n4/; on welfare leavers and stayers, <http://aspee.hhs.gov/>

Table 2: Employment and Program Participation Rates for Low-Income Adults, by Work Limitation and Income Status, 2001

	Income below 200% of FPL		Income below 100% of FPL	
	With work limitations	Without work limitations	With work limitations	Without work limitations
Employed in the previous year(%)	39.3	76.2	28.3	63.5
Any cash transfer program ^a (%)	51.5	13.4	52.2	15.8
Any noncash transfer program ^b (%)	59.1	22.5	67.9	34.6
Population (weighted-millions)	7.3	22.7	3.8	7.9

Source: David Wittenburg, A Health Conscious Safety Net? Health Problems and Program Use among Low-Income Adults with Disabilities, Washington, DC: The Urban Institute, September 2004, Author's calculations.

Notes: Adults are age 25-55. Low-income adults are those with family incomes below 200 percent of the federal poverty level (FPL). Some cells may not sum exactly because respondents participate in multiple transfer programs.

a. Includes respondents who reported cash benefits from Supplemental Security Income (SSI), Disability Insurance (DI), Workers Compensation (WC), Veterans Benefits (VB), Private Disability Insurance (PDI), Temporary Assistance for Needy Families (TANF), General Assistance (GA), or Unemployment Insurance (UI).

b. Includes respondents who reported in-kind assistance from Medicare, Medicaid, Food Stamps, or Housing Assistance.

POLITICAL REPORT

The Commission on Medicine, Genomics and Health: Realigning Race and Science

By Gary A. Puckrein and Gretchen C. Wartman

“Race” is a term that most of us use on a routine basis in our professional and social spheres, relying on the generally unconscious assumption that scientific consensus informs its meaning. It must be noted that opinions regarding the relationship among geographic origin, race/ethnicity, environment, and health vary from positions of oppositional polarity to those that are more equivocal. There is consensus that the racial categories currently in use reflect the American sociocultural construct more than anthropological findings.

Two relatively recent developments have heightened the debate: the announcement that the genetic sequence of any human being is estimated to be 99.9 percent identical to that of any other unrelated person, and the decision of the pharmaceutical company NitroMed to conduct the African-American Heart Failure Trial (A-HeFT) for the drug BiDil. The concerns posited in the literature are complex and are informed as much by scientific evidence as by concerns about the potential for misapplication and/or the biological reification of race. In “Changing the Paradigm from ‘Race’ to Human Genome Variation,” Charmaine D. M. Royal and Georgia M. Dunston have cogently articulated the policy challenge:

Human genome knowledge has been likened to a “double-edged sword,” with power to exacerbate health disparities if (i) its benefits are realized only by the most affluent members of society; (ii) its research is carried out and applied

mainly toward the medical treatment of rare diseases; (iii) its message is distorted into impressions of group inferiority; (iv) its information is used to discriminate and stigmatize; and (v) its power is used to further the image of a single physical ideal. Conversely,... this same knowledge can be effectively

Media headlines trumpeting the advent of “race-based medicine” overshadowed the positive message associated with A-HeFT as a clinical trial that placed a priority on the responses of African Americans.

used to eliminate health disparities if (i) its applications are focused on common complex diseases in the least healthy groups in society; (ii) its study provides valuable insights into the causes of health disparities; (iii) its benefits are shared with vulnerable population groups; and (iv) its message is understood as valuing human variation as an instrument of self-discovery.

The recent experience with BiDil serves to underscore the challenges that the African American community faces. BiDil was approved by the Food and Drug Administration on the basis of a clinical trial that included only patients who self-identified as African American. A-HeFT was co-sponsored by the Association of Black Cardiologists and NitroMed. Unfortunately, media headlines trumpeting the advent of “race-based medicine” overshadowed the positive message associated with A-HeFT as a clinical trial

that placed a priority on the responses of African Americans. BiDil is undeniably an efficacious pharmacological agent for the treatment of chronic heart failure, but it is neither a “race drug” nor an example of the individualized medicine envisioned by Valentine J. Burroughs, Randall W. Maxey, and Richard A. Levy—drug treatment tailored to a patient’s genetic “fingerprint.”

The A-HeFT/BiDil experience is important for another reason. It triggered an essential discourse that resulted in the creation of the Commission on Medicine, Genomics and Health. The Commission’s co-chairs are Dr. Gail Christopher, Director of the Joint Center Health Policy Institute, and Dr. Randall Maxey, President of the Alliance of Minority Medical Associations. Other founding organizations

are the NAACP, the Genetic Alliance, the Association of Black Cardiologists, the National Medical Association, and the National Minority Health Month Foundation.

Research will continue to explore the link between environment and genetic variation, as well as the effect of social bias/racism on access to health services and quality of care. Even as substantive, legitimate differences of opinion continue to exist, the Commission provides a new forum for coordinated action and leadership around the issues of medicine, genomics, and health. □

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LIFE OPTIONS FOR YOUNG MEN OF COLOR

Continued from cover

proceed in this direction, convening the Dellums Commission as a key element in HPI's agenda. According to Dr. Christopher, public policies at the local, state, and federal levels have had the combined and cumulative effect of limiting life options for young men of color. Working with her to set up the Commission were Ronald D. Walters, Professor of Political Science at the University of Maryland, and C. Patrick Babcock, Senior Policy Advisor of Public Policy Associates, Inc.

"This is a community health issue," asserts Dr. Christopher, because:

- High incarceration rates among minority youth are symptoms of unaddressed family, school, and community challenges.
- Disproportionately high rates of drug offense prosecution are substitutions for adequate drug treatment options.
- High incarceration rates mask unmet mental health needs and the lack of appropriate mental health services.
- Resource allocations within local communities (education, public health, mental health, economic development, housing, public safety) are policy decisions or have policy implications.

Although the statistics are well known, it is worth emphasizing some of the more sobering numbers that the Commission has reviewed:

- About one-third of male youth of color (primarily African American and Latino) fall into what the U.S. Department of Labor describes as a "disconnected youth" category: young people who are isolated and have little or no participation in the labor force.
- Almost two-thirds of the U.S. prison population are people of color, predominantly African American and Latino and predominantly male.

- Ten percent of black men between the ages of 25 and 29 were in prison in 2001, compared with 2.9 percent of Latino men and 1.2 percent of white men in the same age group.
- The Sentencing Project estimates that one in three African American men between the ages of 20 and 29 is under correctional supervision in some jurisdiction.
- In the 100 largest cities in the United States, 58 percent or more of the ninth-grade students in high-minority schools do not graduate four years later, and African American drop-outs are eight times more likely to be in state or federal prison than are white drop-outs.
- Nationwide, African American students are three times more likely than white students to be labeled mentally retarded and twice as likely to be labeled emotionally disturbed.

To look more closely at these and other data, their economic impact, and innovative practices that illustrate how policy changes can make a difference, Chairman Dellums and his colleagues have commissioned seven research papers:

- **Correctional Policy Incarceration** (Adolphus G. Belk, Jr., Winthrop University) looks at the wide-ranging impact of the large increase in state and local public funding for correctional programs and at the extent to which the private corrections industry has influenced and driven national, state, and local policy on criminal justice programs.
- **Correctional Policy—Alternative Sentencing and Waivers** (Michael L. Lindsey, Consultant) studies the use of alternative sentencing—including alternatives to incarceration and the use of waivers—and its effect on young men of color.
- **Correctional Policy—Reentry and Recidivism** (Sandra Edmonds Crewe,

Howard University) explores what actually happens to young men of color when they are held in juvenile detention, jails, and prisons. How are they managed? Are they managed in ways that will minimize recidivism? How do they gain access to education and health services?

- **Educational Policy and Literacy** (Kay Randolph-Back, Consultant) examines the implications of national, state, and local educational policy changes over the last 20 years with respect to preparing young men of color to succeed in K-12 education and to enter post-secondary education, technical training, and other areas of career and personal choice.

- **Health Policy** (Jorielle Brown, Consultant) assesses how community health strategies can improve the life options of young men of color and can strengthen community life.

- **Family Support and Child Welfare** (James Hyman, Consultant) analyzes how federal and state policies on family support and child welfare over the last three decades have affected the stability and strength of families of color.

- **Media and the Negative Portrayal of Men of Color** (Robert Entman, North Carolina State University) addresses the media bias toward negative portrayals of men of color and evaluates the effect of this bias on white individuals, white-run institutions, men of color, and society as a whole.

To maximize the effect of its work, the Commission asked the researchers to focus on the implications for policy changes in nine key states (CA, FL, GA, IL, MD, MS, NM, NY, TX) and the District of Columbia, all of which have high concentrations of people of color. At this writing the papers are in draft form, but it is nonetheless clear already that public policies enacted

The Dellums Commission

incrementally over the past three to four decades—policies such as “zero tolerance,” mandatory sentencing requirements, and an emphasis on punishment over rehabilitation, even for nonviolent drug offenders—have contributed to the disproportionate school drop-out rates and rates of incarceration among young men of color. The growing incarceration rates have led to sizeable increases in expenditures for criminal justice systems at the expense of public monetary support for programs in education and community health that would be able to ameliorate this problem. It is equally clear that public policies related to education, community health, and criminal justice are intertwined and must be addressed holistically.

Building Coalitions

To address this broad range of public policies effectively and reverse the troubling trends, Dr. Christopher and Chairman Dellums recognized at the outset that a broad coalition of interests would be essential. Thus, the Commission includes current and former elected officials, members of the judiciary, educators, health care providers, and representatives from the faith community, the corporate community, and academia. The Commission is also diverse racially and ethnically. A complete list of the Commission members accompanies this article.

These sobering realities were discussed in some detail during the public debut of the Commission at Howard University on July 25, 2005. During an all-day session, authors of the papers, members of the Commission, invited respondents, and community leaders shared ideas and insights based on both research and actual experiences. The proceedings of the day are available on the Joint Center’s website, at www.jointcenter.org. On July 26, the Commission held a press briefing at the National Press Club, where Chairman Dellums issued a “call to action,” asking all who “care about the future of our country” to “join us in rescuing our young men of color, and by so doing, living up to our commitment to life, liberty,

- ❑ The Honorable Ronald V. Dellums, Principal, Dellums and Associates, former Member of Congress, Chair
- ❑ Alvin F. Poussaint, M.D., Professor of Psychiatry, Harvard Medical School, Honorary Vice Chair
- ❑ Estela Mara Bensimon, Ed.D., Professor and Director, Center for Urban Education, Rossier School of Education, University of Southern California
- ❑ The Honorable Arthur L. Burnett, Sr., Executive Director, National African American Drug Policy Coalition
- ❑ The Honorable Thelma Wyatt Cummings Moore, Judge, Superior Court of Fulton County, Atlanta Judicial Circuit
- ❑ Reverend Dr. James A. Forbes, Jr., Senior Minister, Riverside Church, New York
- ❑ Badi G. Foster, Ph.D., President, Phelps-Stokes Fund
- ❑ W. Frank Fountain, Senior Vice President, Government Affairs, DaimlerChrysler Corporation
- ❑ The Honorable Nancy E. Gist, Director, Athlete Legacy Network
- ❑ Gloria J. Grantham, Ph.D., Chief Executive Officer, Chester Upland School District of Pennsylvania
- ❑ Norbert S. Hill, Jr., Executive Director, American Indian Graduate Center
- ❑ Sherry M. Hirota, Chief Executive Officer, Asian Health Services
- ❑ The Honorable Arthenia L. Joyner, Representative, Florida House of Representatives
- ❑ The Honorable Gayraud A. Townsend, Alderman, Common Council, 4th Ward, City of Ithaca
- ❑ Loretta F. Jones, M.A., Executive Director, Healthy African American Families

and the pursuit of happiness for all our citizens.” Subsequent public hearings will lead to a final report in July 2006, with a detailed plan of action that speaks to Chairman Dellums’s commitment to “make a tangible difference.” This plan of action can help to make real the mission of HPI: “To ignite a ‘Fair Health’ movement that gives people of color the inalienable right to equal opportunity for healthy lives.” ❑

- ❑ The Honorable Bob Knight, former President, National League of Cities, former Mayor of Wichita, Kansas
 - ❑ The Honorable George Flaggs, Jr., Representative, Mississippi House of Representatives
 - ❑ The Honorable Alexander C. Lipsey, Esq., Representative, Michigan House of Representatives
 - ❑ The Honorable John R. McCoy, Representative, 38th Legislative District, Washington State Legislature, House of Representatives
 - ❑ Joseph F. McDonald, Ed.D., President, Salish Kootenai College
 - ❑ The Honorable Bob McEwen, former Member of Congress
 - ❑ The Honorable Felix W. Ortiz, Assemblyman, 51st Assembly District, State of New York
 - ❑ The Honorable Bernadette M. Sanchez, Senator, 26th District, Bernalillo County, New Mexico Legislature
 - ❑ Ronald D. Walters, Ph.D., Distinguished Leadership Scholar and Director of African American Leadership Institute, the Academy of Leadership, University of Maryland
 - ❑ Roger E. Goodman, Director, Drug Policy Project, King County Bar Association
 - ❑ The Honorable William F. Winter, Watkins Ludlam Winter & Stennis P.A., former Governor of Mississippi
 - ❑ Phillip Dixon, Chairman, Journalism Department, Howard University
- Senior Consultants:
- ❑ C. Patrick Babcock, Public Policy Associates, Inc., Lansing, MI
 - ❑ Janie L. Jeffers, MSW, Jeffers and Associates, LLC, Silver Spring, MD

Michael R. Wenger is a program development consultant for the Joint Center Health Policy Institute. He is former director of the Network of Alliances Bridging Race and Ethnicity (NABRE) for the Joint Center and former deputy director for Outreach and Program Development for President Clinton’s Initiative on Race.

INFANT MORTALITY: Re-envisioning the Problem and Its Resolution

By Ronald David

For the first time since 1957–1958, the overall infant mortality rate in the United States increased rather than continuing its slow but steady decline. Moreover, African American infants still suffer a proportionately greater risk of dying before reaching their first year of age than other racial or ethnic groups in the United States. For example, for African American infants the overall risk of dying is one-and-one-half to two times greater than the risk for European American infants and greater than the risk for infants born to first-generation Mexican American immigrant women—even though the latter are economically worse off than African American women. (In fact, in an apparent paradox, the infant mortality rates for infants born to first-generation Mexican immigrant women are comparable to rates for middle-class European American infants, although Mexican American mothers receive relatively less medical prenatal care than do European American women.) Furthermore, infants of African American women who are economically stable and well-educated adults suffer a greater risk of dying than do infants born to poor, adolescent European American women.

To understand this vexing and tragic state of affairs better and to respond accordingly, the Health Policy Institute of the Joint Center for Political and Economic Studies has convened a National Commission on Infant Mortality. The Commission's objectives are to review the history of infant-mortality-rate analysis and interpretation, examine basic assumptions, redefine the problem, and imagine new possibilities for action. In particular, the Commission is drawing on the evolving concept of relationality—the notion that relationships define what it means to be human—as a key to comprehending infant mortality and shaping a policy response to it.

Even a cursory review of the history of infant-mortality-rate analysis confirms that in the area of public health prevention policies, presumptions of causality have acquired political meaning. In three overlapping historical phases, public health professionals have attributed the risk of infant death to a variety of factors. In the first phase, from about 1850 to the early 1880s, public health professionals presumed that urban dwelling was hazardous to health—so much so that cities were considered infant abattoirs or “slaughterhouses.” This presumption gave rise to a sanitary reform movement. But infant mortality rates remained stubbornly high, so in the second phase of infant-

In particular, the Commission is drawing on the evolving concept of relationality—the notion that relationships define what it means to be human—as a key to comprehending infant mortality and shaping a policy response to it.

mortality-rate analysis (roughly the mid-1880s to 1920), public health reformers shifted their focus to improving the quality and safety of food supplies for infants. This shift in focus led to the development of nutrition education programs and the establishment of urban “milk stations” from which families could obtain nutritional resources. This phase coincided with the emergence and validation of pediatrics as a professional guild providing mothers with expert counsel on the care of children.

The third phase of the public health response to infant mortality began around 1920 and continues to this day, with some refinement; that is, public health professionals have tried to reduce infant death rates by emphasizing medical prenatal care. This phase has been

associated with the growth of obstetrics and gynecology—a professional guild of male birth attendants virtually supplanting the sisterhood of midwifery.

Thinly disguised misogyny has been implicit both prior to and throughout the three phases of infant-mortality-rate analysis described. For example, as early as 1769 a physician named William Buchan asserted as a “melancholy fact” that “almost half the human species perish in infancy by neglect or improper management [by their mothers].” As recently as 1995 a physician opined in the *Wall Street Journal* that “sexually promiscuous mothers or those who abuse drugs or have psychological pathology”

were responsible for “unflattering” infant mortality statistics. In one sense, misogynists' attitudes have made it easier to focus public health policy on changing mothers—educating them, improving their access to medical supervision, and providing them with supplemental foods—rather than focusing on changing the environmental and social forces that threaten the health of expectant mothers.

While acknowledging the substantial contributions of public health reform and advances in medical care to improvements in maternal and child health, the Commission is challenging conventional wisdom. For example, the Commission assumes a priori that women are knowledgeable, competent, and moral beings—often despite toxic and dysfunctional relationships that undermine

their best efforts and from which they cannot escape. Moreover, in accord with a growing number of health care experts, the Commission asserts that greater access to prenatal care as it is currently constituted probably will not further reduce infant mortality rates, if it ever did. From the data it is evident that the risk of preterm birth—a major factor contributing to infant mortality—has risen steadily since 1990 despite the fact that the percentage of women receiving timely prenatal care has been increasing and that the percentage of those not initiating care until late in pregnancy has been decreasing.

The seemingly bewildering array of anomalous epidemiological data alluded to has inspired the Commission to articulate a paradigm and an explanatory hypothesis to account for the complex and heart-wrenching dilemma of infant mortality.

The paradigm to which the Commission has turned is that of “relationality,” an evolving field of study known in the physical sciences as “systems theory,” in political science as “social capital,” in behavioral science as “social cohesion,” and in theological discourse as “love.” In essence, relationality posits that relationships are basic to what it means to be human and are what human beings require if they are to survive and thrive. Relationships are primary. All else is derivative. In this paradigmatic context, the Commission hypothesizes that infant mortality is among a host of other suboptimal health outcomes that derive from the stress associated with absent, distant, and/or disordered relationships. Such tears in the fabric of relationships—best studied in the social sciences as isolation, alienation, and anomie—are manifest at both the micro level of “domestic” or family relationships and at the macro social and cultural level. They are most obviously manifest in horrific examples of domestic violence. Yet isolation, alienation, and anomie are equally anathema to human beings manifest in the more covert experiences of racism, sexism, and class-based ostracism.

Early in its deliberations the Commission was intrigued by the

human experience of breastfeeding as an exemplar of healthy relationality. The data strongly suggest that breastfeeding significantly reduces infants’ risk of dying even in the harshest physical and social environments. Although the nutritional and immunological advantages are well appreciated, less well known are the substantial effects on the infant’s and mother’s biological, psychological, and emotional well-being. The infant’s relative vulnerability notwithstanding, he or she is an exquisitely competent partner in emotional dialogue. There occurs between mother and child an “affect synchrony” that serves as the foundation for immediate biological adaptation as well as for future

Efforts to reduce maternal and infant mortality and morbidity must focus on the repair and support of interpersonal relationships at all levels so that they embody mutual participation and reciprocity.

cognitive development.

The Commission therefore views breastfeeding as the infant’s primer for and the mother’s reminder of the practice of relationality. Together, mother and infant offer the gift of relationship remembrance to the family and community. Their example of “mutual indwelling” is the template for future relationships—relationships that are “self-giving” and “other-receiving.”

Of course, self-giving and other-receiving are not manifest only in the breastfeeding experience. Mutual indwelling between family members and members of the community at large is manifest primarily in sharing both the common meal and the common weal. Across cultures and throughout human history, sharing a meal has been a common gesture of hospitality. Like breastfeeding, sharing a meal is sharing sustenance that is both nutritional and emotional. In table fellowship we give of ourselves and we are potentially transformed by the other. Similarly, when we have regard for the other, we strive for the equitable distribution of the commonwealth for the common good.

For mothers to provide an emotionally and physically nurturing environment in which their infants can thrive, the mothers themselves must be embedded in environments that are physically, psychologically, socially, and culturally nurturing. To that end, though it is early in its deliberations, the Commission is shaping a wide range of policy recommendations. The foundational rationale of the Commission’s policy recommendations can be simply stated: efforts to reduce maternal and infant mortality and morbidity must focus on the repair and support of interpersonal relationships at all levels (domestic, communal, national and international) so

that they embody mutual participation and reciprocity.

Contemporary efforts to reduce infant mortality rates are prime examples of the “medicalization” of a social problem—the basing of intervention on a medical model. Because the medical model has prevailed for too long with only minimal effect, the Commission is striving to articulate a definition of the problem and potential strategies for resolving it that include but greatly transcend that model. Reconsidering the tragedy of infant deaths in the social context of relationality could lead to improvements in pregnancy outcomes, economic prosperity, and meaningful political participation for all women and especially for women of color. □

Ronald David, MD, MDiv., is the co-chair of the Joint Center Health Policy Institute’s National Commission on Infant Mortality.

Medicaid on the Chopping Block: Dangerous Times for Health Care and Economic Stability

By Stan Dorn and Avram Goldstein

As Congress moves forward this fall with plans to trim \$10 billion from Medicaid over the next five years despite growing demand for health care, some state and federal officials and interest groups are proposing caps on enrollment and other steps to lower anticipated spending. The nation's 53 million Medicaid enrollees—many of whom are members of minority groups—are not the only ones with reason to be alarmed.

Economic risks

The preliminary results of research conducted by the Economic and Social Research Institute (ESRI), with funding from the Joint Center, indicate that everyone who has a stake in the national economy should be worried about the unintended consequences of some of the changes proposed for the massive health care program. (These findings were presented at a May 2005 forum convened by the Joint Center and the American Public Health Association.) Aside from creating medical hardship for millions of low-income people, some of the proposed policies could do significant long-term damage to the economy as a whole.

Jointly funded by federal and state government, Medicaid is an entitlement program that expands automatically when more people fall into economic distress. As a result, spending goes up when the economy nosedives, providing an economic stimulus that can make recessions shorter and shallower. This basic feature of Medicaid has been acknowledged by experts at the Federal Reserve Board, the Congressional Budget Office, the Urban Institute, and elsewhere.

Converting Medicaid into a block grant, or otherwise capping federal spending inflexibly, regardless of the changing demand for assistance, could water down Medicaid's ability to cushion the widespread effects of economic downturns. ESRI's research is intended to identify the possible magnitude of this effect.

Rigorous macroeconomic modeling has shown that unemployment insurance (UI) reduces the erosion of the Gross

Domestic Product by 15 to 17 percent during recessions, saving more than 100,000 jobs during the average recession's peak year alone. Unfortunately, similarly comprehensive macroeconomic modeling of Medicaid cannot be completed soon enough for the results to inform congressional deliberations this year. However, by building on the existing analysis of UI, ESRI's researchers have gained a good sense of Medicaid's potential economic role. ESRI's research compares Medicaid spending levels during the past 25 years with spending on UI and with changes in the unemployment rate. The results are striking: aggregate spending on both Medicaid and UI changes in similar ways and at roughly the same magnitude when unemployment rises and falls. For example, during the economic slowdown that began with an official recession in 2001 and continued through additional years of high unemployment, the increases in Medicaid spending that were related to higher enrollment involved approximately the same total amount of spending as increases in UI.

This analysis suggests that Medicaid and unemployment insurance may play comparable roles in stimulating the economy during economic downturns. In other words, Medicaid, no less than unemployment insurance, may now be one of the nation's most important tools for

fighting recession. If policymakers upset Medicaid's responsiveness to broader economic trends, the consequences for the economy as a whole could be severe when the business cycle again turns south.

And when recession strikes, the toll can be particularly high in the African American community. Black workers typically suffer deeper job losses than their white counterparts. Moreover, because average African American households have fewer assets, they have less to fall back on in hard times. From another perspective, the stresses that come with an economic downturn ultimately translate into worsened health, particularly for people of color who suffer disproportionately high rates of elevated blood pressure and diabetes, making them more vulnerable to the health problems that can accompany job loss. When workers lose their jobs, even otherwise healthy people are at heightened risk of heart disease, mental illness, lung cancer and domestic violence. Job loss increases mortality rates by 37 percent among previously healthy workers, according to one study. In addition, other members of the family are more likely to experience health problems.

Health coverage at risk

Even without widespread Medicaid caps, the number of uninsured Americans has

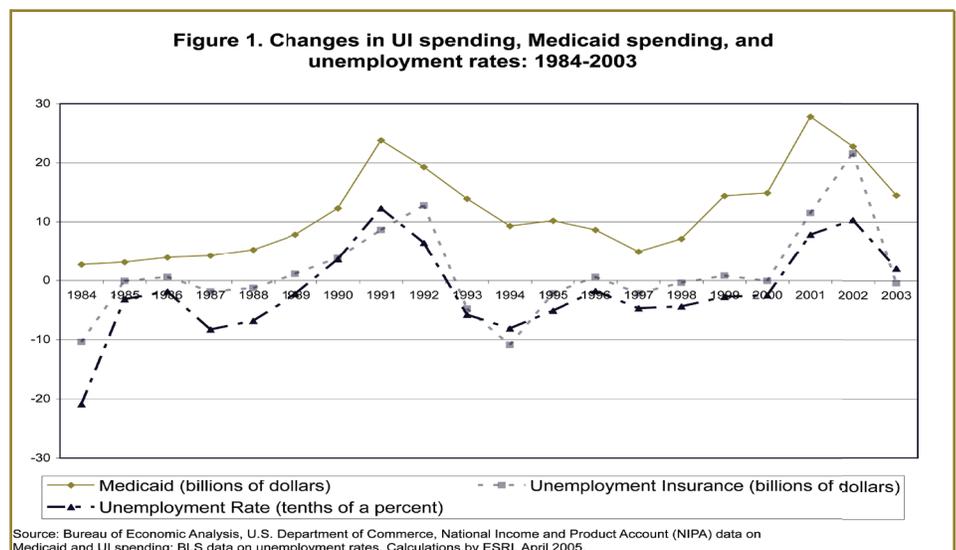
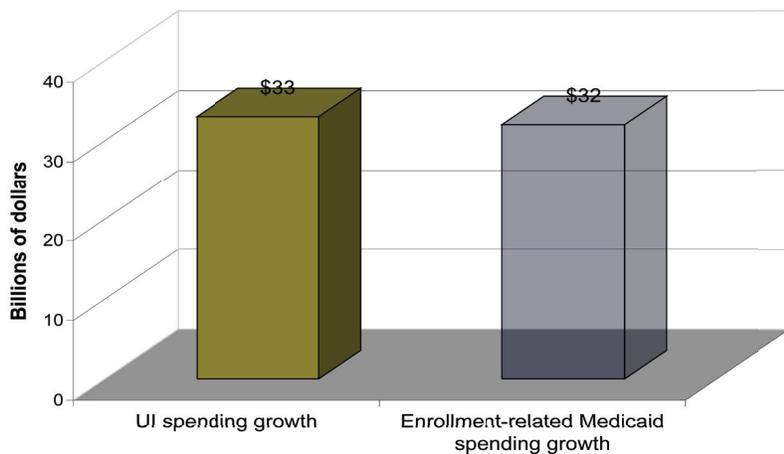


Figure 2. Total UI spending growth vs. enrollment-related Medicaid spending growth: 2000-2002



Sources: Urban Institute analysis of Medicaid spending growth, January 2005; Bureau of Economic Analysis, U.S. Department of Commerce, National Income and Product Account data on UI spending. Calculations by ESRI, April 2005.

continued to rise in recent years, growing from 40 million in 1999 to about 45 million in 2003. If caps on Medicaid enrollment had been in place during that period, the nation's uninsured population in 2003 would have surged to at least 50 million rather than 45 million, according to ESRI's research.

The health harm caused by such Medicaid caps or other ill-considered Medicaid cuts could be particularly severe in the black community. Medicaid covers 44 percent of African American children, 72 percent of poor black children, 38 percent of poor African American adults, and 38 percent of poor black seniors.

Policy implications

With health care costs continuing to rise, many state governors and national officials are looking to cut Medicaid spending. Proposals include (among others) eliminating coverage for Medicaid recipients, cutting payments to doctors and hospitals, limiting reimbursement for prescription drugs, capping federal spending, abolishing certain state financing strategies, preventing seniors and people with disabilities from transferring assets in order to qualify for Medicaid coverage of long-term care, limiting beneficiaries' right to sue state Medicaid programs for violating federal law, limiting covered services, cracking down on fraudulent providers, and increasing charges to low-income beneficiaries.

Stepping back from the important

specifics of these proposals, policymakers could try to achieve Medicaid's budget targets without changing the program's basic structure—or they could cap growth or spending. While the former route may or may not damage low-income Americans' access to essential health care (depending on the policy details), the latter route could have a very different, unintended effect of undermining the economy's ability to recover from future recessions, as noted above. According to Louis W. Sullivan, M.D., former Secretary of Health and Human Services and moderator of the forum at which the ESRI results were presented, the conflict between expanding Medicaid coverage and reining in costs must be resolved carefully, without harming minorities or others for whom Medicaid is the only source of essential health care. Dr. Sullivan is working in partnership with the Joint Center to expand access to health care among minorities by increasing racial and ethnic diversity in the health care workforce.

To the Bush administration's credit, the president's 2006 budget proposal abandons the notion of capping federal Medicaid spending. Instead, the president's budget proposes specific policies to achieve savings without reducing Medicaid's capacity to respond to changes in the economy. Regardless of the advantages and disadvantages of these budget proposals, it is commendable that the administration accepted the responsibility of suggesting particular policy changes and keeping the program's basic structure intact, rather than

simply proposing limits on federal funding and then letting states take the heat for deciding where the ax should fall. However, interest groups and some in Congress have kept alive the idea of capping some or all federal Medicaid spending, as has HHS Secretary Michael O. Leavitt in some of his comments.

In addition to following the basic rule of doing no harm, federal officials could consider using unemployment rates as automatic triggers that increase federal matching funds for state Medicaid programs. For 2003-2004, Congress increased federal matching fund rates to help states cope with the recent economic slowdown, which forestalled Medicaid cuts in 31 states. However, the change in federal match was temporary, enacted after prolonged federal debate. If such increases were instead made automatic, the resulting economic stimulus could be substantially more effective because it would begin precisely when it was needed and would end promptly, when no longer required.

Besides enhancing the economic stimulus provided by Medicaid during hard times, an automatic adjustment in federal matching rates could also help Medicaid do a better job serving its low-income constituents. Currently, whenever recession hits, Medicaid caseloads grow but state revenue drops. Faced with constitutional requirements to balance their budgets, states often make significant cuts to Medicaid precisely when the economy sours and assistance is most needed. If, instead, federal funding levels automatically rose along with unemployment rates, states could avoid deep cuts during economic downturns, preserving health coverage of those most in need and enhancing the program's support for the economy as a whole. □

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Factors Affecting the Health of Men of Color in the United States

By *Wilhelmina A. Leigh*

Men of color face many challenges in achieving and maintaining good health. Their socioeconomic circumstances and cultural norms, as well as society's discriminatory treatment of men of color, often engender in these men unhealthful responses. In addition, our nation's health care safety net has gaping holes when it comes to low-income men, many of whom are men of color. The more than 40 million men of color (Hispanic or Latino men, and non-Hispanic men who are American Indian or Alaska Native, Asian American, Black or African American, and Native Hawaiian or Other Pacific Islander) represent about 30 percent of all men in the United States. This article provides a brief summary of their health characteristics and the factors that influence these characteristics.

Health Characteristics

Life expectancy in the United States is lower for men than for women, with the gaps between men of color and women of color far greater than between white men and women. According to the most recent data, the two major causes of death for men of color are diseases of the heart (cardiovascular diseases) and malignant neoplasms (cancer). Hypertension, a major cause of heart disease, affects a third or more of American Indian/Alaska Native men and African American men. Three main types of cancer (lung and bronchus, prostate, and colorectal) account for half of the deaths due

to this second-ranked killer of men. Unintentional injuries are the third-ranked killer of all except Asian and Pacific Islander men, for whom cerebrovascular diseases are third-ranked. HIV infection and AIDS also are major causes of illness and death among African American and Latino men. (A majority of the cases of HIV infection and AIDS reported by men of color result from male-to-male sexual contact and injection drug use.) In addition, one out of every nine African American men, compared with one out of every 25 white men, has diabetes mellitus.

Factors Influencing the Health of Men of Color

The major factors that influence health (for all people) fall into five domains: genetic and gestational endowments; social circumstances; environmental exposures; behavioral choices; and medical care. While only about two percent of all deaths in the United States are attributable to genetic diseases, as much as 60 percent of late-onset cases of diabetes, cancer, and cardiovascular disease may have a genetic component.

The health of men of color is influenced by numerous social circumstances, three of which (limited education, scarce employment opportunities, and limited income) converge in the workplace, which is a source of some of their health problems (e.g., lack of health insurance, exposure to environmental toxins,

and stress). Economic marginality is also a contributing factor to the overrepresentation of men of color among the following populations: homeless individuals, incarcerated persons, substance abusers, and people with severe mental illness. In addition, lifestyle and behavioral choices—related to diet, physical activity, sexual activity, one's approach to safety, and strategies for coping with stress—are important determinants of health. Although sizable numbers of persons in the United States lack health insurance, men of color are the most likely to be uninsured among all gender and race categories and, thus, the most likely to lack access to quality health care.

The health needs of men of color could be better addressed by actions that would enhance the health care of all people of color. These include larger samples of racial/ethnic subgroups in health surveys, mandated collection of racial/ethnic identifiers in health care settings, and culturally competent care. In addition, targeted measures—such as expanding government health insurance coverage for low-income men and mandating gender specific standards for men's health care—could further improve the health of roughly a third of the male population of the United States. □

*Wilhelmina A. Leigh is a senior research associate at the Joint Center. For further information see the report, *Factors Affecting the Health of Men of Color in the United States*, which may be accessed at www.jointcenter.org.*

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