



How Far Have We Come in Reducing Health Disparities?: Progress Since 2000: Workshop Summary

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Karen M. Anderson, Rapporteur; Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities; Board on Population Health and Public Health Practice; IOM

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HOW FAR HAVE WE COME IN REDUCING HEALTH DISPARITIES?

Progress Since 2000

Workshop Summary

Karen M. Anderson, *Rapporteur*

Roundtable on the Promotion of Health Equity and the
Elimination of Health Disparities

Board on Population Health and Public Health Practice

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OF THE NATIONAL ACADEMIES

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Willing is not enough; we must do.”*

—Goethe



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This report has been reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise, in accordance with procedures approved by the National Research Council's Report Review Committee. The purpose of this independent review is to provide candid and critical comments that will assist the institution in making its published report as sound as possible and to ensure that the report meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the process. We wish to thank the following individuals for their review of this report:

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1

Introduction¹

At the turn of the 21st century, several important reports and events on health disparities took place. These efforts were designed to raise awareness of health disparities and to describe initial efforts to reduce health disparities.

In 2000, the Surgeon General's office released several reports that showed dramatic disparities in tobacco use and access to mental health services by race and ethnicity (HHS, 1999, 2000). People of color were found to experience worse health outcomes than whites, and evidence of both higher levels of tobacco use and lower levels of access to necessary mental health services compared with those for the majority white population was detected.

At the same time, the first real legislation focusing on the reduction of health disparities was passed by Congress and signed into law by President Bill Clinton. Among other actions, the law created the National Center for Minority Health and Health Disparities within the National Institutes of Health (NIH) and authorized the Agency for Healthcare Research and Quality to measure progress on the reduction of disparities on an ongoing basis.

A year later, in 2001, the Institute of Medicine (IOM) released a land-

¹ The planning committee's role was limited to planning the workshop, and the workshop summary has been prepared by the workshop rapporteur as a factual summary of what occurred at the workshop. Statements, recommendations, and opinions expressed are those of individual presenters and participants, and are not necessarily endorsed or verified by the Institute of Medicine, and they should not be construed as reflecting any group consensus.

mark report, *Crossing the Quality Chasm: A New Health System for the 21st Century*. The report highlighted the importance of a focus on health care quality rather than a focus only on access and cost issues. And in 2003, the IOM released *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, the first comprehensive documentation that racial and ethnic minorities have less access to health care and that the care these groups do have access to is often of poor quality.

Building upon these seminal reports, the IOM held a workshop on April 8, 2010, that discussed progress to address health disparities and focused on the success of various federal initiatives to reduce disparities. The workshop's statement of task was as follows:

The Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities uses public workshops to inform its meetings and discussions on relevant topics. An ad hoc committee will plan and conduct the workshop that will feature invited presentations and discussions. The planning committee will define the specific topics to be addressed, develop the agenda, select and invite speakers, and moderate the discussions. The workshop will explore progress in reducing health disparities and promoting health equity in the past decade.

One essential task is to look at various kinds of intervention strategies to improve health outcomes in vulnerable populations, particularly in the present context of enduring economic inequality for people of color nationwide. Additionally, there are state and local efforts under way to reduce health disparities (IOM, 2011) that involve collaboration among agencies at the federal, state, and local levels such as the Centers for Disease Control and Prevention's (CDC's) REACH (Racial and Ethnic Approaches to Community Health) program as well as collaborations with local universities. Several of these collaborative efforts were presented during the workshop.

SCOPE OF THE WORKSHOP

On April 8, 2010, the IOM's Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities sponsored a public workshop to focus on what, if any, progress has been made to address health disparities. The workshop had three major objectives: first, to assess the progress that has been made; second, to consider the scope and effectiveness of efforts to address the social determinants of health disparities; and third, to determine what still needs to be elucidated about efforts to address social determinants and reduce health disparities.

The workshop, *Ten Years Later: How Far Have We Come in Reducing Health Disparities?*, was organized to further advance the dialogue about health disparities by facilitation of a discussion of the topic among stake-

holders, including members of the community, academia, the health care community, and business; policy makers; and philanthropic organizations. The goal of the meeting was to consider the progress—or lack thereof—that has been made over the past decade to reduce health disparities. The workshop also highlighted federal, state, and local efforts to reduce health disparities.

WORKSHOP AGENDA

Following introductory comments by Roundtable chair William Vega, a panel of three experts addressed the question of what progress to reduce health disparities has been made. Brian Smedley of the Joint Center for Political and Economic Studies, David Williams of Harvard University, and Steven Woolf of Virginia Commonwealth University shared their thoughts from a historical perspective.

This panel presentation was followed by remarks from the assistant secretary for health of the U.S. Department of Health and Human Services, Howard Koh. A panel titled Federal Perspectives on Reducing Health Disparities featured presentations by John Ruffin of the National Center on Minority Health and Health Disparities (NCMHD)² of NIH and Carolyn Clancy from the Agency for Healthcare Research and Quality.

Presentations focusing specifically on the topic of disparities in childhood obesity were then given by Roundtable member Mildred Thompson, who discussed the obesity program of the Robert Wood Johnson Foundation Center to Prevent Childhood Obesity, Susan Sher of the President's Task Force on Childhood Obesity, and Mary Lou Fulton of The California Endowment's Building Healthy Communities program in California.

A distinguished panel of presenters addressed the question, What do we still need to learn about reducing health disparities? Dennis Andrulis, Roundtable member Anne C. Beal, and Paula Braveman shared their thoughts.

The final panel of the day featured presentations by three congressional staff members. Each provided an update on the status of health care reform legislation and its potential to affect health disparities. At the end of each panel, a question-and-answer period was included.

² At the time this workshop was held, NCMHD was still a center. Since the passage of the Patient Protection and Affordable Care Act (ACA), the center was elevated to an NIH institute, now known as the National Institute on Minority Health and Health Disparity (NIMHD).

KEY THEMES

Throughout the workshop, individual speakers and workshop participants highlighted several recurring themes:

- **Persistence of health disparities.** Health disparities are not going away. Many participants agreed that health disparities have persisted over time and across the life course. Furthermore, people of color experience an earlier onset and a greater severity of negative health outcomes.
- **The state of the economy.** Several participants noted that the current economic downturn has had—and will continue to have—serious effects on health, particularly for low-income families and people of color. Living in poverty is a major risk factor for poor health outcomes. Furthermore, race/ethnicity and income are inextricably intertwined in the United States.
- **Race and racism.** Despite a general feeling that the United States is in a “postracial” period (e.g., Whitehead, 2009), several participants noted that institutional racism and racial discrimination are very much alive and well. Institutional racism and its effects have well-documented negative effects on health outcomes.
- **The importance of place.** Many speakers discussed the important role of community environmental factors in influencing health outcomes. Residential segregation continues to be a major problem for people of color living in low-income communities.
- **Awareness of health disparities.** The need to raise awareness of the existence of health disparities in the United States continues to be important; several speakers commented on the low levels of awareness of health disparities by the general public.
- **Health in all policies.** Many participants commented that although the integration of large governmental sectors and policies is complex, it is necessary to improve health outcomes for all people. Several major federal efforts to infuse health into the policies of federal agencies other than those directly related to health are under way.
- **The role of the community in creating a health disparities agenda.** Throughout the day, it was noted that health disparities cannot be addressed without input from the local community level. Additionally, communities themselves are creating their own health initiatives, often funded by the philanthropic sector.
- **The promise of the Patient Protection and Affordable Care Act (ACA).** There are a number of provisions in the law that promote health equity by increasing access to health care and making health insurance more affordable. Throughout the day, participants

described the potential for reducing disparities through the implementation of the ACA.

- **Other topics for further research.** A number of participants mentioned the challenges involved with measurement of cultural competence, the need to bring interventions to scale, and the critical role that prevention plays.

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2

What Progress in Reducing Health Disparities Has Been Made?: A Historical Perspective

William Vega noted that a decade has passed since several seminal reports on health disparities were released, including Surgeon General David Satcher's series of reports showing dramatic racial and ethnic disparities in morbidity and mortality rates and in certain risk behaviors, such as tobacco use (HHS, 1998). He also noted that members of racial and ethnic minorities have access to a lower quality of health care services than majority group members.

At about the same time, the Institute of Medicine (IOM) published its routinely cited study focusing on health care quality, *Crossing the Quality Chasm: A New Health System for the 21st Century* (IOM, 2001). Furthermore, in 2000, the first federal legislation focusing on the reduction of health disparities was signed into law.

Taken together, these developments helped shine a light on the problem of health disparities. Even today, however, some dominating issues continue to perplex the field because they are not easy to disentangle. First, no agreed-upon definition of "health disparities" exists. To effectively monitor changes in health disparities, definitions that are widely accepted need to be available. Furthermore, although data indicate that some health indicators are improving for all racial and ethnic groups, the gap between groups remains constant.

Second is the issue of scale. When the promotion of healthy lifestyles across the life course is considered, the integration of large sectors and policies across sectors that have never before been integrated can seem daunting. Moreover, sectors such as housing, transportation, and energy are

not typically associated with health, which makes efforts to integrate these sectors into promotion of healthy lifestyles more complex.

Finally, the magnitude of the effort that is necessary to eliminate health disparities should be acknowledged. Because the problem of health disparities is so intransigent, an effort of a magnitude appropriate to the scale of the problem should be made.

BUILDING STRONGER COMMUNITIES FOR BETTER HEALTH: MOVING FROM SCIENCE TO POLICY AND PRACTICE

Brian Smedley is director of the Health Policy Institute at the Joint Center for Political and Economic Studies. His presentation focused on policy and programmatic trends that relate to health inequities and the progress that has been made in addressing these trends.

Challenges to Advancing the Health Equity Agenda

Advancing the health equity agenda has three major challenges, said Smedley. First, the effects of the current economic downturn cannot be underestimated. It is likely that over the next few years the data will show that health inequities have widened rather than narrowed.

Second, the perception among Americans that the United States is now in a postracial period is inaccurate, Smedley said. Because the country has an African American president and because many people of color are leading major corporations, some believe that U.S. society is now color-blind (e.g., Cho, 2009). The research shows, however, that structural inequalities and racial discrimination persist at significant levels.

One example of this line of research uses matched-pair testers. By this approach, two people—one white and one Latino or African American—are equally matched on levels of education, personality, clothing, and so on. The two people are then sent out into a community to apply for jobs, obtain rental housing, apply for a mortgage, or seek to purchase a home. Studies consistently show that the paired tester of color receives poorer treatment, on average (Turner et al., 2003).

In one study that was replicated in two different cities, Pager (2003) found that when the paired testers—one white member with a criminal background and one African American member with no criminal background—were sent out to seek employment, the white member of the pair had a better chance of being hired for a job than the African American member. These findings, Smedley explained, show the depth of the persistent discrimination experienced by people of color in the United States.

The third challenge is the value that American society places on the strong individual determinist ideal. Americans believe that their success is

determined by how hard they work and how hard they pull themselves up by their own bootstraps. The nation is oriented toward personal responsibility, said Smedley. This orientation means that people fail to pay attention to context or environmental factors, but the context in which a person is born affects the life opportunities available to that person.

One example of the tendency to ignore environmental influences on individual behavior can be found in research on local retail food environments. Low-income neighborhoods frequently lack decent grocery stores, and the source of food is often limited to convenience stores, carryout places, and fast-food restaurants. These characteristics of low-income neighborhoods make access to nutritious foods difficult (Powell et al., 2007; Ver Ploeg et al., 2009). Moreover, Smedley noted that systematic differences in the quality of retail food available in different communities exist by race and geography.

Developments from 2000 to 2010

Smedley indicated, however, that it is important to acknowledge that some major developments in both the governmental and private sectors to address health inequities occurred between 2000 and 2010. During that period, the increase in the levels of attention and awareness about health inequities by all levels of government and by the general public was dramatic.

The federal government, in particular, is making significant efforts to address health inequities. For example, the Patient Protection and Affordable Care Act (ACA) of 2010 will help improve access to care for many and will disproportionately improve access for low-income people and people of color. Smedley commented that more needs to be done in the area of community-based primary prevention. However, an important development is the elevation of the National Center on Minority Health and Health Disparities to an institute within the National Institutes of Health so that it is now the National Institute on Minority Health and Health Disparities.

The federal government also addressed health inequities through the stimulus funding provided through the American Recovery and Reinvestment Act of 2009, which led to the creation of the Communities Putting Prevention to Work initiative. Smedley stated that this initiative is critically important because it focuses on the importance of place and the need to create healthier conditions within communities.

The private sector has also provided important leadership in this area. In fact, earlier in the decade, Smedley said, private-sector leadership was critical in bringing attention to health inequities. For example, both the Robert Wood Johnson Foundation's Commission to Build a Healthier America and the Kellogg Foundation's ongoing focus on health inequities

and racial healing led to major efforts to reduce health inequities. Similarly, The California Endowment is emphasizing the importance of place and the need for investing in communities. Finally, initiatives of the Kaiser Family Foundation and the MacArthur Research Network on Socioeconomic Status and Health are taking significant steps to advance efforts to reduce health inequities.

Scientific advances have played a role in educating elected officials and the general public about the causes of health inequities. One example of such an advance is the debunking of the use of race as a biological construct. Race has no genetic or biological basis, explained Smedley, but rather is a social construct and should be studied as such. It is still essential to study race as a social construct because of its implications for health inequities and because in the United States race often structures opportunity in powerful ways. According to Smedley, “It is the lived experience of race in America that has biological and health consequences. So this is where our focus needs to be.”

Smedley believes that a greater appreciation of the social determinants of health exists today. Research findings accumulated over the past 20 years make it clear that social and economic inequalities shape many of the health disparities in the United States. In particular, the role of residential segregation in shaping health inequities cannot be underestimated.

Residential Segregation

Although much progress in the desegregation of communities was made in the aftermath of Jim Crow laws¹ and other legal means of enforcing racial segregation, segregation persists at high levels in the United States, Smedley said. Describing patterns of residential segregation in the United States, Smedley explained that demographers use an index called the “dissimilarity index” (Massey and Denton, 1988), which is the percentage of people in a defined geographic area who would have to move to create integration in that area. Detroit, Michigan, for example, has a dissimilarity index of 85; in other words, 85 percent of white and African American Detroiters would have to move to create racial integration.

Residential segregation in many other U.S. cities is not far behind that in Detroit. Milwaukee, Wisconsin; New York City; Chicago, Illinois; and Newark, New Jersey, all have dissimilarity indexes of 80. In other words, four out of five residents of those cities would have to move to achieve integration in those cities.

An additional link can be drawn between residential segregation and

¹ Jim Crow laws were enacted in southern states and localities after the Civil War in order to institutionally segregate African Americans and whites (Woodward, 1955).

the percentage of people of color who live in communities with highly concentrated poverty (defined as 30 percent or more of the population living below the federal poverty line). A large body of research shows that living in these communities is harmful to people's health. This is because health-enhancing resources (access to physician care, for example) are generally harder to find in these communities. At the same time, conditions that present health risks (for example, environmental degradation, lack of access to healthy food, and lack of access to appropriate outdoor spaces that encourage physical activity) are generally more prevalent in these communities.

For example, no single major chain grocery store is located within the Detroit city limits. Therefore, a person living in Detroit has to go outside Detroit, to the suburbs, to purchase low-cost fresh fruit and vegetables. Furthermore, because little public transportation is available, a person living in Detroit without a car will find it nearly impossible to maintain a healthy diet.

Figure 2-1 shows that the percentage of poor families living in high-poverty neighborhoods declined from 1960 to 2000 (although in every decade, more African American families than families in other racial and ethnic groups still lived in high-poverty neighborhoods). In 1960, for example, about 64 percent of poor African American families and about 54 percent of poor Latino families lived in high-poverty neighborhoods.

However, Smedley noted that the decline was more rapid for poor

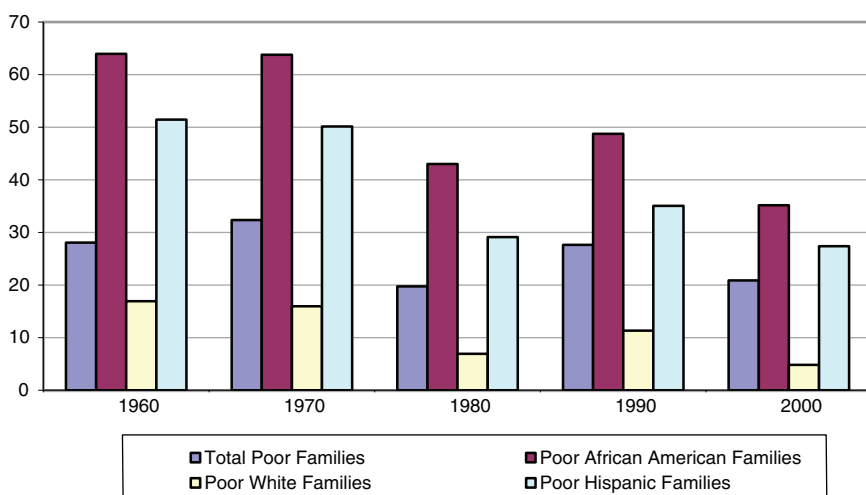


FIGURE 2-1 Percentage of poor families living in high-poverty neighborhoods (poverty rate of 30 percent or more), 1960 to 2000.

SOURCE: The Opportunity Agenda (2006).

white families than for African American or Latino families living in high-poverty neighborhoods (Figure 2-1). What, then, is the relative risk that families of color (relative to white families) live in neighborhoods of concentrated poverty? In 1960, the relative risk for African American families was 13 (that is, African American families were 13 times more likely than white families to live in high-poverty neighborhoods). By the year 2000, the relative risk had increased to 36: African American families were 36 times more likely to be living in a community with high concentrations of poverty. The same trend can be seen for Latino families (Figure 2-2).

A more specific look at poor families shows that poor African American families were almost six times as likely as poor white families to live in a high-poverty neighborhood in 1960. By 2000, that relative risk had increased to 11. Poor Latino families were four times as likely as poor white families to live in a high-poverty neighborhood in 1960; by 2000, the relative risk had increased to 6.7.

What does this information mean? Although the overall percentage of poor families living in concentrated-poverty neighborhoods (Figure 2-2) declined, many families of color were left behind. Smedley speculated that this might be due to white flight from high-poverty neighborhoods.

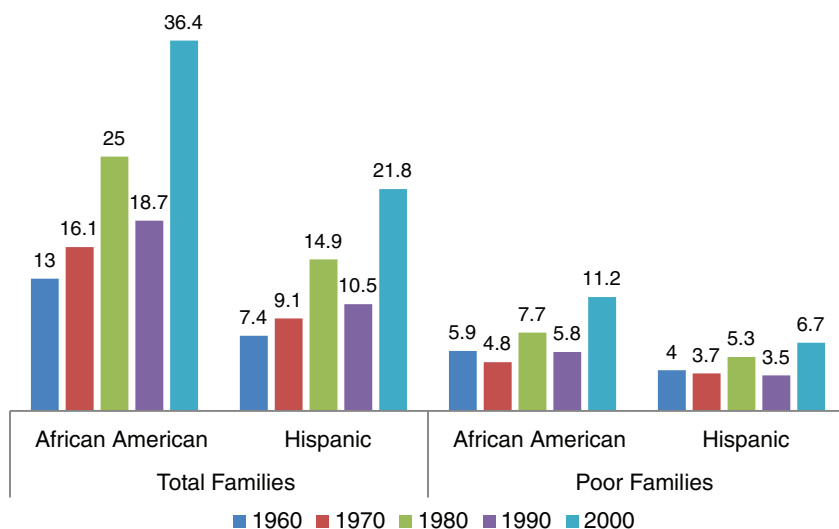


FIGURE 2-2 Relative risk of living in a neighborhood with concentrated poverty (40 percent or more). The relative risk for white families is 1.00. SOURCE: Smedley (2010).

Strategies for Addressing the Effects of Segregation on Health

Smedley concluded his comments by noting that two general strategies for addressing segregation and its relationship to health may be used. The first is a set of people-based strategies to increase housing mobility options. In this way, people would have the ability to move out of communities experiencing stress and disinvestment and into communities with greater investments.

The second set consists of place-based strategies, which are designed to increase investments in communities, thereby improving the conditions for better health in those communities. An example is the effort to provide incentives for large chain grocery stores to move into communities characterized as “food deserts.” Other place-based strategies include increases in investments in housing, transportation, and job creation. Dr. Smedley emphasized that these are the most important issues to be tackled to reduce health inequities.

WHERE DO HEALTH DISPARITIES STAND TODAY?

David Williams has an academic and research background in public health as well as in the social, cultural, and historical issues associated with the health of African Americans. His presentation focused on the status of health disparities in the United States today.

Persistence of Disparities Over Time

The first characteristic of health disparities that Williams pointed out is that racial and ethnic health disparities have persisted over time. For example, the rate of heart disease—the number one cause of death in the United States—has declined over time for both African Americans and whites. In 1950 (Figure 2-3), no disparity in rates of death from heart disease existed between African Americans and whites. However, even though rates of death from heart disease for both groups have steadily declined, since 1980, a gap in rates between whites and African Americans that was not present in 1950 has appeared.

A similar pattern exists for rates of death from cancer, which began increasing for both groups. In 1970, however, the rate for African Americans began to show a steeper increase than that for whites. Although by 1990 cancer death rates began to decline for both groups, a gap remains between African Americans and whites.

These gaps in death rates do not exist only between whites and African Americans. Data from the Indian Health Service (Figure 2-4) indicate that since the 1950s American Indians have consistently had higher rates of

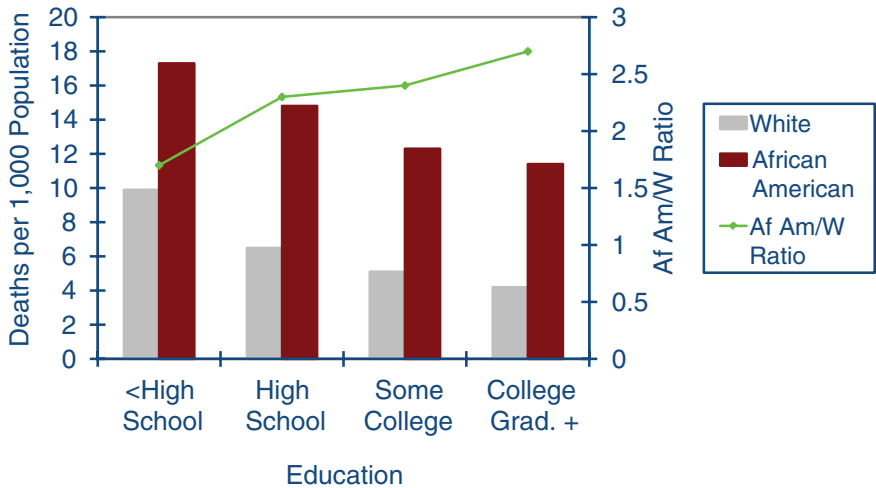


FIGURE 2-3 Rates of mortality from heart disease among African Americans (Af Am) and whites (W).
SOURCE: Miniño et al. (2007).

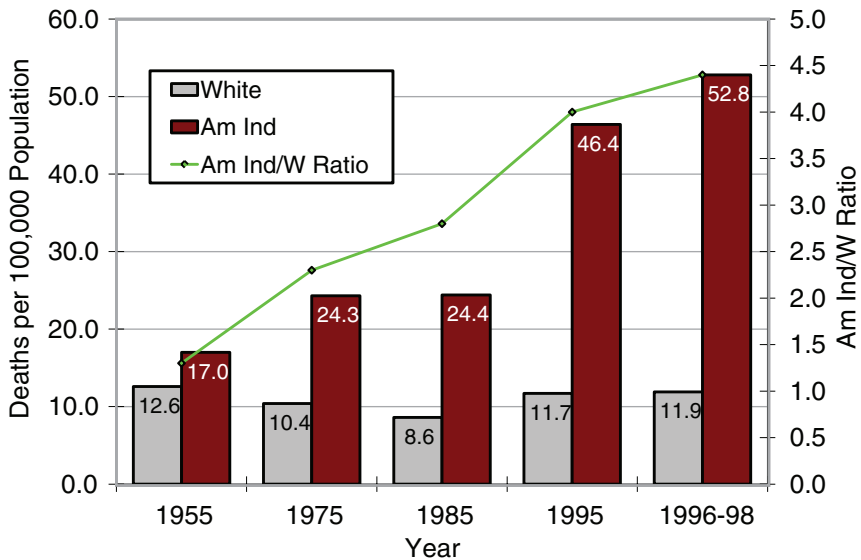


FIGURE 2-4 Rates of disparity in mortality from diabetes among American Indians (Am Ind) and whites (W), 1955 to 1998.
SOURCE: Indian Health Service (2001).

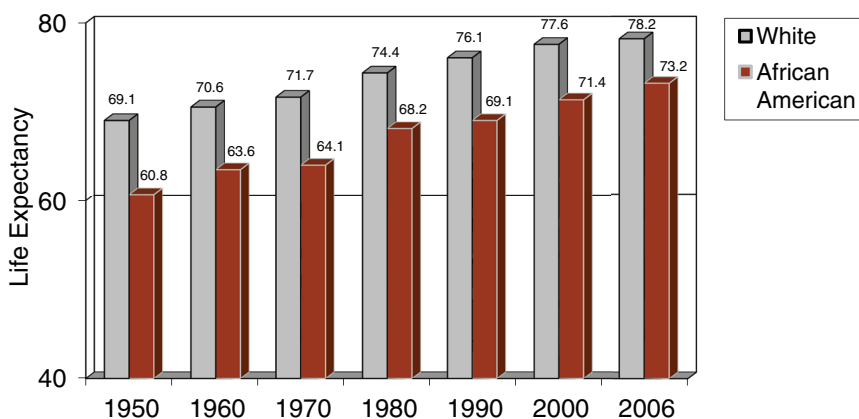


FIGURE 2-5 Life expectancy rates for African Americans and whites, 1950 to 2006.

SOURCE: Arias et al. (2010).

death from diabetes than whites. However, the rate has increased dramatically for American Indians and far outpaces that for whites.

Another way to document health disparities is to look at life expectancies for African Americans and whites (Figure 2-5), as life expectancy rates serve as a widely used indicator of health. In 1950, the life expectancy for whites was 69.1 years. However, it was not until 1990 that the life expectancy for African Americans reached 69.1 years, four decades later. In other words, it took African Americans 40 years to catch up to the life expectancy of white Americans in 1950.

Disparities Across the Life Span

A second characteristic of health disparities by race and ethnicity is that they exist across the life course. Beginning with the first part of life (under 24 years of age), ratios of the rates of mortality for minorities to rates for whites are the highest for infants and children from 1 to 4 years of age. For infants under 12 months, the mortality ratios are higher for African American and American Indian infants than white infants. For young children (ages 1 to 4 years), American Indians have the highest mortality compared to whites.

In midlife (ages 25 to 64 years), the mortality ratio for African Americans to whites is highest during every decade of life (25-34, 35-44, 45-54, and 55-64 years), followed by the mortality ratio for American Indians

to whites. The same pattern exists for ages 65 years and older, with the exception of the group age 85 years and older; although the mortality ratio for African Americans to whites is still the highest for that age group, the mortality ratio for Latinos to whites is higher than that for American Indians to whites.

In short, health disparities exist from the cradle to the grave, Williams said. Even since 1999, the data show elevated rates of mortality for African Americans and American Indians at all ages compared with those for whites. Moreover, mortality rates for African Americans are trending downward, while mortality rates for whites are trending upward. This is another disparity that exists over time and generations.

First and Worst

Having documented the higher death rates for minority groups than whites, Williams stated that not only are mortality rates higher for racial and ethnic minorities, but these groups must also contend with earlier disease onset and a greater severity of disease. Breast cancer is a good example of a disease with earlier onset for racial and ethnic minority groups and serves as a classic example of the need to look more closely at the data. Although white women have a higher overall incidence of breast cancer than African American women, this pattern is reversed for African American women under age 40 years.

Even worse, stated Williams, African American women are more likely than white women to be diagnosed with cancer when the cancer is at a more advanced stage, to have more aggressive forms of the cancer that are resistant to treatment, and to have what are called “triple-negative tumors” (tumors that grow more quickly, recur more quickly, and kill more frequently). African American women also have higher rates of mortality from breast cancer than white women. In short, although African American women have a lower overall incidence of breast cancer than white women, their health outcomes after breast cancer are worse for every indicator.

Major depression provides another example of “first and worst,” said Williams. National-level data indicate a lower overall prevalence of current and lifetime rates of major depression for African Americans than whites. However, those African Americans who are depressed are more likely than whites to be chronically depressed, to have higher levels of impairment, to have more severe symptoms, and to not receive treatment. Again, although the overall incidence of major depression is lower for African Americans than for whites, on every measure of severity, African Americans do more poorly.

One of the most striking examples of first and worst can be seen from the patterns of neonatal mortality for women having their first birth.

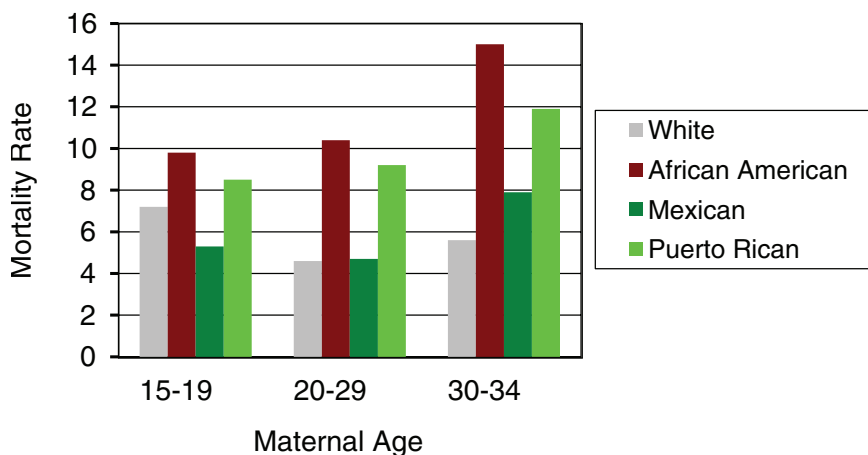


FIGURE 2-6 Neonatal mortality rates for first births in the United States.
SOURCE: Geronimus and Bound (1991) and CDC (1983).

For white women and Mexican American women (Figure 2-6), delaying childbirth until they are in their 20s or 30s results in lower mortality rates (Geronimus and Bound, 1990). In contrast, rates of neonatal mortality are higher when African American and Puerto Rican women delay their first births. The authors of the study explain this finding by suggesting that minorities living in disadvantaged circumstances and under adverse conditions have been physiologically compromised. Thus, their wait until later in life to have a child means that they have had greater exposure to adverse conditions at the time that they become pregnant. It should be noted, however, that as indicated by Figure 2-6, neonatal mortality rates are highest for African Americans across all three age groups, with Puerto Rican women the second highest across all age groups when compared to white and Mexican women.

Migration

Patterns of migration should be considered when health disparities are examined, Williams said, because migration has powerful influences on health. According to 2000 census data, almost 69 percent of Asians in the United States are foreign born and more than 40 percent of Latinos are foreign born. This is important because immigrants of all racial and ethnic groups have better health outcomes than their counterparts born in the United States. Across the board, Williams said, the data show this “healthy immigrant” effect.

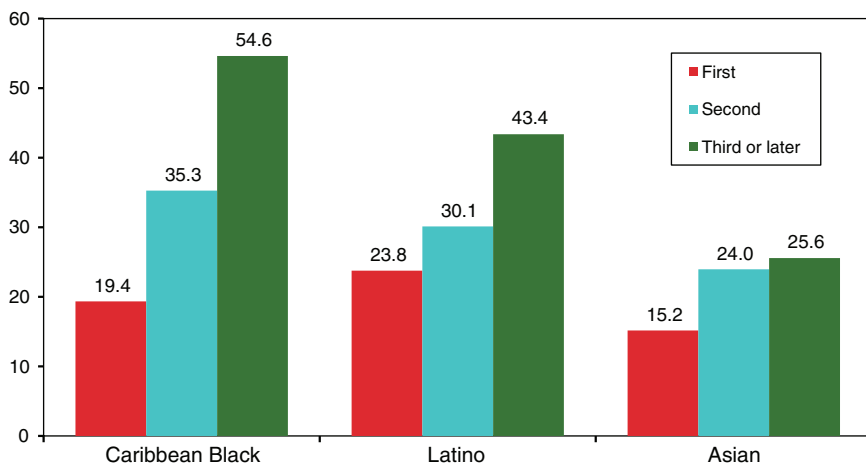


FIGURE 2-7 Lifetime prevalence of psychiatric disorders by race and generational status (in percent).

SOURCE: Alegria et al. (2007), Takeuchi et al. (2007), and Williams et al. (2007).

Unfortunately, the longer that an immigrant remains in the United States, the worse his or her health becomes. Similarly, declines in health outcomes are seen with an increase in generational status. That is, the longer that a family stays in the United States, the greater is the decline in health across a broad range of health indicators. Figure 2-7 shows an example of one worsening health outcome by generational status among three immigrant ethnic minority groups: lifetime prevalence of psychiatric disorder. What drives this pattern is not clear, said Williams, but it is critical to understand it and to consider what interventions can be implemented to reverse the trajectory of worsening health for immigrant populations over time.

Socioeconomic Disadvantage and Geographic Marginalization

For those populations that have lived in the United States for multiple generations (American Indians and African Americans), the data show a pattern that points to the roles of geographic isolation, residential segregation, and socioeconomic disadvantage in the creation and maintenance of health disparities. Williams noted that socioeconomic status, in particular, is one of the most powerful predictors of health status in virtually every society.

Census data from 2006 (Figure 2-8) demonstrate that although the

majority of people living in poverty in the United States are white, African Americans and Latinos are overrepresented in the population of poor Americans. African Americans make up 12.8 percent of the U.S. population but make up 23.1 percent of the people living in poverty. Similarly, Latinos make up 14.4 percent of the general population but represent almost 24 percent of the people living in poverty.

However, race/ethnicity and socioeconomic status are not interchangeable systems of inequality, said Williams. It is therefore essential to look at both of them together. Although socioeconomic status accounts for a large portion of health disparities, race/ethnicity is an added burden that is linked to poor health.

Data showing the relationship between the mother's level of education (which is closely related to socioeconomic status) and infant mortality illustrate this linkage. Figure 2-9 shows that even white mothers who are high school dropouts have lower infant mortality rates than college-educated

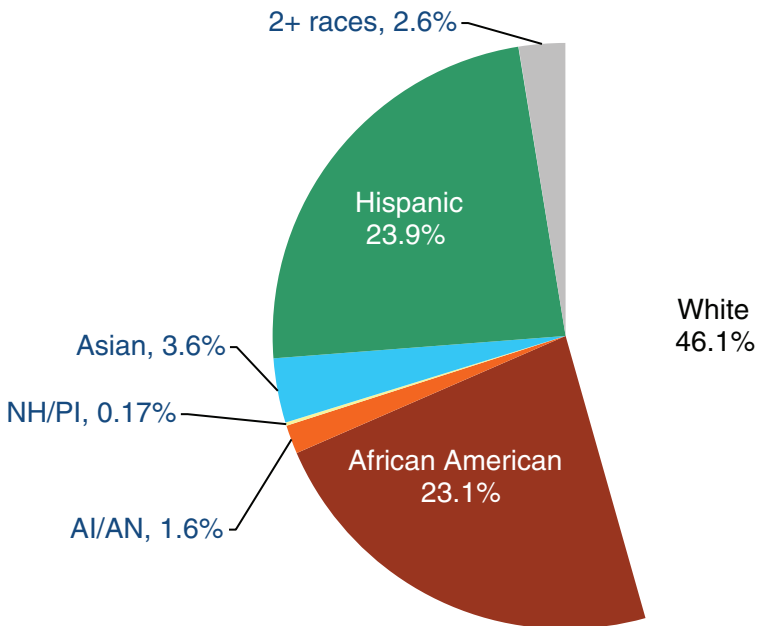


FIGURE 2-8 Racial/ethnic composition of people in poverty in the United States. AI/AN = American Indian/Alaska Native; NH/PI = Non-Hispanic/Pacific Islander. SOURCE: DeNavas-Walt et al. (2007).

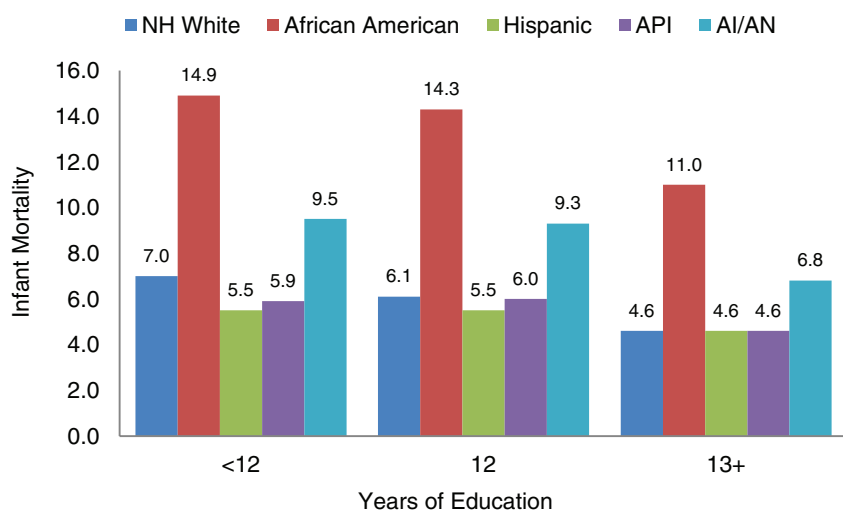


FIGURE 2-9 Infant mortality rate by mother's education (infant death per 1,000 live births).

AI/AN = American Indian/Alaska Native; API = Asian/Pacific Islander; NH = Non-Hispanic.

SOURCE: CDC (2001).

African American mothers. The best-off African American mothers had worse health outcomes than all other racial/ethnic groups (with the exception of American Indian/Alaska Native high school dropouts).

Williams posed the question, Why does race matter so much? Three different lines of research evidence can help provide an answer. First, indicators of socioeconomic status are not equivalent across races/ethnicities. Compared with whites, African Americans with the same level of education earn less income. Compared with whites with the same income level, African Americans have less purchasing power because of the higher costs of goods and services in the places where African Americans live. The dismaying conclusion is that people of color have far fewer assets and a lower net worth than whites, even low-income whites. This is called the "wealth gap."

Second, although current socioeconomic status has a major influence on health, exposure to social and economic adversity across the life course also influences health. For example, an African American woman who was herself born with a low birth weight is more likely to give birth to an infant with low birth weight. Clearly, early life adversities have long-term effects on health and on intergenerational health, said Williams.

Finally, Dr. Williams explained that personal experiences of discrimination and institutionalized racism affect the health of minority populations by multiple mechanisms. The effects of racism on health are not limited to the United States; data from Australia, South Africa, and New Zealand show the persistent health effects of exposure to discrimination and racism among people of color.

Residential segregation, too, has a disturbing effect on African Americans, Williams noted. Sampson and Wilson (1995) looked at the largest 171 cities in the United States. In none of those cities did African Americans and whites live under the same conditions and in the same circumstances. In fact, they found that the worst conditions for whites were better than the best conditions for African Americans. Residential segregation for the Latino population in the United States is also growing.

Access to Care

Not surprisingly, large differences in access to health care also exist between whites and people of color. Both Latinos and Native Americans have low levels of health insurance coverage. Among all people with some form of health insurance, Latinos, African Americans, and Native Americans are more likely to have some form of public health insurance, such as Medicaid, than private insurance.

Good health, however, is about more than just having access to care. It is critical to consider what happens before an individual needs to go to a doctor's office and to consider what is happening in the community where that individual lives. Where people live, work, worship, and play, said Williams, has a greater impact on health outcomes than having access to a physician. This means that it is essential to look at ways to reduce inequalities in the nonmedical social determinants of health. "We need to redefine health policy to include housing, employment, community development, income support, transportation, and environmental policies," he said.

Williams offered an example illustrating this. Since 1970, the group experiencing the biggest gains in overall life expectancy is African American women, and in fact, African American women have a higher life expectancy than white men. What caused this increase in life expectancy rates? Williams speculated that this increase is largely due to the positive health effects arising from civil rights policies. For example, the civil rights movement narrowed the economic gap between whites and African Americans by offering access to more and better jobs. Additionally, the desegregation of hospitals in the South due to civil rights policies led to the survival beyond infancy of an additional 5,000 to 7,000 infants between 1965 and 1975 due to access to better health care (Almond et al., 2006).

Unfortunately, since 1978, the African American–white income gap

has again widened; the situation got worse in the 1980s, leading to a decline in life expectancy for African Americans. Worsening of economic conditions during the 1980s led to worsening of health outcomes, a finding that points to the strong link between social and economic conditions and overall health.

Closing Comments

Williams concluded his comments with a list of resources for learning more about racial disparities in health and the role of social conditions in causing those disparities:

- The MacArthur Foundation Research Network on Socioeconomic Status and Health (www.macses.ucsf.edu)
- *Unnatural Causes: Is Inequality Making Us Sick?* (www.unnaturalcauses.org)
- Robert Wood Johnson Foundation's Commission to Build a Healthier America (www.commissionhealth.org)

The Robert Wood Johnson Foundation's Commission to Build a Healthier America also supports the establishment of national benchmarks for health. For example, the infant mortality rate serves as an indicator of overall health. The data show that even college-educated women of all races and ethnicities do not have a level of health that reaches the benchmark established by the commission. This finding can be interpreted to mean that the country as a whole is not enjoying the best health possible. Therefore, not only do the gaps in health need to be addressed, but also the health of Americans across all racial and ethnic groups must be dealt with, said Williams.

A recent report from the Joint Center for Political and Economic Studies documents the finding that these health disparities are quite costly (LaVeist et al., 2009). For example, health care costs, lost work productivity, and premature death are all significant costs, Dr. Williams explained. Furthermore, LaVeist and his coauthors concluded that the economy loses \$390 billion per year because of health disparities.

W.E.B. DuBois wrote about African American health in the publication *Philadelphia Negro*, noting that “the most difficult social problem in the matter of Negro health is the peculiar attitude of the nation toward the well-being of the race. There have . . . been few other cases in the history of civilized peoples where human suffering has been viewed with such peculiar indifference” (DuBois and Easton, 1899). Dr. Williams emphasized that it is time to consider what investments need to be made now to give every American child, of any race, ethnicity, or socioeconomic status, the tools to

be healthy and to achieve the American dream. Doing nothing has a cost that the United States should not continue to bear.

MAGNITUDE AND CONSEQUENCES OF HEALTH DISPARITIES

Steven Woolf, professor of family medicine at Virginia Commonwealth University, began his presentation by noting that his remarks have recurring themes: historic trends in the patterns of health disparities, levels of education, and income.

The first recurring theme involves historic trends in the patterns of health disparities. In 1963, for example, President John F. Kennedy noted that African Americans had a life expectancy that was 7 years shorter than that for whites. This disparity in life expectancy has persisted over the decades, as depicted in Figure 2-10.

Woolf commented that “in the back of our minds, most people understand that disparities are not a good thing for health.” In the United States, a tension between two competing arguments about how to reduce disparities exists. The first argument focuses on efforts to increase the efficacy and effectiveness of medical treatments. A huge amount of money is invested in this enterprise, with the goal of creating more powerful treatments and thereby doing a better job of providing health care. The second argument is that the focus should be on increasing equity and on closing the gaps

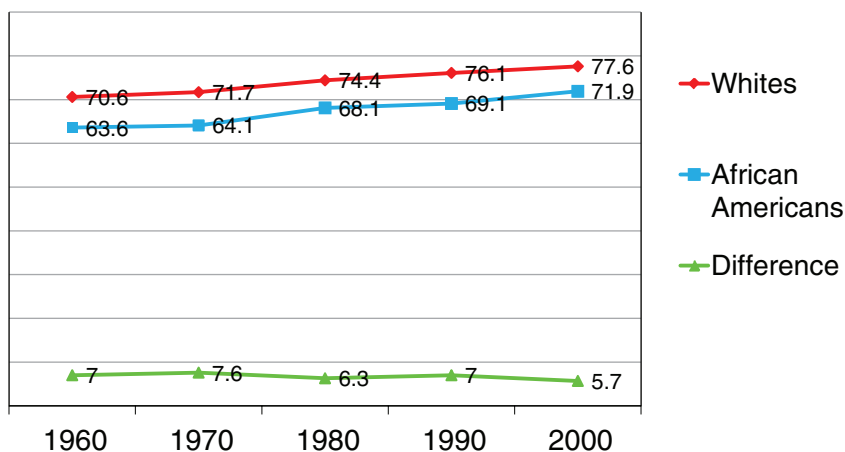


FIGURE 2-10 Life expectancy, 1960-2000.
SOURCE: Arias (2002).

in life expectancy between whites and people of color. Woolf argued that most people—including policy makers and members of the general public—believe that the first approach is going to achieve more substantial health improvements than the second one.

Describing an experiment he conducted to compare these two approaches (Woolf et al., 2004), Woolf and colleagues compared the number of lives saved by medical advances that resulted in a reduction of the number of deaths attributable to excess mortality among African Americans (176,663 deaths averted) with the number of lives saved when mortality rates between whites and African Americans are equalized (886,202 deaths averted). In other words, “achieving equity may do more for health than perfecting the technology of care” (Woolf et al., 2004, p. 2078). For each single life saved via biomedical advances, five would be saved by eliminating the discrepancy in mortality rates between African Americans and whites.

The second recurring theme involves levels of education. As discussed earlier in this chapter, it is clear that low levels of education mean worse health outcomes (Figure 2-11). It is also clear that stark disparities in

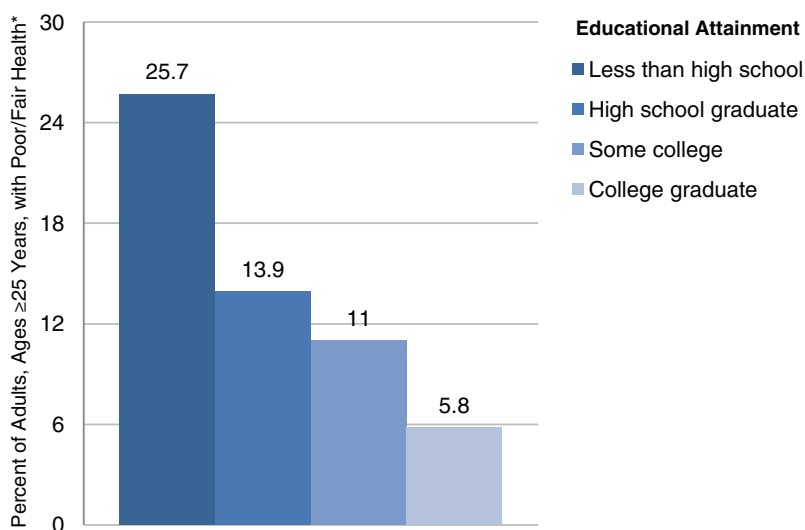


FIGURE 2-11 Less education is linked with worse health. Compared with college graduates, adults who have not finished high school are more than four times as likely to be in poor or fair health.

*Age-adjusted.

SOURCE: National Health Interview Survey, 2001-2005. Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco. © 2008 Robert Wood Johnson Foundation. www.commissiononhealth.org.

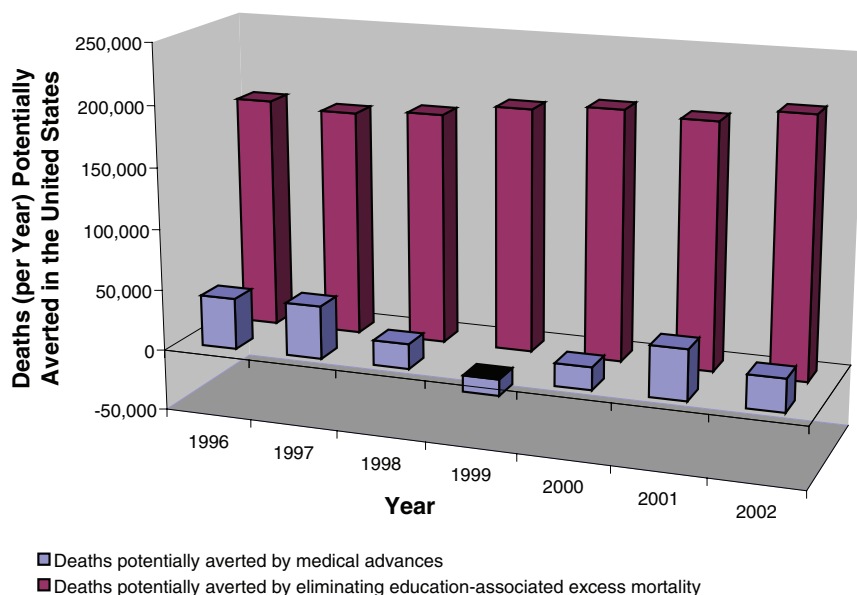


FIGURE 2-12 Deaths potentially averted by medical advances and elimination of education-associated excess mortality.

SOURCE: Woolf et al. (2007).

educational attainment exist among racial and ethnic groups. In a second study, Woolf and his colleagues (Woolf et al., 2007) again compared the number of potential lives saved by biomedical advances with the number of potential lives saved if every person over the age of 25 years had the mortality rate of people with some college education. They found that for each single life saved by biomedical advances, eight would be saved by addressing educational disparities, as seen in Figure 2-12.

The Robert Wood Johnson Foundation created a web-based interactive tool for the Commission to Build a Healthier America. The tool allows users to target a state or county of interest and then manipulate the educational attainment of the population in that state or county. The tool shows the user how many deaths could be averted if educational attainment was improved. (As of December 2009, the Robert Wood Johnson Foundation's Commission came to a close; however, information may still be found at the following link: <http://www.commissiononhealth.org/Education.aspx>.)

Along with race/ethnicity and education level, income is a third recurring theme affecting health inequities. Over the past decade, the United States has seen a widening gap between the rich and the poor. Describing a recently published study of Virginia, Woolf compared the richest and

poorest counties. If the mortality rate of the richest counties was applied to everyone in the state, 25 percent of all deaths would not have occurred.

Woolf concluded his remarks by circling back to the issue of clinical care. As seen in Figure 2-13, health is more than health care, and health is more than just individual behavior choices. When disparities are discussed, much of the attention in the past has focused on how disparities in the way in which patients are treated and managed can be reduced or eliminated. Although vitally important, Woolf stated that efforts to reduce discrimination in clinical settings have a relatively marginal impact on the reduction of health disparities. Rather, the focus needs to be on the root causes of health disparities, including the living and working conditions in the communities where people live. These factors, said Woolf, play a much larger role in health disparities than anything that is a part of clinical care. Furthermore, the larger economic conditions—poverty, low educational attainment—have an even greater role in health disparities.

The movement toward a “health in all policies” approach to shaping public policy will improve health conditions for all. For example, promoting transportation policies that make it easier for people to walk and bike in their communities will affect health, as will the promotion of housing policies that support reduced exposure to lead and radon in the home. In short, Woolf concluded, it is time to begin thinking more broadly about

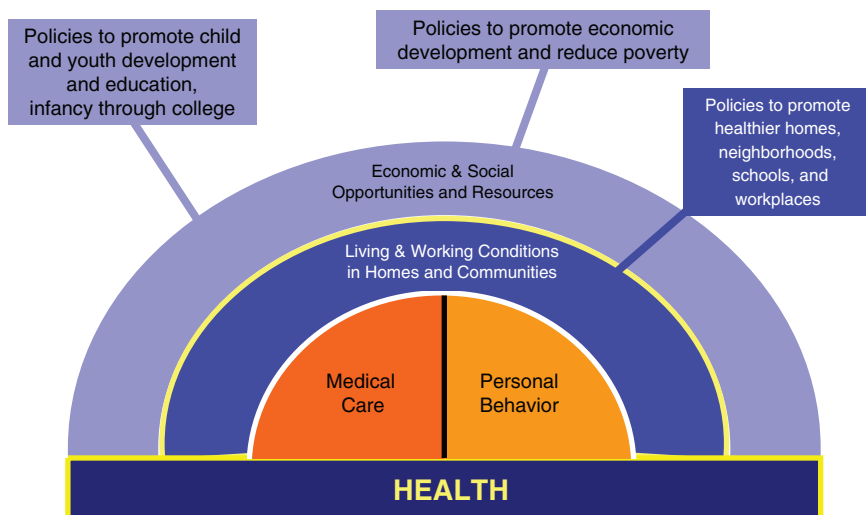


FIGURE 2-13 Importance of social factors.

SOURCE: Robert Wood Johnson Foundation, Commission to Build a Healthier America (2009).

public policy approaches to the elimination of health disparities. This will involve thinking about policy issues that are typically thought of as being outside the health arena.

DISCUSSION

Ruth Perot of the Summit Health Institute for Research and Education raised the issue of community engagement and the importance of connecting systems changes with the political process. David Williams commented that most Americans from all racial and ethnic groups are still unaware of the existence of health disparities. Although these issues have been discussed for years, even most African Americans are unaware of the disparities in rates of infant mortality and life expectancy between African Americans and whites. Thus, the issue of first raising awareness is critical. One powerful tool for raising awareness of health disparities at the community level is the *Unnatural Causes* television series, Williams pointed out.

Additionally, since the election of President Barack Obama, many Americans believe that race is less of an issue now than in the past. Because of this general feeling that race is less of an issue, people are less supportive of policies to address racial inequities in the United States, Williams noted.

Brian Smedley commented on the growing recognition that any effort to intervene in the reduction of health disparities needs to include the community as a partner. Some pragmatic solutions can be implemented at the local level, for example, solutions involving land use policies and zoning. However, these solutions cannot be put into place without meaningful community engagement.

Much of the action to address health inequities is taking place at the local levels, Smedley said. However, health disparities will not be completely solved until the broader issues of social and economic inequalities are addressed because stark differences in access to opportunity exist between people of color and whites in the United States.

Steven Woolf added that two large events that took place in the past 10 years have affected how Americans look at race and poverty: Hurricane Katrina and the ongoing recession and economic crisis. Hurricane Katrina brought brief attention to issues of poverty and race because of the television images of events in the lower Ninth Ward of New Orleans. Unfortunately, that attention did not last.

The ongoing economic crisis has also brought a brief focus on the issue of race and poverty, said Woolf. Because of the scope of the economic crisis, it has affected the middle class and more affluent groups in the United States, and now might be the time to try to build interest in addressing social issues, such as jobs and unemployment. They are no longer solely the problems of the lower classes.

Aida Giachello from the University of Illinois at Chicago described efforts under way in Brazil to improve health outcomes for all. First, the constitution was changed to include a statement that health care is a right and not a privilege. Second, policy makers in Brazil began to integrate health into all national policies, including housing, education, and commerce. Brazil recognizes that the health of a community cannot be improved without also improving the economic well-being of that community, and so health is an issue that cuts across all national policies.

With this background information, Giachello asked the panelists to again address the question of whether progress in the reduction of disparities in the United States has been made. Woolf responded that evidence of some positive trends can be seen; for example, educational attainment rates are increasing for all population groups in the United States. Positive trends from the health care sector are reductions in mortality rates and some increases in access to preventive services and other clinical services for disadvantaged populations. Unfortunately, the ongoing economic crisis does not bode well for the continuation of these positive trends.

Williams agreed that although some good news can be provided, the country nonetheless has a long way to go to reduce health disparities. However, he said, “The very fact that the IOM has a Roundtable on this topic is good news, and that is progress” because it means that these issues are being considered at the highest levels. Additionally, Howard Koh, assistant secretary for health of the U.S. Department of Health and Human Services, outlined the many prevention provisions in the health reform law (the ACA of 2010) that also mean good news, including additional resources for community health centers. The Obama administration also has a number of initiatives that address the social determinants of health in new ways. In short, Williams said, although much remains to be accomplished, these issues are receiving more attention than ever before.

Smedley concluded this conversation by commenting that he worries that the country is only “nibbling at the margins” rather than dealing with big policy questions. For example, public school systems across the United States are re-segregating to pre-*Brown v. Board of Education* levels. He believes that this is a disturbing trend because educational attainment is such a powerful predictor of health status. Wealth inequality between racial and ethnic groups is also increasing; along with the current economic downturn, this could lead to increasing—rather than decreasing—health inequities.

Chiquita Collins of the Altarum Institute raised a question about dismantling systemic institutional racism. Williams responded that a large body of scientific research documents the finding that exposure to racism at the individual level has pervasive adverse consequences on health status. Additionally, exposure to unfair treatment on the basis of race or ethnic-

ity adversely affects the health of all population groups, including whites. Therefore, he said, it is critical to treat racism as an important topic and to think about ways to achieve racial healing.

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3

Healthy People 2010: How Far Have We Come in Reducing Health Disparities?

Howard Koh, in his role as assistant secretary for health at the U.S. Department of Health and Human Services (HHS), oversees a broad portfolio of public health activities and programs. He has also served as a clinician, a professor, and a state health commissioner in Massachusetts.

As the assistant secretary for health, Koh says that he values the importance of the World Health Organization (WHO) definition of health: “a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity” (WHO, 1946). It is unlikely, however, that many societies and countries are meeting this standard of health.

The racial and ethnic disparities in health and well-being that people of color in the United States experience are also often referred to as “inequities.” These inequities are a major challenge in public health today. Health disparities or inequities can be viewed through multiple lenses (Figure 3-1). The left of Figure 3-1 shows population variables, including race/ethnicity and socioeconomic status. The lens of geographic location is on the right. Diseases are at the top, and risk factors, both individual and environmental, are at the bottom. These lenses overlap, depending on a host of real-world conditions (Koh et al., 2010).

HEALTHY PEOPLE

The assistant secretary for health at HHS oversees Healthy People, a comprehensive framework for improving the health of all Americans. Koh gave a broad overview of the Healthy People Initiative, the updated frame-

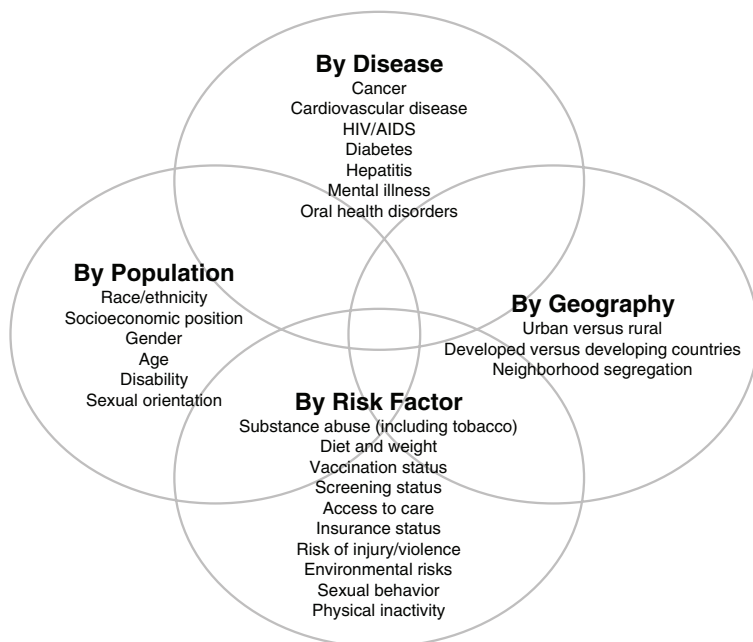


FIGURE 3-1 Multiple and overlapping lenses for viewing health disparities.
SOURCE: Koh et al. (2010).

work, and an overview of data regarding several Healthy People health indicators.

Healthy People began in 1979 under Julius Richmond, then assistant secretary for health and surgeon general. The document sets out health goals for the nation, and the framework is updated every 10 years. In 2010, *Healthy People 2010* (HHS, 2000) concluded a decade of an inclusive public process that reflected input and feedback from a diverse group of individuals and organizations nationwide. With 28 focus areas and 467 specific objectives, *Healthy People 2010* had two overarching goals: first, to improve both the quantity and the quality of life and, second, to eliminate health disparities.

Box 3-1 identifies the 10 leading health indicators, which cover 31 objectives. Preliminary findings show that over the past decade progress toward or achievement of the targets has occurred for about half of these objectives.

In another analysis of the leading health indicators in *Healthy People 2010*, Sondik and colleagues (2010) evaluated progress toward meeting the targets. They concluded that “although some progress has been made, there is much work to be done toward the *Healthy People 2010* targets

BOX 3-1 Leading Health Indicators

Ten indicators (31 objectives):

- Access to health care
- Environmental quality
- Immunization
- Injury and violence
- Mental health
- Overweight and obesity
- Physical activity
- Responsible sexual behavior
- Substance abuse
- Tobacco use

Preliminary findings show that over the past decade progress toward or meeting of the targets has occurred for about half of these objectives.

SOURCE: HHS (2000).

and both overarching goals” (p. 271). More specifically, they noted that no significant change in disparities had occurred for at least 70 percent of the leading health indicator objectives. The group seeing the fewest advances was American Indians/Alaska Natives.

A number of examples provide evidence of these disparities. Life expectancy (Figure 3-2) has steadily increased since 1970, although major disparities remain. African American males have the shortest life expectancy of all groups in Figure 3-2. HIV infection/AIDS is another area in which large disparities exist (Figure 3-3). African American men are at a particularly high risk of dying from HIV infection, despite the introduction of highly active antiretroviral therapy (HAART) in the mid-1990s.

For mortality rates due to coronary heart disease, the *Healthy People 2010* target of 162 deaths per 100,000 was met for all groups except African Americans. Heart disease remains the number one killer in the United States; however, African Americans have higher rates of mortality from coronary heart disease than other groups. Figure 3-4 shows the gap between the group with the highest rate of mortality (African Americans) and the group with the lowest (Asians); this gap needs to be narrowed going forward, Koh said. As Figure 3-4 demonstrates, the gap between the groups with the highest and lowest rates of mortality from coronary heart disease has remained constant over time.

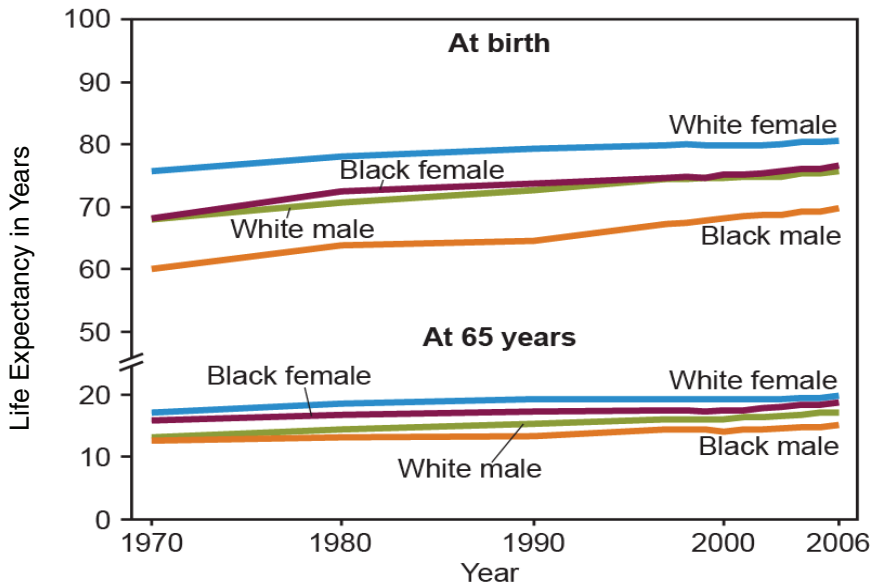


FIGURE 3-2 Life expectancy.
SOURCE: Arias et al. (2010).

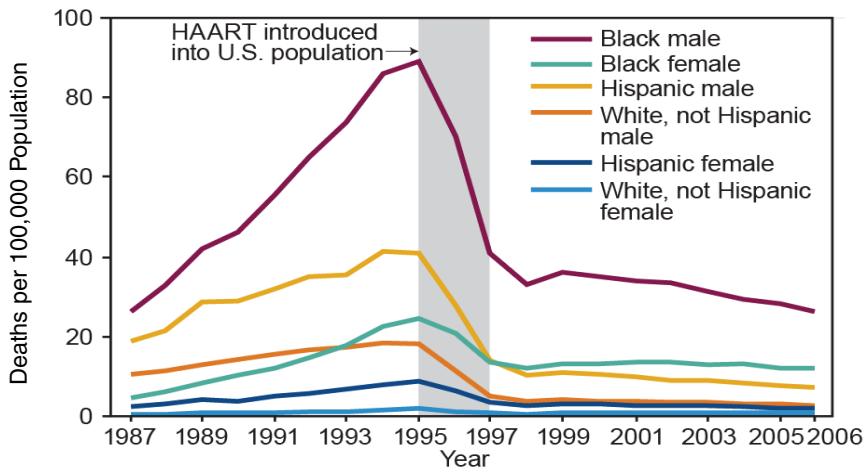


FIGURE 3-3 Rates of death from HIV infection and introduction of highly active antiretroviral therapy (HAART).
SOURCE: NCHS (2010).

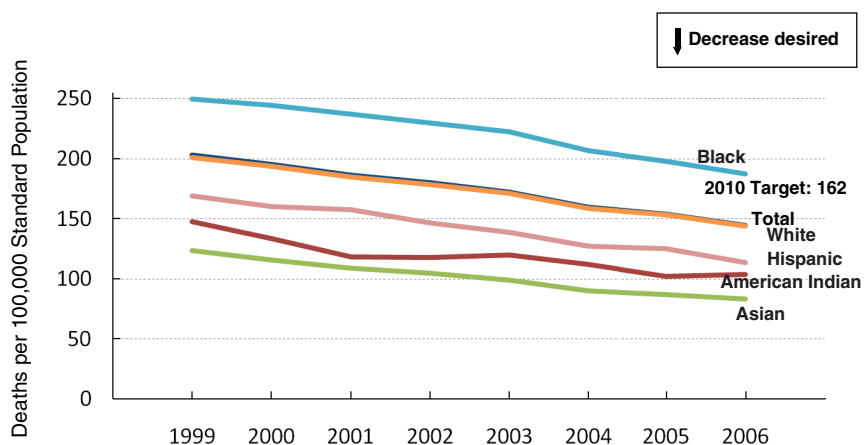


FIGURE 3-4 Rates of mortality from coronary heart disease.

NOTES: Data are age-adjusted to the 2000 standard population. American Indian includes Alaska Native. Asian includes Pacific Islander. The black and white categories exclude persons of Hispanic origin. Persons of Hispanic origin may be any race. Only one race category could be recorded.

SOURCE: Heron and Tejada-Vera (2009).

Mammography rates by race/ethnic group represent a piece of good news. The gap between the group with the highest rate of mammography screening (whites) and the group with the lowest (as of 2010, Latinos) has narrowed over time. However, the picture changes when rates of mammography are examined by socioeconomic status (Figure 3-5). The rates for poor and near-poor women are still far too low, especially compared with those for middle- and high-income women.

Data from the National Vaccine Program Office indicate that racial/ethnic disparities in childhood immunization rates have narrowed significantly since the mid-1990s. The same narrowing in adult immunization rates has not been seen, however.

Much current attention is focused on the trend of increased rates of obesity in the United States. Figure 3-6 clearly indicates not only how far the nation is from meeting the target, but also that the trends are worsening instead of improving. The issue of combating obesity will be discussed in more detail later in this summary.

Figure 3-7 provides data for another area in which the target has not been met—health insurance coverage rates. Latinos are the population group that is least likely to be insured. This finding that Latinos have the

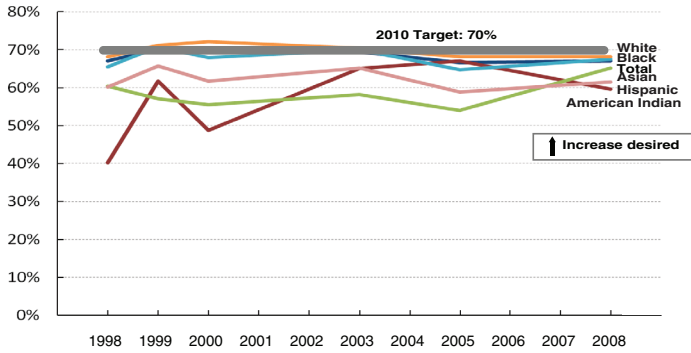


FIGURE 3-5 Rates of mammography screening from 1997 to 2009.

NOTES: Data are for women aged 40 years and older who received a mammogram within past 2 years. Data are age-adjusted to the 2000 standard population. American Indian includes Alaska Native. The black and white categories exclude persons of Hispanic origin. Persons of Hispanic origin may be any race. Only one race category could be recorded.

SOURCE: NCHS (2010).

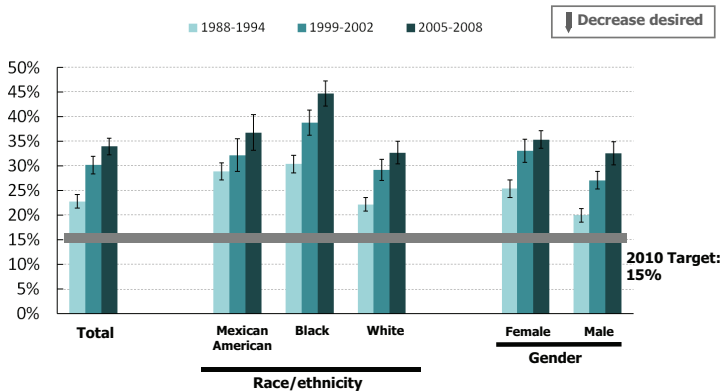


FIGURE 3-6 Obesity among adults ages 20 years and over.

NOTES: I = 95% confidence interval. Data are for adults aged 20 years and over and are age-adjusted to the 2000 standard population using the age groups 20-29, 30-39, 40-49, 50-59, 60-69, 70-79, and 80 years and over. Obesity is defined as BMI \geq 30.0. The black and white categories exclude persons of Hispanic origin. Persons of Mexican American origin may be any race. Prior to 1999, respondents were asked to select one race category; selection of more than one race was not an option. For 1999 and later years, respondents were asked to select one or more races. Data for the single race categories are for persons who reported only one racial group.

SOURCE: NHIS (2010).

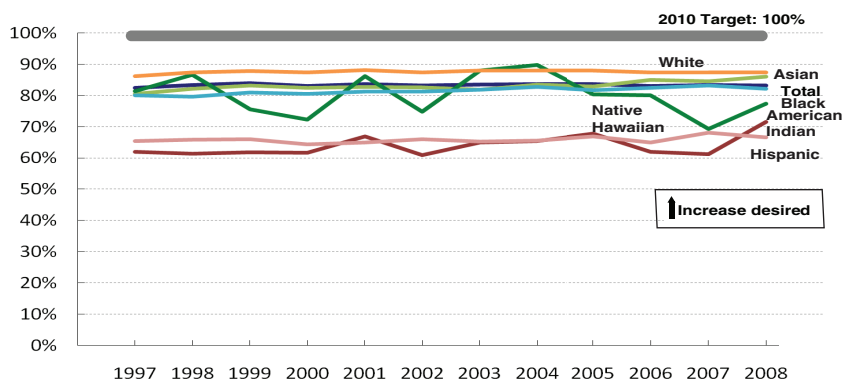


FIGURE 3-7 People with health insurance.

NOTES: Data are for adults under age 65 years who have any public or private health insurance. American Indian includes Alaska Native, and Native Hawaiian includes Pacific Islander. The categories black and white exclude persons of Hispanic origin. Persons of Hispanic origin may be any race. Respondents were asked to select one race prior to 1999. For 1999 and later years, persons were asked to select one or more races. Data for the single race categories shown are for persons who reported only one racial group.

SOURCE: NHIS (2010).

highest rates of uninsurance of all racial and ethnic groups remains true in Massachusetts, even after passage of health care reform legislation in that state (IOM, 2011).

Koh raised the question of how changes should be made to achieve these objectives. One suggestion is to focus on translating research results into effective community programs. This is the science of implementation and dissemination. “We need to focus on maintaining and sustaining progress over many generations,” said Koh. These are all issues now relevant to the recent launch of *Healthy People 2020*. One strategy for maintaining and sustaining progress is to use the RE-AIM (Reach, Efficacy, Adoption, Implementation, Maintenance) evaluation framework (see Table 3-1) for the translation of findings from research on efficacy (evaluated by use of interventions delivered under optimum conditions) into findings on effectiveness in the community (evaluated by use of interventions delivered under real-world conditions) (Glasgow et al., 2003).

TABLE 3-1 RE-AIM (Reach, Efficacy, Adoption, Implementation, Maintenance) for Translating Research Efficacy into Community Effectiveness

	REACH: Participation rate and representativeness of participants	EFFICACY/ EFFECTIVENESS: Effect of an intervention on specified outcomes	ADOPTION: Number of and representativeness of settings and interventionists	IMPLEMENTATION: Quality and consistency with which intervention is delivered	MAINTENANCE: How long intervention holds up
RE-AEIM					
Efficacy (Limited Research Settings)	Homogenous sample	Intense specialized intervention	One setting	By research staff	Few or no issues
Effectiveness (Broad Community Settings)	Heterogeneous sample	Brief, feasible intervention	Multiple settings	By variety of people	Major issues

SOURCE: Howard Koh presentation to the Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities, April 2010, Washington, DC. Modified from Glasgow et al. (2003).

HHS AND EFFORTS TO REDUCE DISPARITIES

Koh's final comments outlined the efforts of HHS to address disparities in health. First, Medicare has paid increased attention to health disparities through the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. MIPPA requires HHS to concentrate more effort on data collection, measurement, and evaluation of health disparities.

Second, the Agency for Healthcare Research and Quality (AHRQ), to be discussed in more detail later in this summary, is the entity within HHS responsible for its biennial *National Healthcare Disparities Report*. The most recent report, for 2009, was released in early 2010 (AHRQ, 2010).

Third, the American Recovery and Reinvestment Act (ARRA) of 2009 also contained provisions relevant to attainment of reductions in health disparities. The Communities Putting Prevention to Work (CPPW) initiative focuses on community-based interventions that affect social determinants. The legislation also made significant investments in community health cen-

ters. Finally, ARRA contained funding for patient-centered health outcomes research (PCORI).

The Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 establishes a national committee that is looking at ways to track race, ethnicity, and primary language data through electronic data collection methods. This legislation also promotes increased use of electronic health records and specifically provides funding for the Indian Health Service to assist with health information technology adoption.

HHS AND HEALTH CARE REFORM

Koh briefly reviewed health reform measures at HHS and their relation to the goal of promoting health equity. The passage of the health care reform legislation in 2010, the ACA, also addresses health disparities. First, the act expands on Office of Management and Budget standards and directs that more emphasis be placed on the dedicated collection of data on race, ethnicity, gender, and the primary language spoken. Second, the National Center on Minority Health and Health Disparities, within the National Institutes of Health, is elevated to the level of an institute—the National Institute on Minority Health and Health Disparities. Additionally, four new offices of minority health are in development within HHS, which will assist in the coordination of disparities reduction efforts. The legislation also mandates a study of value-based purchasing programs, including programs for Medicare populations, by race/ethnicity.

HHS AND PREVENTION

Koh noted that the ACA also contains a number of important provisions directed to the promotion of prevention. Perhaps the most important provision is that the legislation established the new Prevention Trust Fund, funded at \$500 million for fiscal year 2010, with that amount expected to rise in coming years.

Other components of the ACA that promote prevention include the following:

- New private health insurance plans must cover the high-value prevention recommendations of the U.S. Preventive Services Task Force (USPSTF) as well as the recommendations of the Advisory Committee on Immunization Practices (ACIP).
- Medicaid must also encourage states to cover the USPSTF and ACIP recommendations.

- Medicaid must cover the costs of comprehensive tobacco cessation programs for pregnant women.
- A no-cost-share rule for preventive services was established for Medicare and went into effect on January 1, 2011.

In addition, the HHS Health Disparities Council, co-chaired by Howard Koh and Sherry Glied, assistant secretary for planning and evaluation, was established under the ACA. The goal of the council is to coordinate activities across departments and to develop the infrastructure necessary to promote activities directed at attainment of reductions in health disparities.

Another new activity is the National Partnership for Action to End Health Disparities (NPA). Coordinated by the Office of Minority Health, HHS released two guiding documents in response to the NPA Call to Action:

- The *National Stakeholder Strategy for Achieving Health Equity* provides “an overarching roadmap for eliminating health disparities through cooperative and strategic actions” (OMH, 2011, p. 1). The strategy includes the collection of ideas and suggestions from thousands of people who offer comments. The focus is to encourage public- and private-sector partnerships to support community-driven approaches to achievement of health equity.
- The *HHS Action Plan to Reduce Racial and Ethnic Health Disparities* is designed to be used in coordination with the stakeholder report to address national goals to eliminate health disparities and to build upon the objectives of *Healthy People 2020*. The vision of the Action Plan is to attain “a nation free of disparities in health and health care” (OASH, 2011, p. 11).

Koh closed his comments by indicating the need for a focus on leadership in health equity activities (Koh and Nowinski, 2010). In an ambiguous and multidisciplinary world, it is critical to promote a “health in all policies” approach. This means working across agencies and engaging agencies such as the U.S. Departments of Justice, Education, and Transportation to address health equity. The ultimate goal is to renew a sense of community dedicated to prevention and public health and to eliminate health disparities in the future.

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4

Federal Perspectives on Reducing Health Disparities

Noting that making further progress in the reduction of health disparities is going to take a much longer period of time, session chair Mildred Thompson said that the speakers on the panel described in this chapter would be discussing potential solutions. In 2000, the first real legislation focusing on health disparities was signed into law by President Bill Clinton—Minority Health and Health Disparities Research and Education. Among other actions, the National Center on Minority Health and Health Disparities (NCMHD) was created within the National Institutes of Health (NIH), and the Agency for Healthcare Research and Quality (AHRQ) was tasked to measure disparities every other year. Other federal efforts to reduce health disparities have built upon these actions.

JOHN RUFFIN

John Ruffin is director of NCMHD (now the National Institute on Minority Health and Health Disparities [NIMHD]) and oversees the agency's budget of approximately \$210 million. Under Ruffin's leadership, NIH convened its first summit on health disparities in 2008.

Ruffin began his comments by referring to *Healthy People 2010*, described earlier by Assistant Secretary Howard Koh. He noted that the hope was that racial and ethnic health disparities would be eliminated by 2010. Although this has not occurred, a foundation is now in place to move toward the elimination of health disparities, Ruffin said.

Acknowledging the efforts of the previous speakers in highlighting health disparities, Ruffin stated that he began the activities of NCMHD by

asking a very fundamental question: “What is it that we should be doing that we are not doing?” Ruffin said that what he and his colleagues at NIH have tried to do is to bring responses to this question and other related recommendations from the community back to NIH and then convert those recommendations into good science. In this way, he said, a new paradigm is created by keeping things simple and asking the right questions.

NCMHD was founded in 2000 to bring increased national attention to health disparities. Through its specific programs, together with a formal and comprehensive agenda for research on health disparities, NCMHD has increased investments in minority health and health disparities research and activities and improved collaboration within NIH and across federal agencies.

NCMHD Programs

The legislation creating NCMHD mandated that the center establish several programs, Ruffin said. The first is a loan repayment program (LRP), which helps attract the best and the brightest people to this field by paying off their school loans. The model for the LRP is borrowed from a similar program established several decades ago for recruiting scientists to study HIV/AIDS.

The LRP established by NCMHD has successfully built and diversified the biomedical research and health professions workforce in 49 U.S. states, and more than 2,000 individuals have benefited from the program. The program is unique in that graduates from all health professions (for example, physicians, psychologists, and biologists) are eligible, and it is the best way to attract the brightest people working on health disparities. The LRP provides up to \$35,000 per year toward student loan repayment if the recipient enters the field of health disparities research. About 38 percent of participants in the LRP are Caucasian, 34 percent are African American, 19 percent are Latino, and about 9 percent are Native American.

The second program established by legislative mandate is the Centers of Excellence (COEs) program, Ruffin said. The program has supported more than 85 centers to conduct scientific research on enhancement of the understanding of minority health and health disparities. Most of these COEs are collaborative partnerships between research-intensive universities and institutions that serve minority populations (for example, Emory University with the Morehouse School of Medicine and the University of Alabama with Tuskegee University). The COEs make both parties equal partners in their work together to resolve health disparities. For example, minority institutions can help with the recruitment of minority patients into clinical research or clinical trials.

The third program is a research endowment program. The program is

unique within NIH and has allowed approximately 20 institutions to create or expand their health disparities research and training opportunities in biomedical research. One outcome of the research endowment program is the creation of endowed chair programs in areas such as HIV/AIDS and cardiovascular disease at institutions serving minority populations.

NCMHD also initiated a community-based participatory research (CBPR) program that has brought the community into the research process as equal partners working with scientists and has introduced CBPR to the scientific community as a viable strategy to address health disparities. Ruffin noted that one common complaint from communities is that researchers conduct studies within the community until the funding runs out. When the funding ends, the researchers then leave the community and the community reaps little or no benefit from the research.

The CBPR program offers 11 years of sustainable funding through three phases. First is a 3-year planning phase, during which partnerships are created and a community needs assessment is conducted. Second is a 5-year research intervention phase; this is followed by a 3-year information dissemination phase. This final phase of funding includes research translation, information dissemination, and community outreach efforts. The ultimate goal of the program is to bring scientific research results back into the community.

One unique aspect of the CBPR program is that community-based organizations can now apply directly to NIH for funding. The United States currently has 40 CBPR programs, and 11 of those are led by community-based organizations rather than academic institutions.

Ruffin described NCMHD's minority health and health disparities international research training program. By exposing students to hands-on research experience at sites in 50 countries, a talented pool of undergraduate and graduate students is trained to study health disparities in their careers. The international program is administered through 24 academic institutions.

Other new initiatives that Ruffin implemented include an investigator-initiated research grant program for research investigating the social determinants of health. Another recent initiative focused on dealing with faith-based issues. The element common to these new initiatives is that they arise from issues that the community believes need to be addressed by NIH.

The scientific potential for the reduction of health disparities exists, Ruffin said, and it is NIH's responsibility to continue to increase support for intramural and extramural research programs focusing on the reduction of health disparities. For example, the NCMHD intramural program will focus on the linkage between the biological and non-biological determinants of health in populations in which health disparities exist. This will

lead to a pool of investigators that will enhance the diversity of the NIH intramural research program.

Through the intramural program, NCMHD also launched a career development initiative called DREAM (Disparities Research Education Advancing Our Mission). An extension of the LRP, the DREAM program is designed to retain those LRP recipients conducting biomedical research on health disparities by offering a career development path. The program provides 5 years of support to create and sustain a research program in health disparities, with the first 2 years of the program taking place at NIH in the intramural program and the final 3 years of the program taking place at the originating academic institution. The program creates a career development track for scholars investigating health disparities and creates a growing cadre of researchers who are the best and the brightest in this field of inquiry.

The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 also meant changes for NCMHD, Ruffin explained, the most important being the elevation of NCMHD from having the status as a center within NIH to being one of the institutes of NIH. The newly created NIMHD is responsible for meeting a congressional mandate requiring NCMHD to coordinate all minority health and health disparities research activities for NIH. One principal component of the efforts to coordinate research activities is NCMHD's responsibility for the development of the NIH Health Disparities Strategic Plan and Budget. The strategic plan outlines the health disparities research priorities for each of the 27 NIH institutes and centers. The plan will be posted on NCMHD's website for public recommendations. Again, Ruffin emphasized, comments and suggestions from the public are encouraged.

NCMHD Partnerships

The other important component needed to achieve success in the reduction of health disparities is a focus on partnership and collaboration. Ruffin noted that health disparities are a complex problem, and to address these issues, agencies need to work together. NCMHD thus works with partner agencies and programs outside NIH:

- the REACH (Racial and Ethnic Approaches to Community Health) program of the Centers for Disease Control and Prevention (CDC),
- the Health Resources and Services Administration (HRSA) Health Disparities Collaborative,
- the U.S. Department of Justice (DOJ) (juvenile detention research),
- AHRQ's EXCEED (Excellence Centers to Eliminate Ethnic/Racial Disparities) program,

- the National Science Foundation (science education initiatives), and
- the U.S. Department of Health and Human Services (HHS) Office on Minority Health (OMH) (outreach activities).

These critical federal collaborative activities help to develop programs and address important issues on health disparities, Ruffin noted.

Ruffin emphasized that interest in the reduction of health disparities is not enough; it should also be a priority. Once the reduction of health disparities becomes a priority, the resources required to make it happen will follow.

CAROLYN CLANCY

Carolyn Clancy is director of AHRQ within HHS and launched the first report to Congress on disparities in health care and health care quality (AHRQ, 2003).

Clancy began her presentation by acknowledging that awareness about health disparities has grown dramatically in the past 10 years. With the passage of the ACA, the stage is set to make progress in eliminating disparities because people will have better access to health care. However, Clancy cautioned that although access to health insurance is necessary, it is not sufficient. Everyone needs to continue to push to reduce health disparities.

AHRQ was created at the end of 1989 in response to emerging research demonstrating significant variations in Medicare spending in different regions of the United States and that populations in those regions where spending was higher did not have better health outcomes. The hope was that the Medicare data could be shared with researchers, who in turn could provide the agency with information about what works and what works with which populations.

The agency quickly discovered that although Medicare claims are good for billing purposes and collection of fees, the claims cannot provide the critical information needed to make clinical inferences about medical procedures.

However, Medicare claims forms can be linked to the Medicare enrollment database so that information about a patient's race, ethnicity, and other sociodemographic information can be used to examine disparities. This information helped to make the case that health disparities are pervasive in the United States. Clancy also noted that the majority of studies reviewed in the Institute of Medicine (IOM) report *Unequal Treatment* (IOM, 2003) were funded by AHRQ.

AHRQ Quality and Health Care Disparities Reports

AHRQ is also responsible for producing annual reports on quality and disparities. Clancy explained that steady and statistically significant improvements in quality of care have taken place every year. However, she noted that a big gap remains between the best possible care that could be received and the care that is routinely provided. Quality-of-care problems, Clancy said, are pervasive.

The health care disparities reports continue to demonstrate the widespread disparities in access to care and the quality of care in association with individual patient characteristics, such as race, ethnicity, and income (AHRQ, 2007, 2009). As measured by the number of page views online, the health care disparities reports are widely used and studied. Clancy addressed the importance of the data in these reports by noting that they are used within HHS to guide efforts to reduce health disparities. She provided several examples of how the data from these reports have been used.

The first health care disparities report was released at the end of 2003. Looking at the findings, Clancy pointed out that the report has limited information about why disparities in health care exist (Box 4-1). Quoting the reports, she said “the most important limitation of this first report is the scarcity of information about why disparities in healthcare exist” (AHRQ, 2003, p. 222).

The 2006 report (AHRQ, 2007) noted that the disparities in quality measures and access measures remained and that disparities between whites and other racial and ethnic groups had narrowed only for African Americans for the core quality measures if conditions were controlled by a clinician or health care system. On the other hand, for the core access measures, African Americans saw no improvements.

The 2008 report (AHRQ, 2009) showed that disparities were not get-

BOX 4-1
Key Findings in the AHRQ 2003
National Healthcare Disparities Report

- Inequality in quality exists.
- Disparities come at a personal and societal price.
- Differential access may lead to disparities in quality.
- Opportunities to provide preventive care are frequently missed.
- Improvement is possible.

SOURCE: AHRQ (2003).

ting smaller. That report identified a core set of quality and access measures that are tracked over time (from 2000-2001 to 2005-2006):

- For Latinos, 80 percent of the core access measures either remained unchanged or got worse.
- For African Americans and Asian Americans, 60 percent of the core access measures either remained unchanged or got worse.
- For low-income populations, 57 percent of the core access measures remained unchanged or got worse.

The quality and health care disparities reports make it clear that dramatic improvements in quality, safety, and disparities reduction have not taken place. One exception, said Clancy, is the Michigan Project to reduce serious, often fatal, bloodstream infections for people in intensive care units (ICUs). This intervention varies from hospital to hospital, but all hospitals share a common focus on changing the culture of the hospital. For example, nurses can intervene if they believe that the physician is not prepared enough for a procedure, and more importantly, they are encouraged to do so and are reinforced for doing so. The hospital staff thus see a connection between their everyday activities and the overall goals of the health care team. Hospitals using the checklist from the Michigan Project report sustained dramatic reductions in infections for ICU patients.

Clancy emphasized that much of the effort to reduce health disparities needs to happen at the local level. This is a major strength of the community-based participatory research projects funded by NCMHD.

Plenty of opportunities to make improvements in health disparities and quality of health care are available, as outlined in provisions of the ACA. For example, the new law will change the health care marketplace for insurance through the creation of exchanges and new requirements for health insurance plans. However, it bears repeating that access to health care is necessary but not sufficient to reduce health disparities and improve quality. In the Medicare population, for example, although national health insurance is available at age 65 years, people of color and low-income seniors still have worse health outcomes. So, although access to health insurance is a good place to start, more dedicated work will be needed to reduce and eliminate health disparities.

Quality and disparities reduction efforts should be intrinsically linked, Clancy said, and it is essential that health care providers become more comfortable with treating racially and ethnically diverse populations. For example, the Robert Wood Johnson Foundation project Expecting Success involved 10 hospitals that developed and then shared tools for improving cardiac care for African American and Latino patients. By developing effec-

tive quality-improvement strategies, the hospitals were then able to improve their provision of cardiovascular care to African Americans and Latinos.

Clancy reviewed other important efforts to move the quality and disparities agendas ahead, including HHS's response to the American Reinvestment and Recovery Act (ARRA). ARRA legislation allocated \$1.1 billion for comparative effectiveness research programs, funded through AHRQ, NIH, and the HHS Office of the Secretary. Those programs included ones being carried out by NCMHD (HHS, 2009).

Disparities Reduction and Health Information Technology

Clancy discussed the role of AHRQ's health information technology (IT) portfolio of innovative projects with the objective of ensuring that health IT can be used as one of several potential solutions in addressing health disparities. For example, the Prospective Outcome Systems Using Patient-Specific Electronic Data to Compare Tests and Therapies (PROSPECT) Initiative, also funded through ARRA, includes a focus on ensuring that underrepresented populations are represented in clinical trials. The goal is to assist clinicians with the development of better electronic data records so that the data in those records can be used for research. This will lead to the availability of data to perform comparative effectiveness research on diagnostics, therapeutics, behavioral interventions, and procedures. A second innovative program is the Middle Project, which uses innovative communication technologies to improve the health of young African American women through the creation of a virtual patient advocate avatar. Finally, a third project involves the use of health IT as a strategy to improve quality in discharge planning.

After the release of the 2006 health care disparities report in 2007, Clancy said, AHRQ reviewed what were seen as the major targets of opportunity from the report. Improving diabetes prevention among Latino elders emerged as a major target of opportunity, and the Latino Elders Initiative was designed to improve the self-management of diabetes. The agency began to work with other agencies such as CDC and the Administration on Aging in eight metropolitan communities. Each of the communities is home to a high proportion of Latino elders. A research agenda focusing on the initiative is also in development.

Disparities Reduction and AHRQ Collaborations

Clancy noted several other collaborative activities that AHRQ is involved with to reduce health disparities, including

- the Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities at the IOM, which engages parties from academia, industry, government, philanthropy, the corporate sector, and the community to facilitate ongoing attention to health disparities issues, www.iom.edu/healthdisparities;
- the Federal Collaboration on Health Disparities Research, co-led by NCMHD and OMH, which identifies and supports research collaborations across federal departments and agencies including the Department of Housing and Urban Development, the Environmental Protection Agency, the Department of Transportation, and others, <http://minorityhealth.hhs.gov/fchdr>; and
- the National Partnership for Action to End Health Disparities, spearheaded by OMH, which is a multifaceted effort to mobilize and connect individuals and organizations across the country in efforts to eliminate health disparities, <http://minorityhealth.hhs.gov/npa>.

Emphasizing that although the awareness of health disparities has increased and the measurement of health disparities has improved, actual change is occurring more slowly, Clancy said. To sustain the promise of implementing health care reform, better and more robust efforts are needed in all aspects of data collection. Box 4-2 outlines several future directions that are guiding the work of AHRQ in advancing excellence in health care for all.

BOX 4-2
Future Directions for AHRQ

- Improve the quality of health care and health care services for *all* Americans.
- Promote consistent, reliable, and longitudinal data collection to identify the nature and extent of disparities, develop and target quality-improvement initiatives, and measure changes over time.
- Partner with communities to ensure research activities are relevant to their populations and that findings are adopted and implemented effectively.
- Evaluate the importance of cultural competence and health literacy to improve quality and reduce health care disparities.

SOURCE: Clancy (2010).

DISCUSSION

Winston Wong of Kaiser Permanente asked Carolyn Clancy about the *National Healthcare Disparities Report*. Given that many speakers throughout the workshop emphasized the importance of looking at issues of empowerment, civil rights, economic opportunity, and residential segregation as a means of reducing health disparities, he asked if AHRQ was considering the integration of these issues within the next *National Healthcare Disparities Report*.

Clancy noted that an IOM committee had provided recommendations for future directions. She also said that AHRQ wants to get better data from the local level because better local data overall can help provide an understanding of the interplay between the social determinants of health and inequalities in health care. John Ruffin concurred, stating that NCMHD is focused on funding research related to the social determinants of health.

A participant asked about the role of the federal agencies in encouraging and recognizing the importance of community-based participatory research. Clancy said that this is at its core an opportunity to strengthen communities. However, she noted that researchers, grant makers, and peer reviewers often do not recognize this. In response, Ruffin stated his “strong opinion” that the community should be a part of every phase of a research project, from the planning to the intervention, evaluation, and dissemination efforts. He said that “the operative term here is ‘inclusion from beginning to end.’”

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5

Promising Practices in Addressing Social Determinants: Obesity Prevention

Session chair Pattie Tucker of the Centers for Disease Control and Prevention (CDC) introduced the session on social determinants of health by indicating that the focus is on promising practices to address social determinants of health (in this case, obesity).

THE PRESIDENT'S TASK FORCE ON CHILDHOOD OBESITY

Susan Sher is an assistant to the president and chief of staff for First Lady Michelle Obama. In this role, she works closely with the First Lady and her staff on issues related to military families, national service, elimination of childhood obesity, and promotion of healthy living. Sher's presentation focused on the First Lady's Initiative to Combat Childhood Obesity, which is a component of the President's Task Force on Childhood Obesity.

Sher stated that the United States faces a serious epidemic of obesity, with a well-documented rise in adult obesity levels occurring over the past 20 years. For children, obesity rates increased from 12 percent of all children to 33 percent of all children during that same time period. If these trends continue, more than 100 million American adults will be obese by 2018 (United Health Foundation, 2009). Furthermore, if the prevalence of obesity continues, the nation's next generation will live shorter, sicker lives than their parents. This is because obesity plays a critical role in many diseases, such as diabetes, heart disease, and certain types of cancer.

Data for a large racially and ethnically diverse population of 2- to 19-year-olds recently released by Kaiser Permanente indicate that 7.3 percent of boys and 5 percent of girls are extremely obese. These rates are even

higher for Latino teenage boys, at 11.2 percent, and for African American girls, at 12 percent (Koebnick et al., 2010).

Low-income families in every racial, ethnic, and gender group also have higher obesity rates. Sher acknowledged that the relationship between obesity and poverty is a complex one. However, “food deserts” (urban areas without access to fresh, healthy, and affordable fruits and vegetables) are one major reason for the linkage between impoverishment and obesity in disadvantaged areas. More than 23 million Americans—6.5 million of them children—live in low-income neighborhoods that are more than a mile from markets with access to fresh foods. This means that those communities that can least afford fresh foods end up bearing the brunt of the costs associated with obesity. Food insecurity and experiences of hunger among children in the United States are even more widespread, Sher said. A recent report from the U.S. Department of Agriculture (USDA) showed that 17 million households experienced hunger multiple times throughout the year (Nord et al., 2009).

Obesity is also associated with more chronic conditions than either smoking or excessive drinking, said Sher, and by 2020 the United States is projected to spend over \$343 billion on health care costs attributable to obesity. Today, spending attributable to obesity is approximately \$150 billion.

However, the costs of obesity and obesity-related diseases are more than simply financial in nature. Obese people are more likely to experience social disengagement and have fewer opportunities in education and the workforce. Obese children tend to become sad, lonely, and more likely to engage in high-risk behaviors, such as smoking or drinking alcohol. Other data indicate that children’s body mass index (BMI) and level of physical activity within the school day affect their academic performance in both reading and math. Sher noted that the obesity problem has reached “epidemic proportions.”

Let’s Move

In response to the obesity epidemic, Sher highlighted First Lady Michelle Obama’s Let’s Move campaign to solve the problem of childhood obesity. As a mother struggling to balance a healthy lifestyle with her family’s hectic schedule, Mrs. Obama is committed to reaching the national target of eliminating childhood obesity within a generation. Let’s Move is a comprehensive collaborative and community-oriented initiative that includes strategies to address the various factors that lead to childhood obesity (The White House, 2010). By fostering collaboration among leaders in government, science, business, education, athletics, and community

organizations, the goal is to create practical tools tailored to children and their families facing a wide range of challenges and life circumstances.

The Let's Move campaign has four pillars. The first pillar is "empowering parents to make healthy family choices." With acknowledgment that parents play a key role in making food choices for their children, part of this pillar is to create or redesign tools to educate parents across communities to make healthy food choices. By working with different food industries, Sher said, the Task Force on Childhood Obesity is trying to improve product labeling regulations to make it easier to read food labels. At the same time, USDA has created the Food Environment Atlas (www.ers.usda.gov/foodatlas), a database that maps the components of healthy food environments down to the local level across the country. For example, this system can help identify areas that are food deserts and areas with a high incidence of diabetes.

The second pillar is "serving healthier foods in schools." This is an essential component of the campaign because many disadvantaged students consume 50 percent or more of their daily calories at school through the National School Lunch Program and the National School Breakfast Program. More than 31 million children participate in the lunch program, and more than 11 million participate in the breakfast program. One component of this pillar is to increase the number of schools participating in the Healthier U.S. Schools Challenge Program. The program establishes rigorous standards for school food quality, meal programs, physical activity, and nutritional education.

The third pillar is "increasing access to healthy, affordable foods." An important component of this pillar is the establishment of a new program, the Healthy Food Financing Initiative. A partnership between the U.S. Departments of the Treasury, Agriculture, and Health, the initiative will invest \$400 million per year to provide financing to bring grocery stores and farmers markets to underserved areas. Financing will also help corner grocery stores, convenience stores, and bodegas to carry healthier food options. Moreover, grants will be available to bring farmers markets and fresh foods into underserved communities. For example, in Philadelphia, a public-private partnership¹ led to the opening of a huge new grocery store in an underserved area.

The last pillar is "increasing physical activity." In disadvantaged neighborhoods, however, promotion of physical activity faces numerous challenges. For example, violence contributes to the lack of safe spaces for

¹ Public-private partnership between the Food Trust and the Greater Philadelphia Urban Affairs Coalition is managed by The Reinvestment Fund, known as Pennsylvania Fresh Food Financing Initiative, and "has become a model for communities nationwide committed to combating obesity and improving food access" (The Food Trust, 2004).

exercise, thereby creating a relationship between obesity and neighborhood violence. Let's Move will incorporate programs to increase children's physical activity opportunities by creating safe areas for exercise, particularly in disadvantaged neighborhoods. Let's Move will include a multilingual awareness campaign and direct recommendations on improving the built environment and making outdoor play areas accessible in all communities. Other components of the fourth pillar include a revamping of the President's Physical Fitness Challenge and an expansion of the Presidential Active Lifestyle Award.

Noting that some people legitimately believe that the government should not be telling people what to do, Sher emphasized that the position of the administration is that it should arm parents with the information to help them make better decisions. The recommendations are not designed to tell parents what to do.

Sher presented some of the recommendations that are being discussed. For example, recommendations on how to communicate nutrition information in simple, actionable ways will apply to the first pillar. Other recommendations related to the first pillar will focus on front-of-package food labels and the inclusion of calorie counts on menus and menu boards.

Recommendations made as part of the second pillar, on the nutritional quality of the food that is available in schools, will be paramount in efforts to reduce childhood obesity. The nutritional quality of school lunches and school breakfasts will be addressed, as will the nutritional quality of vending machine choices in schools. Other school-related factors include nutrition education, cafeteria design, and minimization of the stigma of receiving free or reduced-price meals at school. Foods served in juvenile justice facilities will also be considered.

Recommendations relevant to the third pillar, access to healthy and affordable food, will include a focus on the elimination of food deserts. Food pricing, particularly the relative pricing for healthy and unhealthy foods, will be considered. Product reformulation will also be discussed. For example, conversations with the food industry about reducing sodium levels can lead to voluntary commitments to lower sodium levels by 5 percent a year.

Recommendations for the fourth pillar, increasing physical activity, will include limitations to television watching and computer time for children. Many factors will be considered, including the number of hours of physical activity at school, school design, after-school activities, organized sports, and time simply to play. Access to safe playgrounds, parks, and both indoor and outdoor recreation opportunities will be the focus of attention. Spaces for indoor activities are particularly important in areas with extreme climates and areas where children are more likely to have asthma or other

health-related conditions. The role of the built environment—having walkable, bikeable communities—is also important.

The recommendations will also include a focus on factors well outside parental control. For example, some research suggests that fetal or infant exposure to chemicals in the environment is related to obesity. Other cross-cutting recommendations will focus on prenatal care, breast-feeding, and the quality of food in child care settings. For instance, health care providers can also play a role in controlling obesity. The American Academy of Pediatrics is encouraging its members to measure the BMI of their patients. Pediatricians can also “prescribe” constructive recommendations for parents about healthy foods and exercise by writing them on a prescription pad.

Several other programs are related to the Obama administration’s efforts to reduce childhood obesity. The first program is the White House Task Force described earlier, which establishes an interagency task force on childhood obesity with the Department of Health and Human Services (HHS), USDA, the Department of Education, and the Office of the First Lady being the lead agencies. The first project of the task force is to create an action plan with specific recommendations.

Another program of the White House Task Force that Sher described is the Partnership for a Healthier America, funded by several philanthropic organizations. The partnership is a separate foundation that focuses on

- raising awareness of the health risks of obesity by independent, nonpartisan efforts,
- coordinating voluntary commitments by the private sector and the not-for-profit sector, and
- holding the federal government accountable by establishment of aggressive benchmarks.

Discussion

Anne Beal from the Aetna Foundation noted that although consensus around the recognition that obesity is a major health problem in the United States does seem to exist, there is considerably less agreement on how best to approach the problem of obesity. For example, some states are proposing a tax on sugary drinks and sodas. However, the federal government provides subsidies to farmers who grow some of the sugars used in these drinks. This is an issue that crosses policies at the local, state, and federal levels, and there is no easy way to resolve policy conflicts such as this one. Susan Sher noted that although this is a federal issue, there is no real consensus on resolving the federal farm subsidies. Rather, the First Lady’s office is focused on those areas where consensus can be achieved.

REDUCING CHILDHOOD OBESITY: A STRATEGY TO ADDRESS HEALTH DISPARITIES

Mildred Thompson is director of the PolicyLink Center for Health and Place. Her work focuses on understanding community factors that affect health disparities and identifies practice and policy changes needed to improve individual, family, and community health.

Thompson began her comments by noting the shared focus of her work with First Lady Michelle Obama's Let's Move initiative described by Susan Sher. Addressing childhood obesity will require a multipronged approach, Thompson said, involving the federal government, private philanthropy, local government, and community action.

Thompson explained that because poor diet and physical inactivity have become the second leading actual cause of death in the United States (Mokdad et al., 2004), it is imperative to address the childhood obesity problem. In California, for example, 56 percent of adults are either obese or overweight, and 32 percent of adults in the United States are obese (Babey et al., 2009). The country now faces both moral and economic imperatives to make a real difference on this issue. The economic bottom line is that obesity costs families, governments, and the health care industry more than \$6 billion per year in California alone.

Looking at national trends in childhood obesity (Figure 5-1), Thompson pointed out the constant increase from the mid-1970s to 2004. Although rates for older children (ages 12 to 19 years) appear to have leveled off, the younger children (ages 6 to 11 years) present a great cause for concern. The distressing point is that these children suffer the effects of being obese in multiple ways, when obesity itself can be prevented in the first place.

Figure 5-2 shows the disproportionate rates of childhood obesity across the United States, with the southern states having the highest obesity percentage rates. It is imperative that attention to childhood obesity be given to those regions that are hit the hardest by rising childhood obesity rates.

The consequences of childhood obesity are more than simply cosmetic. Rather, they are about the biology of obesity and how obesity affects the life course through a shortened life expectancy (Olshansky et al., 2005), the early onset of adult chronic diseases, and the associated medical costs of \$147 billion (Finkelstein et al., 2009), Thompson said.

In response to these alarming trends in childhood obesity, a number of initiatives have been established to help alleviate the situation. For example, RWJF has invested \$500 million in initiatives that will address childhood obesity. One key strategy has been the creation of the Robert Wood Johnson Foundation Center to Prevent Childhood Obesity (<http://www.rwjf.org/childhoodobesity>). Box 5-1 presents the vision of that center. The center's

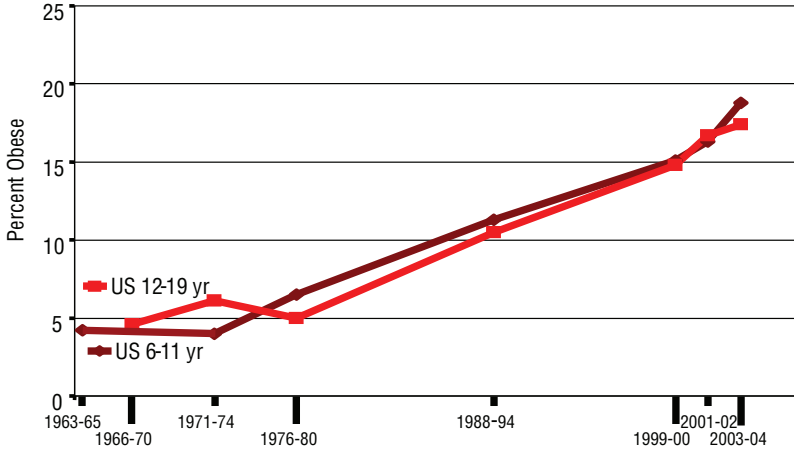


FIGURE 5-1 National childhood obesity trends.
SOURCES: Ogden et al. (2002, 2006).

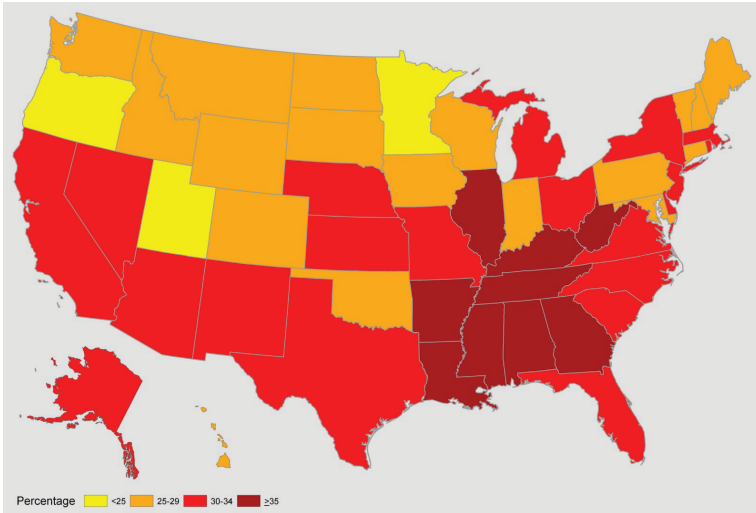


FIGURE 5-2 Percentage of children who are overweight or obese ages 10-17 years by state (2007).
SOURCE: Data retrieved from the Child and Adolescent Health Measurement Initiative, 2007 National Surveys of Children’s Health, Data Resource Center for Child and Adolescent Health website (www.nschdata.org [accessed May 26, 2009]).

BOX 5-1
**Vision of the Robert Wood Johnson Foundation Center to
Prevent Childhood Obesity**

- To be a strategic leader of the national movement to reverse childhood obesity
 - Harness the impact of the RWJF programs and affiliated resources
 - Advance a comprehensive policy agenda at the federal, state, and local levels
 - The center's policy strategy focuses on reversing childhood obesity and eliminating disparities by changing the environmental landscape in which this epidemic has developed
- Building community capacity to effect federal policy is the role of technical assistance for the center

SOURCE: Thompson (2010).

goal is to reverse the childhood obesity epidemic by 2015; funding is provided to support research on strategies to prevent obesity and encourage healthy eating.

Thompson noted that a nationwide movement is under way to address childhood obesity, with several other foundations being involved. For example, The Convergence Partnership is a national funder collaborative consisting of RWJF, The W.F. Kresge Foundation, Kaiser Permanente, the Nemours Foundation, The California Endowment, the Kellogg Foundation, and CDC, all of which are working to create healthy people in healthy places. This partnership, administered by PolicyLink in partnership with the Prevention Institute, seeks to support regional and national efforts to reduce obesity by focusing on creating healthy environments, both the food environment and the physical environment (www.convergencepartnership.org).

To make the kinds of complex changes needed, a focus only on individual behavior will not work, Thompson said; the environment has a significant impact as well. Where and how people live affect the trajectory of their lives. Therefore, to reduce obesity, the focus should be on changing the environments in which people live. By building community capacity, people can access the tools and resources to make better choices.

At present, RWJF is focused on creating a framework to shift the energy balance by (1) increasing children's consumption of healthy food and beverages and decreasing the consumption of unhealthy foods, (2) addressing the need for increased physical activity, and (3) building awareness and support for efforts to reduce obesity. The factors of interest needed

to create this shift in the energy balance include the food environment, the built environment, and the educational setting.

Figure 5-3 provides a model demonstrating that communities are not created equal. Comparison of the physical environments of high-income communities of opportunity with those of low-income communities of opportunity clearly shows the corresponding differences in health status between the two types of communities as a result of the different environments. This comparison shows why the focus should be on changing the environment, Thompson said.

Specifically, the educational environment is paramount as an influence on children's health. Unfortunately, children from different communities have hierarchal opportunities based on where they live. If a neighborhood school does not offer advanced placement courses, for example, students at that school do not have the same kinds of educational opportunities available. This lack of opportunity, in turn, will affect their college performance. The educational environment should be changed to improve children's health, Thompson said.

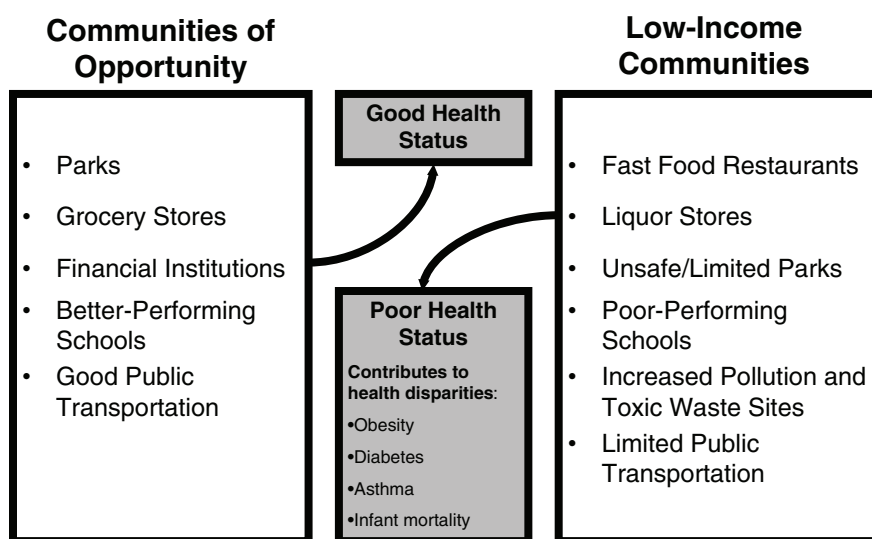


FIGURE 5-3 Communities of opportunity versus low-income communities. SOURCE: Thompson (2010).

Policy Priorities

Thompson addressed the policy environment, an important component of the RWJF initiative, at the federal, state, and local levels. First, at the federal level, health care reform was a beginning and was more of a promise of achieving the right to health care for all Americans. At the state level, physical activity in school is critical; although many states have laws mandating physical activity, those laws are not always enforced.

A second federal initiative is the Child Nutrition Act. Thompson described the importance of the creation of food standards for schools and restaurants so that an informed consumer population can be created.

Third, public transportation in communities should be considered. Access to transportation provides increased opportunities for access to work, education, and health care. Access to transportation simply broadens one's life choices, Thompson explained. Therefore, it is critical that federal transportation initiatives include public transportation as a component, and public health considerations should be a part of the transportation reauthorization conversation.

Fourth, food marketing is another issue of concern. Because children spend so much of their free time on "screen time" (television, cell phones, videogames, computers, other digital equipment), it is easy for food marketers such as fast food chains to bombard them with messages about food that are incorrect or encourage the consumption of unhealthy foods. Thompson suggested that one avenue to address this problem is to work with the Federal Trade Commission.

Additionally, access to fresh, healthy foods is critical to battling obesity. As mentioned earlier by Sher, one federal effort to increase access to fruits and vegetables is based on the Fresh Food Financing Initiative, a successful statewide model in Pennsylvania. The Obama administration's Healthy Food Financing Initiative is an effort to replicate and scale up that successful model to a national level.

Furthermore, the United States is rapidly becoming a more diverse nation, with changing demographic data indicating rapid growth in the Latino population in particular. Faced with increasingly diverse communities, care should be taken to meet the broad range of needs that will help new population groups become—and remain—healthier. As David Williams described earlier (see Chapter 2), immigrants entering the United States tend to be healthier than those immigrants who have lived here for a period of time. Therefore, a crucial task is to focus on addressing the social determinants of health through strategies such as the RWJF Childhood Obesity program so that more communities of opportunity can be created. Talking about food deserts is not enough. Rather, a variety of strategies should be implemented, including provision of access to supermarkets, increasing

the numbers of farmers markets in urban communities, and working with convenience store owners to change their product placements and provide more refrigeration for fruits and vegetables. Rather than telling people what they are doing wrong, Thompson said, “assist them with making better choices.”

Lastly, the connection to the built environment also needs to be better understood. Land use policies and zoning laws should also be subject to policy changes. Initiatives are under way in some cities (for example, Los Angeles) to place moratoriums on the number of new fast food restaurants in communities that are already filled with fast food choices.

THE CALIFORNIA ENDOWMENT’S BUILDING HEALTHY COMMUNITIES INITIATIVE

Mary Lou Fulton is program officer for The California Endowment’s (TCE’s) Building Healthy Communities Initiative. Acknowledging the comments of earlier speakers in highlighting the strategies for building healthy communities, Fulton stated that the Building Healthy Communities Initiative is moving forward with these innovative strategies and trying them out at the community level.

TCE is California’s largest foundation focused on health. Its mission is specifically focused on improving the health of underserved populations in the state. Previously, grant-making efforts focused on three policy areas: access to health care, cultural competence and workforce diversity, and community health and disparities. Although important progress was made, Fulton said, the question became whether a more focused strategy could have a greater impact.

Therefore, a new strategy combines policy and place to achieve greater progress. Place, Fulton emphasized, determines the opportunities available for good health. In other words, an individual’s zip code—where that person lives—determines how long and how well that person lives. The strategy also focuses on the nexus of community, health, and poverty. The conversation really needs to be about preventing disease in the first place, Fulton said, and all of the factors that exist in the surrounding communities are essential to making that happen.

The Building Healthy Communities Initiative is a 10-year strategy investing in 14 communities in California. As California has an extremely diverse population, the selected communities are diverse themselves. The strategy is focused on changes to policies and systems rather than provision of funding for services. In this way, local neighborhoods have the opportunities to define those policies and systems that need to change to create healthier communities. The strategy is about giving local communities the power to make changes in their community, Fulton said, and the hope is

that the innovations coming from the grassroots level will provide models for statewide and even nationwide systems change.

The strategy is structured around 10 outcomes and 4 big results (Box 5-2). The outcome areas range from children's health, the built environment, and land use policies to economic development, schools, and youth development. In particular, a special focus is on boys and young men of color in California and targeting of funding specifically for the challenges that they face. The four big results are the indicators of achievement for the strategy, including a "health home" for all children, a reverse of the childhood obesity epidemic, increases in school attendance, and reductions in youth violence. The project also has a strong focus on community organizing and youth development. Other institutions in the public and private sectors will ideally become involved and participate in the process of making change happen.

BOX 5-2
The California Endowment's
Building Healthy Communities Initiative

Ten Outcomes and Four Big Results

Ten outcomes

- All children have health coverage
- Families have access to a "health home" that supports healthy behaviors
- Health and family-focused human services shift resources toward prevention
- Residents live in communities with health-promoting land use, transportation, and community
- Children and families are safe from violence in their homes and neighborhoods
- Communities support healthy youth development
- Neighborhood and school environments support improved health and healthy behaviors
- Community health improvements are linked to economic development
- Health gaps for boys and young men of color are narrowed
- California has a shared vision of community health

Four big results (indicators of achievement)

- Provide a "health home" for all children
- Reverse the childhood obesity epidemic
- Increase school attendance
- Reduce youth violence

SOURCE: <http://calendow.org/healthycommunities> and <http://MidCityCAN.org>.

Mid-City Community Advocacy Network

Diana Ross is the director of the Mid-City Community Advocacy Network (Mid-City CAN) in City Heights, San Diego, California. City Heights is home to 1 of the 14 Building Healthy Communities sites funded by TCE. It is located about 16 miles north of the United States–Mexico border crossing and is east of the downtown coastline of San Diego. City Heights is also bordered by four of the five major freeway arteries in the San Diego metropolitan area.

Ross noted that the City Heights of today can be traced back to the policies of the 1960s, when deliberate policy decisions were made to create density in the City Heights community as part of an economic development strategy. Inevitably, said Ross, in the 1970s this led to “white flight”; absentee landlords; and decreases in the quality of life, health, and well-being of City Heights residents. This serves as a clear case of how decisions related to policies and systems can disproportionately affect particular communities, which in turn can create pockets of disparities.

Ross described City Heights as the most diverse community in San Diego, with a population of about 90,000 people. The local school district has identified 30 different languages and 80 dialects spoken in students’ homes. Unemployment rates are more than 20 percent, roughly double the average rate for both the county and the United States. Average income levels for a family of four are at about the federal poverty line. Moreover, City Heights also has high rates of school dropout, obesity, violent crime, and sexual assault.

Moreover, San Diego has very high hunger rates, as well as some of the lowest rates of participation in the federal food stamp program. Ironically, said Ross, efforts to reestablish a community garden required significant grassroots organizing and advocacy. Access to the garden can help families bolster their nutrition, help reduce childhood obesity, and improve the overall health of the community.

The Building Healthy Communities Initiative began in City Heights, Ross described, with Mid-City CAN convening a public community forum that was attended by about 300 residents and nonprofits. Next, the Mid-City CAN Coordinating Council called for residents to submit their names for the Resident Selection Committee. Three members were randomly selected from a total of 89 applicants in a public ceremony held on the steps of the public library. In this way, the process was completely transparent and equitable from the start.

The Resident Selection Committee then developed a short request for proposals for the creation of an Oversight Committee of 13 nonprofit organizations (49 nonprofits had applied). The Oversight Committee was in charge of designing the planning process for the Building Healthy Com-

munities Initiative efforts. These efforts included house meetings with house meeting leaders and momentum teams (working groups).

The purpose of the house meetings was threefold: community organizing at the grassroots level, education about systems and policy change, and data collection. House meeting leaders participated in an intensive 3-day training process. A total of 105 house meetings conducted in 13 different languages were held, and more than 1,550 residents of City Heights participated in those meetings.

The next step was the creation of six momentum teams that served as working groups. These teams worked with more than 1,300 residents. The work of the momentum teams is clustered around TCE's 4 big results and 10 outcomes (Box 5-2). The most important issue raised during the house meetings was how to make concepts like "policies" and "systems change" meaningful to people in the community. Additionally, residents remarked that they were tired of people asking them questions, given that a number of community plans were already working in the region. There was a strong sense that "planning fatigue" was occurring.

The critical distinction between the Building Healthy Communities Initiative process and other community plans is that this process is a community capacity-building process and an education process. Most nonprofits, for example, use a service delivery model. With the Building Health Communities Initiative process, the focus is on advocating for policy and systems change.

TCE required the Mid-City CAN to have the community prioritize its own 10 outcomes. The priority-setting process was based on data collected by house meeting leaders during the house meetings. Both quantitative and qualitative data were collected, processed, and compiled into a report that was fed back to the six momentum teams. Two lenses were used during the prioritization process: the lens of data and the lens of the importance of early wins. City Heights residents believed that it was critical that any strategies arising from the priority setting in particular or from the Building Healthy Communities Initiative in general should directly affect the City Heights community in the form of real, tangible changes.

Ross offered three final conclusions. First, the investment made in grassroots organizing in the City Heights community paid off by community buy-in, an increase in community pride, and a strengthening of civic participation. Second, a critical element of this process was learning to translate the abstract concepts of "policy" and "systems change" into language and ideas that are meaningful to the community. Community capacity building along the way was also essential. This, too, helped to build community buy-in. Finally, careful data collection for the purposes

of prioritization of outcomes helped to cultivate buy-in and kept any one stakeholder group from having undue influence on the process and outcomes. This also helped establish baselines for future evaluation efforts.

DISCUSSION

The discussion opened with a question about sustainability. Patricia Baker of the Connecticut Health Foundation wondered how it is possible to translate what is learned from a successful program into longer-lasting policy change. Mildred Thompson responded with an example of a successful scaled-up policy: California was the first state to ban soft drinks in schools. This ban was implemented in steps, however, rather than all at once. The initial focus was on elementary schools, and the case was made—on the basis of the scientific evidence—that sugar-sweetened beverages are linked to childhood obesity. Then, later, the ban was taken to the high school level, with the eventual result being that all schools in California became soda free. Other states followed California's model, providing an example of how a promising practice at the local level can be scaled up.

A second example, explained Thompson, is the Fresh Food Financing Initiative that began in Philadelphia. This is a public-private partnership effort to bring large-scale grocery stores (as opposed to corner markets) into food deserts, which are urban areas without access to fresh, healthy, affordable fruits and vegetables. This initiative has now expanded to Detroit, Michigan, and New York City as well, with the Obama administration trying to take it to the national level with the Healthy Food Financing Initiative.

Mary Lou Fulton of TCE explained that it is critical to focus funding on both place and policy. Although community-level investments are crucial, funding for advocacy efforts at the regional, statewide, and national levels should also be provided. Both are necessary, she said, to make large-scale changes.

Lisa Egbuonu-Davis of the Gateway Institute for Pre-College Education asked about the inclusion of community businesses and entrepreneurs in the process described by Fulton. She stated that inclusion of these groups among the stakeholders could be important to the long-term sustainability of the systems changes that TCE is expecting. Ross explained that local businesses and entrepreneurs were a part of the partnerships created with their program in City Heights. All of the work of the Mid-City CAN was community driven, she said.

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6

What Do We Still Need to Learn About Reducing Health Disparities?

The following panel addressed social determinants of health disparities and ways to reduce health disparities, promote health equity, and move successful models to a larger scale. Each speaker was asked the question, “What do we still need to learn about reducing health disparities?”

PAULA BRAVEMAN

Paula Braveman is a professor of family and community medicine and has published extensively on disparities in health and health care. She explained that her presentation had three main points, which are outlined in Box 6-1.

Research on Social Determinants of Health Disparities

First, not only is more research clearly needed, but also research that better conceptualizes the social determinants of health. Braveman offered some examples from the research effort behind the Robert Wood Johnson Foundation’s Commission to Build a Healthier America (<http://www.commissiononhealth.org>). Figure 6-1 shows national data on health stratified by the three largest racial and ethnic groups in the United States. Within each of these groups, the prevalence of self-reported poor or fair health is shown by family income level. These data show that as income goes up, self-reported health improves. This is true within each of the three racial/ethnic groups.

BOX 6-1 Priorities for Health Disparities Research

- More—and better—research on the social determinants of health disparities
- More intervention research (based on promising hypotheses)—understanding pathways is not sufficient
 - Multilevel, critical mass, studied longitudinally
- More translational research
 - How to inform the public about health disparities
 - How to get them to care
 - How to create political will

SOURCE: Braveman (2010).

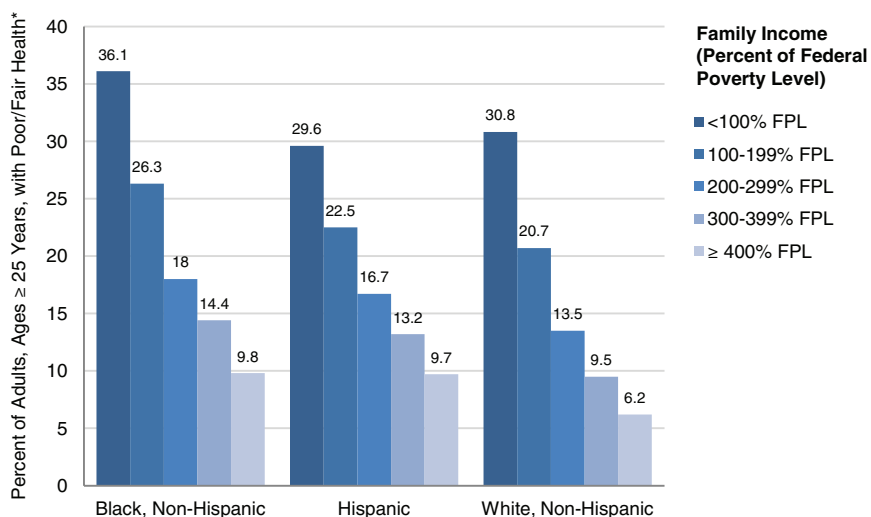


FIGURE 6-1 Income is linked with health regardless of racial or ethnic group. Differences in health status by income do not simply reflect differences by race or ethnicity; differences in health can be seen within each racial or ethnic group. Both income and racial or ethnic group matter.

* Age-adjusted.

SOURCE: RWJF (2009). Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco. © 2008 Robert Wood Johnson Foundation. www.commissiononhealth.org.

However, when the poorest group is compared with all other groups, it is clear that the size of the racial/ethnic disparities is much smaller than the size of the income disparities. It is not enough, then, to look at racial and ethnic differences; socioeconomic differences should also be considered. Braveman explained that without considering both, the long-term effects of the experience of racism are not captured.

Braveman noted that institutionalized racism, independent of socioeconomic differences, also affects health. The effects of institutionalized racism may mean that a child born to an African American family is far more likely to grow up in a neighborhood with fewer opportunities and more adverse effects on health. Residential segregation systematically tracks certain racial and ethnic groups into worse living and working conditions. The effects of crime, toxic hazards, a lack of safe areas to play or exercise, a lack of access to healthy foods, and an environment filled with despair are all a part of an important potential pathway through which disparities are played out, Braveman said.

From a historical perspective, the focus on disparities in health care at the beginning of the disparities movement, Braveman explained, has had both positive and negative effects. One unfortunate outcome of this focus is that it has fed into racial and ethnic stereotypes and led to unfounded assumptions about the basis of racial and ethnic health disparities. For example, a common assumption is that disparities are based on the construct of “culture.” The problem with this construct is that it implies that culture is something that people freely choose.

More measurement work is needed, said Braveman, to enable the field to do a better job of tracing the pathways by which different social factors contribute to the creation of health disparities. A better understanding of those factors, how they operate, and how they perpetuate and exacerbate health disparities is needed.

Figure 6-2 from the Karolinska Institute in Sweden (Burstrom et al., 2010) outlines a simple way to demonstrate how health inequities are created. Differential exposure is related to social position, and social position is reflected by racial/ethnic group. (Social position can also be reflected by sexual orientation, disability status, or any number of other characteristics that define the likelihood that an individual will experience discrimination on the basis of that social position.) Furthermore, social position determines the extent to which a person is exposed to either factors that promote health or factors that have adverse effects on health.

Differential vulnerability should also be considered; that is, social position also affects the extent to which a given level of exposure is likely to result in a given level of damage to health outcomes. For example, increasing knowledge about the physiology of stress—and, particularly, of chronic stress—demonstrates how experiences associated with a lower social posi-

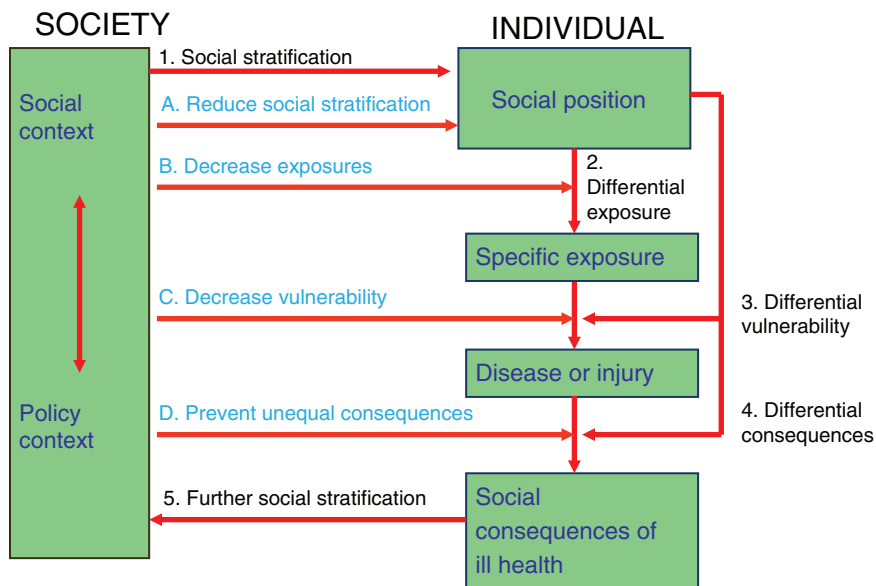


FIGURE 6-2 A way to demonstrate how health inequities are created.
SOURCE: Burstrom et al. (2010).

tion can result in physiological outcomes that create a greater vulnerability to negative health outcomes.

Disease, injury, and the differential consequences of being ill or physically disabled also affect social position and lead to further social stratification. Social stratification—that is, how people sort themselves into hierarchical groups according to characteristics like race or income—in turn affects access to more resources or more opportunities.

Figure 6-2 is also useful in that it indicates the potential points of intervention and puts social stratification, which most researchers do not include in their models, on the table, Braveman said. Most researchers, in fact, do not consider the ways in which the underlying differences in opportunities and resources can result in worse health outcomes.

Braveman noted that another feature of the model in Figure 6-2 is that it shows how disadvantages accumulate across a person's life span and how they can accumulate across generations as well. The consequences of social stratification for the parents can determine the kind of neighborhood in which a child grows up, the influences to which that child is exposed, and even the quality of the schools in that neighborhood.

Poor school quality is one of the most important ways in which place

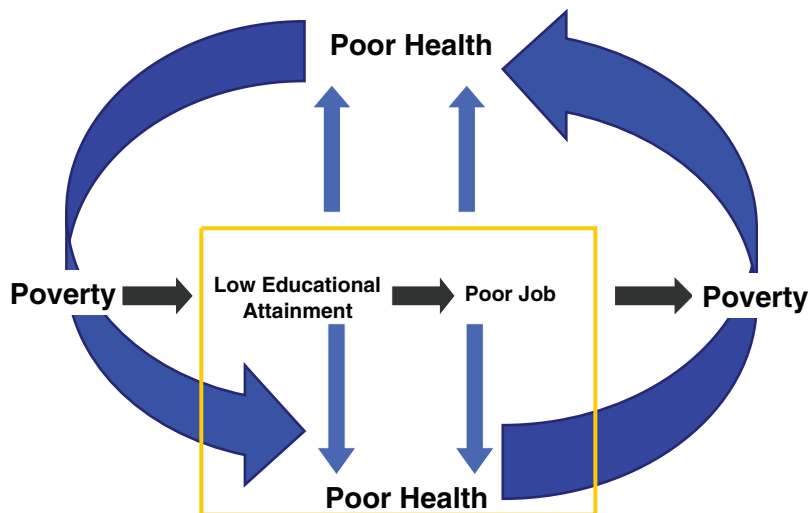


FIGURE 6-3 Vicious cycle of poverty and poor health.
SOURCE: Braveman (2010).

influences health. Figure 6-3 highlights the role of low educational attainment as a critical pathway to poor health. The role of racial segregation, for example, is one of the ways that people are systematically tracked into schools with lower levels of educational attainment. Lower levels of educational attainment, in turn, lead to lower wage earnings, poverty, and poor health outcomes. Although educational attainment influences health by several potential pathways, Figure 6-4 shows the pathway for which the knowledge base is the most limited (inside box).

In short, said Braveman, although more research is needed to better understand how social factors influence health disparities, more research on how to interrupt the pathways is needed. Furthermore, more research is needed to discern how these pathways play out with different populations and in different settings.

Research on Promising Interventions

Second, a massive expansion in intervention research is needed. Braveman noted that a number of promising hypotheses are ready to be tested in the field. Additionally, she said that “going to scale” is the next step because research has already demonstrated success on a small scale. A large body of research, in fact, demonstrates success at a small scale.

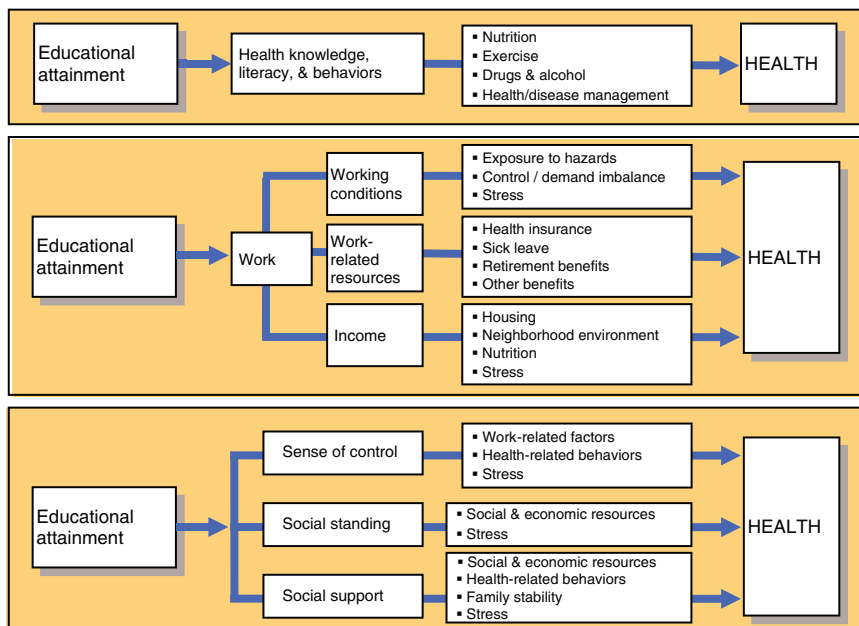


FIGURE 6-4 How could education affect health?

SOURCE: Braveman (2010).

Braveman also cautioned against the “silver bullet trap.” This is the expectation that a single intervention is enough. For example, knowledge about what really works to make schools better is one of the least developed areas. No single program will make a school better; what is needed is a multifaceted approach.

One challenge to conducting research on multifaceted interventions is to convince funding institutions and policy makers to take chances on this research, Braveman said. Because this research involves going at a problem from multiple directions and on multiple levels, it is necessarily messy and complex.

Translational Research

Finally, Braveman stated that more translational research that will translate the existing knowledge base into action is strongly needed. She said that the biggest barrier to reducing health disparities is not a lack of knowledge; rather, it is a lack of political will. Attention should be paid to translational research if reductions in health disparities are to be seen.

Ideas that seem radical in the United States are considered mainstream public health interventions by Europeans, she said; the basic level of social solidarity that exists in Europe is not present here. So how, then, can a greater level of social consensus be created in the United States? This lack of political will, Braveman concluded—not a lack of knowledge—is the biggest obstacle to ending health disparities.

ANNE BEAL

Anne Beal is president of the Aetna Foundation, the independent and charitable arm of the Aetna Insurance Company. She is a physician who specializes in pediatrics and public health.

History of the Disparities Agenda

Beal began her comments by outlining the evolution of research on health disparities in the United States. Initially, the focus was on minority health, that is, the health of “those other people,” she said. The focus then shifted to acknowledgment of a gap between whites and people of color and finally to an interest in closing that gap. It is here that the language of health disparities was first used. The initial research on health disparities was descriptive in nature. It then became clear that disparities could be seen everywhere: in Medicare, Medicaid, health care access, and health care outcomes.

The next step was to look at questions of whether the data were adequate and whether the data were appropriate to capture the extent of disparities. This work was critically important, Beal said, and is reflected in federal legislation such as the Patient Protection and Affordable Care Act (ACA) of 2010. The law includes language around the need for high-quality data on race and ethnicity.

Once the data became available, the next step was to begin to look at the root causes of health disparities. One of the first findings to emerge, said Beal, was that where one lives and where one goes to receive health care are major drivers of health disparities. In other words, Beal said, “where you live makes a difference.” Just as the saying states that “all politics is local,” Beal said that “all disparities are local” as well. Although national data are useful for moving to an evidence-based action plan, what is needed are more localized and focused action plans.

The data on health care quality make it clear that providers who care for more racial/ethnic minority patients have more challenges with delivering high-quality care to those patients. This occurs in nursing homes, hospitals, and health plans. Obviously, challenges related to quality do not exist because a provider who has a large number of minority patients is a

bad provider; rather, something about the milieu in which those providers practice leads to challenges to delivering high-quality health care. Health disparities are thus actually an issue of health care quality; when measures of disparities are considered, those measures are, in fact, showing differences in the quality of care received. Beal said that it is impossible to “talk about quality without talking about quality for everyone.”

It is not a good use of our time and effort, Beal said, to focus on a particular factor such as health literacy, access to health care, or the patient-centered medical home. When health and wellness for people of color are considered, researchers need to look at all of those indicators; this type of research is complicated. This runs counter to the traditional bench research approach in which, ideally, one variable is changed and all other variables are controlled for.

Need for an Evidence-Based Action Plan

What is needed, said Beal, is what Paula Braveman called “intervention research,” that is, research that “tells us where to go in terms of next steps.” This is what Beal called an “evidence-based action plan.” Beal reiterated Braveman’s statement that research to describe disparities is not needed. What is needed is an evidence-based action plan for improving health care quality.

One example that has seen real success in improving health care quality is in the checklist used in intensive care units. Use of a basic checklist to ensure that certain things are done and that patients are appropriately cared for led to significant reductions in the incidence of infections and pneumonia in patients (e.g., Berenholtz et al., 2004).

Unfortunately, Beal pointed out, it is not always easy to get quality-improvement research published. Quality-improvement research does not fit into the randomized controlled trial model. A new paradigm for assessing quality-improvement research is needed, as it does not have the same methodological rigor as bench research that uses the randomized controlled trial model.

For example, when children of color are admitted to the hospital with asthma, they are less likely than white children to be sent home with medications that control asthma. A number of strategies could be taken to address this issue: creation of guidelines to distribute to all staff, patient education, collaboration with pharmacies to ensure that each child is sent home with medications, and working with primary care providers to ensure that appropriate follow-up occurs. As a pediatrician, Beal said that she would keep doing all of these things until 100 percent of her patients were sent home with asthma-controlling medication. By consideration of the data for each of these steps, improvement can take place.

The research that is needed should be linked with a concerted communication plan to share the information from that research with those people who do not know that health disparities are a problem in this country. Health disparities are a national issue that affects the country's economic stability and life expectancy rates for all groups, Beal stated. Furthermore, given the growing diversity of the U.S. population, this issue cannot be ignored.

One of the challenges to creating an evidence-based action plan is that it requires a fresh approach to research. One of the basic tenets of experimental research is the availability of a clear, concise, narrowly focused question to be answered. This kind of reductionist approach will not work when health disparities are addressed.

The reductionist approach also lends support to the idea that a “silver bullet” that can address disparities does exist. The reality is that to get to the root cause of disparities, it is not going to be just one factor. For example, poor health literacy perpetuates health disparities, as does a lack of access to care, a lack of access to a regular provider, and a lack of access to a medical home. No single factor can be considered to be the root cause of disparities.

It is also clear that although national data can provide a direction, local data are needed to determine an appropriate intervention. Beal used as an example the implementation of an intervention to address obesity in The Bronx, New York, versus one to address obesity in rural Mississippi. How an intervention gets implemented on the ground is going to be extremely different in these two locales. This means that everyone must be prepared for complexity.

Beal described a patient she once had, a young Latina, who was dealing with an unplanned pregnancy. She was already 2 months pregnant when she realized that she was pregnant. She then took another month to decide to keep the baby. At 3 months pregnant, she tried to go see a physician. The physician explained to her that she needed to have health insurance, so she had to apply for Medicaid. The young woman did apply for Medicaid, which took another 6 weeks to process. At this point, the young woman was 4.5 months pregnant. The next step was to find a provider who would accept Medicaid. By the time she found a health care provider who would accept Medicaid, she had to wait 6 weeks for an appointment. At 6 months pregnant, she was ready for her first prenatal visit. Several days before her appointment, the young woman went into labor and delivered triplets. The babies ended up doing well, because the mother was quite capable and had strong family support. Clearly, however, said Beal, this is an example of a disparity in access to health care.

What could have been done to help this mother? First, she could have been insured right from the start and provided with coverage that includes access to contraception. She could have had easier access to care. She could

have had easier access to Medicaid providers in her community; however, an inadequate number of providers were willing to accept Medicaid. A situation like this one would have needed several interventions to prevent a disparate outcome. Again, this research is not simple, and all involved need to be prepared for what is not going to be clean research.

Cultural Competence

Cultural competence is critically important, said Beal. Patients need to feel valued, and patients need to be able to talk with their providers. At the same time, this is not enough to eliminate disparities. Beal stated that “cultural competence is important in and of itself, but it is not the panacea, and it is not going to do all that we need to do to address disparities.”

As an example, she talked about her father, who has end-stage renal disease. He reported that he often feels that he is not treated with respect by the hospital staff (for example, they call him by his first name, which he does not find acceptable). Beal’s father also reports challenges with poor care coordination and challenges with payment for home care. This takes the policy discussions about health disparities back to the real world and out of the realm of policy discussions.

The paradigm needs to be shifted from a deficit model of describing health disparities to an asset model that considers solutions, stated Beal. Rather than looking at a community’s disparities, look for a community with no disparities and study them. Those pockets of excellence need to be found and studied. Much as Elliot Fisher demonstrated with the Dartmouth Atlas (www.dartmouthatlas.org), it is essential to look for the communities with high-quality care and low levels of health disparities and to study those communities. Beal concluded by emphasizing several future needs: the need for a paradigm shift from health disparities to health equity, the need for an evidence-based action plan, and the need to be prepared for complexity.

DENNIS ANDRULIS

Dennis Andrulis is a senior research scientist at the Texas Health Institute, where he conducts research with vulnerable populations on the topics of urban health, cultural competence, and language assistance. He was previously associate dean for research in the Drexel University School of Public Health. Andrulis began his comments by stating the three main themes for his presentation, which can be identified by the following questions:

- Where are the knowledge gaps?
- Where does cultural competence stand today?
- What are the next steps?

Knowledge Gaps

In discussing the knowledge gaps in the field of health disparities today, Andrulis acknowledged that research on the incidence and prevalence of health disparities has matured. However, although a base has been established, knowledge gaps persist. Andrulis explained that the knowledge gaps occur at three key levels: the individual, organizational, and community levels.

Individual Level

On the individual level, Andrulis said, although research and knowledge regarding the incidence and prevalence of health disparities-related conditions have matured in many ways, gaps persist in knowledge about why disparities in health outcomes have not narrowed more significantly. The persistence of these knowledge gaps, in turn, leads to three questions:

- Do historic or generational issues (such as poverty) that might change over time exist? He described some earlier research conducted in Prince George's County, Maryland, that found that very high levels of chronic disease and mortality continue to exist there, even though it is one of the wealthiest counties with a predominantly African American population in the United States. In fact, the rates for many conditions or causes of mortality (for example, infant mortality, smoking, and irregular seat belt use) were similar to those seen in inner-city Washington, DC (Lurie et al., 2009).
- To what extent are current and intensifying concerns (such as overweight, obesity, and diabetes) mitigating efforts to reduce health disparities? In other words, are there contributing factors that are superseded by other emerging factors now coming to the fore? Efforts to reduce the effects of these emerging factors on chronic conditions could be mitigating progress in reducing health disparities.
- How and to what extent do race and culture-specific impediments to effective care and management (such as language, health literacy, and communication challenges) contribute to health disparities? This broad set of issues around race, culture, language, and cultural competence should be addressed.

Organizational Level

Health care reform, the ACA, has implications for reductions in health disparities through system incentives, such as reimbursement rates.

In responding to these system incentives, health care organizations can have an effect on reducing disparities. However, resistance to change to address diverse patient needs can intersect with new incentives to improve patient access and quality; therefore, it is critical to note the characteristics of low-performing health systems and compare them with the characteristics of high-performing health systems. Understanding the implications and impact of pay for performance should also be considered in the context of efforts to reduce health disparities. Andrulis noted both an opportunity and an obligation to engage these organizations more fully, directly, and in a measured way to address health disparities, as health care institutions play a key role in affecting institutional racism in the health care system.

Community Level

The influences of place and geography as contributors to health disparities have a very limited research base and several questions remain unanswered. For example, what are the community factors that contribute to and help perpetuate health disparities, aside from the usual suspects (for example, poverty and a lack of education)? What is the importance of each factor to an understanding of health disparities? What about the importance of the mix of factors in different communities?

What Is the Current Status of Cultural Competence?

Although knowledge about the role of cultural competence in access to and quality of health care is growing, more specific detail on the operationalization of cultural competence is needed, said Andrulis. In fact, the National Center on Minority Health and Health Disparities (NCMHD) has included cultural competence in its solicitations for proposals, indicating the importance of cultural competence among access and quality measures.

Lieu et al. (2004) conducted research funded by The Commonwealth Fund on the effects of cultural competence–related policies and practices on outcomes of care for asthma in children and found that cultural competence did play a role in the more positive health outcomes. Although this finding is promising, little research that might flesh out the particular components of cultural competence that make a difference has followed. Much more needs to be done in this area.

Work in the area of standards development for cultural competence has also taken place. For example, the Joint Commission, the Office on Minority Health in HHS, and the National Quality Forum are all developing standards for interpreter qualifications as well as language and culture measures. Although movement in the area of cultural competence is clearly

happening, it is not clear where the movement toward the development of these standards will go next.

Specific Elements of a Cultural Competence Model

Perhaps the biggest knowledge gap in the implementation of cultural competence interventions and the creation of measures involves the specific elements of a cultural competence model. Andrulis asked what works, when, and how. Much work remains to be done in this area. Although practitioners who believe in the concept accept the concept, some skepticism about cultural competence remains.

A second knowledge gap is that little research on what constitutes effective training in cultural competence has taken place. Training should also be standardized, and this has not yet occurred. Again, a much larger literature around training in cultural competence needs to be created.

Finally, the importance of community engagement in the provision of culturally competent care is acknowledged but has not been fully explicated. For example, the Centers for Medicare and Medicaid Services (CMS) is working with quality-improvement organizations participating in diabetes management programs to require these organizations to engage communities and include community-based workers in their programs. Overall, however, much more work is needed in this area.

Next Steps

Andrulis closed his presentation with some suggestions about what needs to happen next in health disparities research. He outlined his suggestions in three separate areas.

First, research is needed to identify effective strategies for tailoring chronic disease and wellness management programs to diverse individuals. Clinical care models (and the components of those models) that might be adapted to the management of health and wellness for diverse populations have not been adequately reviewed or analyzed to date.

Self-management should also be considered a part of these models. What specific strategies of self-management will help diverse populations take charge of their health and wellness? What strategies will help diverse populations respond and adhere to treatment? Models of care management and wellness management should take into account issues around race, culture, literacy, and language. Development of an evidence base for the management of chronic diseases in diverse patients should also be a part of this process.

Second, provision of support for research and assessment activities that link health care organizations with efforts to reduce disparities is a

necessary next step. Organizations should conduct cultural audits of their activities and ensure that the consumer's perceptions match the organization's perceptions of their actions to reduce health disparities and improve cultural competence. A body of work is needed to determine whether it is possible to differentiate actions that work better from others that work less well.

The third area of research needed is the creation and testing of specific interventions that train and educate health care organizations and practitioners to use broader intersectoral strategies to promote health and prevent chronic illness. It is not enough to look at the health care system, because the health care system often serves as the funnel for other problems facing diverse populations (for example, domestic abuse, poor housing options, and homelessness). All of these systems should be considered together, and the barriers across systems should be broken down.

One potential strategy to promote intersectoral work is to change the ways that health care practitioners are rewarded. For example, a physician-practitioner advocate role could be formalized in a way that allows incentives for health care institutions to work with agencies beyond the health care clinic.

Andrulis proposed that the Institute of Medicine (IOM) undertake a comprehensive study to provide guidance about cultural competence to the health care field. With the enactment of health care reform, this would be a very helpful document, he suggested. The report should cover the following issues:

- Define what constitutes the field of cultural competence.
- Identify what data are needed to create an evidence base.
- Develop applicable measures of effectiveness.
- Establish the link between cultural competence and health care quality, cost, and effectiveness.
- Identify what constitutes effective diversity training and education.
- Clarify the role of cultural competence in achievement of prevention outcomes.

A federal strategy to promote intersectoral programs, initiatives, and policies should be created and formalized, Andrulis said. Interagency and community collaborations to promote prevention and health care goals should also be promoted at the state and local levels. Furthermore, the research base should be broadened to include successful demonstrations of collaborative initiatives between health care organizations and housing, transportation, and other relevant agencies with the goal of improving health.

Finally, although CLAS (Culturally and Linguistically Appropriate Ser-

vices) standards are in place, demonstrations and evaluations of programs implementing these and other relevant standards should be conducted. It is important to begin to measure the effects of these standards.

DISCUSSION

William Vega, describing himself as “having been a gardener in the vineyard of cultural competence,” commented that cultural competence is a heterogeneous concept. This makes it difficult to standardize measures and then link them to a specific form of training. Vega explained that because supervisors and chief executive officers set and sustain policies, they should be willing to experiment. And as they experiment, those in leadership roles should be aware of the complexity of measuring cultural competence and the tentative nature of the process that Anne Beal described and have the willingness to go the distance in order to achieve cultural competence. Andrulis responded that leadership should play a key role and that leadership is where the process should begin. At the same time, building cultural competence within an organization among an array of practitioners might assist with sustainability. The recognition that every organization has strengths and assets and the tying of those assets to the measurement of cultural competence can lead to a strategy to build on those assets.

Valerie Welsh, the performance improvement evaluation officer at OMH (Office of Minority Health), described research looking at public awareness of health disparities over time. She reported that although the general public’s awareness of health disparities has increased, the increase has been relatively modest. Awareness of health insurance disparities is higher, and African Americans are more aware of health disparities than are other racial/ethnic groups. The public has a very low level of awareness of health disparities affecting Asian Americans, even among Asian Americans themselves. Welsh said that increasing awareness is the first step in trying to address the problem. Awareness of disparities is markedly higher among physicians than among the general public; nonetheless, physicians too underestimate the degree of the disparities in many areas.

OMH released a strategic framework addressing health disparities in 2008. Welsh said that as the framework was being created, the office found much research about the nature of the problem of health disparities and on the contributing and causal factors. In particular, more Americans are aware that disparities in health insurance coverage exist. However, what was not found was research identifying the specific outcomes at the individual, societal, and systems levels. This raised questions of how those outcomes should be measured so that methodologically sound evaluations of interventions designed to ameliorate those factors can be conducted.

Welsh noted that the research community could be doing a better job of identifying and testing measures of intervention outcomes.

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7

Legislative Actions to Reduce Health Disparities

The final panel of the day focused on the Patient Protection and Affordable Care Act (ACA) of 2010 and the provisions within the law that address health disparities. Three congressional staff members shared their expertise on those aspects of the law that have the potential to reduce health disparities among people of color.

THE SENATE PERSPECTIVE

Senate Health, Education, Labor, and Pensions Committee

Craig Martinez is a health policy adviser to the Senate Health, Education, Labor, and Pensions Committee. His legislative portfolio includes public health, prevention, preparedness, and health disparities.

Noting that Senator Tom Harkin refers to the ACA as a “starter home” for providing health care to all Americans, Martinez acknowledged that much work remains to be done to address health disparities. Nonetheless, the ACA is a critical first step, and a number of provisions in the law relate to low-income communities and communities of color.

Health Insurance Affordability

Ensuring that people can afford health insurance is an important piece of addressing health disparities, Martinez explained. One component of the effort to make insurance affordable is the provision of subsidies to low-income individuals. These subsidies can then be used to purchase coverage

that includes preventive services and out-of-pocket costs. The ACA will lead to new coverage for 32 million Americans who are currently uninsured.

The law also addresses the challenge of the acquisition of insurance for those living with preexisting conditions. Under the new law, it is no longer allowable to drop a patient if he or she gets sick. It is also no longer allowable to deny coverage in the first place.

Access to Health Care Services

Community health centers (CHCs) are an important source of care for individuals in low-income communities, said Martinez. The ACA provides additional support for the creation and expansion of CHCs, including support for nurse-managed health centers and improved access to case management services. School-based clinics are also provided support through the ACA, as schools are often the only point of access for child health services in low-income communities. Martinez indicated that health information technology should be used to facilitate enrollment for services in low-income communities of color and to give patients greater control over the decisions involved in their access to health care services.

Workforce Preparation

The ACA creates a new commission to focus on workforce issues. The commission will consider both worker competence and workforce diversity. Martinez explained that it is clear that individuals in low-income communities have inadequate access to medical specialists and to health care professionals trained in cultural competence. Cultural competence, in fact, should be promoted among all health care providers. The ACA contains initiatives to ensure that medical schools provide training in cultural competence to students as preparation for their future work with patients from different cultural contexts.

Improving Quality of Health Care Services

The creation of quality measures that assess both health care provision and health outcomes is the fourth piece of the ACA relevant to achieving reductions in health disparities. It is not enough, Martinez said, to have health insurance and access to care in communities of color. The quality of health care must also be considered. Chronic disease management, particularly in low-income communities of color, is also critical.

Prevention

The ACA contains a variety of provisions focusing on the role of prevention in the promotion of better health. The law led to the creation of a national health council to promote prevention. The council is predicated on the idea that it is not enough to consider only health care when the discussion is about the improvement of health outcomes for all. Rather, the built environment itself—access to parks, good public transportation, and job opportunities—should be considered. The council’s membership includes the U.S. Department of Health and Human Services (HHS) as well as other federal agencies such as the U.S. Department of Housing and Urban Development (HUD) and the U.S. Department of Transportation.

The Community Transformation Grants (CTGs) that are included in the ACA also focus on improvements to the built environment. Although there is a strong evidence base for the importance of considering the built environment to improve health, many members of the Senate did not understand the connection. The provisions that focus on improvements to the built environment remained in the final bill, however.

Consistent funding streams for preventive services are also included in the law, as is maintenance of the public health infrastructure. Community preventive services such as disease prevention and safety net programs, which have consistently been underfunded in the past, are seen to be important continued investments in the ACA, explained Martinez.

Data Collection Standards

The collection of race and ethnicity data across federal agencies is essential to get a better sense of the degree of health disparities in the United States. The availability of good data also provide the ability to evaluate subpopulations; for example, not all Asian American populations are alike, said Martinez. Data collection efforts should be coordinated across agencies so that a clearer picture of what is occurring in communities of color can be obtained.

Federal Minority Health Agencies

A number of actions relating to the elevation of federal agencies focusing on minority health are a part of the ACA, including elevation of the Office of Minority Health within HHS to the HHS secretary’s office. This gives the office more prominence in the public realm and more clout to accomplish those efforts aimed at achievement of reductions in health disparities in communities of color.

Other federal agencies, including the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration, Agency for Healthcare Research and Quality, Food and Drug Administration, and Centers for Medicare and Medicaid Services (among others), are tasked to create an Office of Minority Health within each agency. This will allow better coordination of efforts across agencies on initiatives to improve health in communities of color.

Finally, the National Center on Minority Health and Health Disparities within the National Institutes of Health (NIH) is now elevated from a center to a formal institute; the center is now known as the National Institute on Minority Health and Health Disparities (NIMHD). This provides NIH with greater authority to coordinate health disparities research and provides access to greater resources to continue to focus on the health issues affecting communities of color.

Martinez concluded by noting that although much remains to be done to reduce health disparities, advances are being made under the ACA. What is important to remember, he said, is that the health insurance provisions will have a positive effect on the residents of low-income communities and communities of color.

Senate Committee on Finance

Kelly Whitener is a health policy adviser to the Senate Committee on Finance. She is also a former Peace Corps volunteer and former community mental health worker.

The Committee on Finance focuses primarily on the cost aspects of the ACA. Whitener explained that the committee considers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Thus, the provisions of the bill relevant to this committee were more narrowly focused than the provisions described in the previous presentation.

One major outcome of ACA, previously mentioned by Craig Martinez, is the improvement of data collection requirements. More specifically, data collection requirements are now more uniform across programs; in the past, for example, Medicaid and CHIP had different requirements. Because the populations served by these programs are similar, it makes sense for data collection requirements to be more uniform.

Whitener stated that the Medicaid program typically receives much less attention than the Medicare program. Therefore, several provisions to improve health disparities in the Medicare program were extended to apply to Medicaid and CHIP as well. This allows the Centers for Medicare and Medicaid Services (CMS) to bring parity across the programs.

The major accomplishment of health reform from the perspective of the

Committee on Finance is improved coverage for low-income Americans. In particular, Whitener said, those childless adults who today do not have access to coverage will be able to get coverage. As Martinez mentioned, 32 million people currently without health insurance will have health care coverage, and 14 million of those will have coverage through Medicaid. Those 14 million people have incomes less than 133 percent of the federal poverty rate. For many, if not most, of these people, this will be the first time that they have a source of health care coverage.

Although much good news is in the ACA, some issues were not adequately addressed in the final legislation, said Whitener. Language and translation services in Medicare, Medicaid, and CHIP were not addressed, for example. It is difficult to provide the best possible care without using the languages that people are most comfortable with. Whitener hopes that this issue, among many others, can be addressed in future legislation.

THE HOUSE OF REPRESENTATIVES PERSPECTIVE

The final panelist was Bernardette Arellano, a legislative assistant from the office of Congressman Mike Honda of California. She is responsible for the labor/HHS component of the Appropriations Subcommittee.

Arellano highlighted several changes in the reconciliation bill that improved some health disparities provisions in the final Senate bill that was signed into law. (Because of the way that the ACA was passed by Congress, the usual process in which a conference committee resolves differences between the House bill and the Senate bill did not occur.)

Institutions Serving Minority Populations

First, funding in support of historically black colleges and universities and other institutions serving minority populations was extended through 2019. In particular, programs focusing on math, science, technology, and engineering were targeted for extension.

Funding for Territories

An important issue for Congressman Honda, an Asian American, was the increase in federal funding for the territories (for example, Guam, American Samoa, and the Northern Mariana Islands). The caps on Medicaid funding were raised, and territories can also elect to operate a health exchange under the language of the reconciliation bill.

Arellano noted that although Americans in general have little awareness of the problem of health disparities in the United States, even less awareness of the problem of health disparities for citizens living in the

territories exists. Each island has very few physicians, no oncologists, no access to podiatric services, and very limited health care access compared with the availability of physicians and access on the mainland.

Funding for Community Health Centers

The reconciliation bill increased funding for Community Health Centers (CHCs) to \$11 billion. As stated earlier, CHCs are the primary point of access to health care in low-income communities of color.

Data Collection

Arellano expressed the need for a richer picture of the differences within racial and ethnic minority communities and praised the final Senate bill for its emphasis on data collection. For example, wide-ranging differences exist between Cambodian Americans and Japanese Americans; without adequate data collection, it is difficult to address those differences.

Issues to Be Addressed in the Future

Like the previous panelists, Arellano outlined several issues that future legislation will need to address to reduce health disparities. Echoing earlier comments, the final bill did not address language and translation services in Medicare, Medicaid, and CHIP.

The House bill also extended Medicaid coverage to legal immigrants during the first 5 years of their residency in the United States. This extension of coverage, however, was not a component of the final bill, likely because of political pressures about immigration reform, said Arellano. She noted that exclusion of legal immigrants—called “citizens in waiting” by Congressman Honda—from a public program designed to keep them and their children healthy is difficult to justify.

Finally, Arellano noted that HHS has a wide range of ACA-related regulations to be promulgated. It is critical that the agency hear from members of the public about their concerns with the proposed regulations.

DISCUSSION

Cara James of the Kaiser Family Foundation asked about the demonstration projects that are built into the ACA. The findings from those demonstration projects are likely to affect health disparities in a variety of ways; for example, the Medicare pay-for-performance measures are designed to improve health care quality, which in turn should affect disparities in care. How will the findings of these projects be considered, disseminated, and

used as a feedback loop? Kelly Whitener responded that a large number of demonstration projects, each with its own timeline and focus, are operating in different states. For those projects with positive preliminary feedback, Congress can make the case that those projects should be continued.

Whitener described, as an example, a demonstration project under Medicare focused on diabetes that has a component serving Native Americans. This demonstration project has worked extremely well in Montana, which has a large Native American population, but has not done so well at other sites. The Senate could therefore push to continue the project for Native Americans. What is helpful, said Whitener, is to have outside groups and experts suggest the good programs to be evaluated.

Pattie Tucker of CDC offered the REACH (Racial and Ethnic Approaches to Community Health) demonstration projects as an example of a successful community-based program that went from making changes in the lives of individuals participating in community programs to changes at the policy level. The challenge is that completion of this transition from changes in individual and community behaviors to broader policy changes during the 5-year grant cycle is difficult. If some projects receive additional funding, CDC hopes to see more dramatic changes in those communities.

Newell McElwee of Merck & Co., Inc., asked about the workforce diversity provisions included in the ACA and its tasks. Craig Martinez said that the overall goal of the workforce commission outlined in the legislation is to provide to Congress and HHS comprehensive, unbiased information on how to better align federal health care resources with national needs. Its purpose is to assess what the workforce looks like today, what the workforce needs are, what needs are unmet, and what must occur to further develop this workforce.

Anne Kubisch of the Aspen Institute asked about the federal inter-agency collaborations around place and communities that are under way. These collaborations include the Sustainable Communities Initiative that brings together HUD, the U.S. Department of Transportation, and the Environmental Protection Agency; the Promise neighborhoods funded by the U.S. Department of Education; and the Choice neighborhoods program funded by HUD. She wondered about the leadership for this work and the role that outside groups such as the Institute of Medicine Roundtable can play in making sure that these programs are implemented as effectively as possible.

Martinez described the organizational culture of federal agencies, saying that different departments are happy in their “silos” and that it can be difficult for them to interact with each other. At the same time, programs across different departments can give a “bigger bang for our buck” when they work together. One example is the Prevention Council, which ACA legislation mandated to be made up of the secretaries of the federal agen-

cies. Additionally, the Prevention Council is a priority for Senator Harkin. This requires a change of culture, however, and that can be scary for people.

Whitener added that a wealth of knowledge about what is actually happening in communities and how programs are having an impact on people is being obtained by the agencies. Because Congress is a very action-oriented place, she said, it is useful to have that knowledge so that a problem can be fixed when it is presented. For example, an effort to coordinate transportation among Medicaid facilities, schools, and clinics would keep four different vans from going to the same neighborhood to pick up neighbors and separately take them to various places simply because they receive funding through separate funding streams. Therefore, it is helpful when outside groups or experts can present a problem and suggest solutions on which Congress can act.

Bernardette Arellano added that allowing federal agencies some flexibility allows for creativity, but it also means that Congress must give up some control. Under a friendly administration, much can be done to work in the interest of low-income people. She also said that use of the report language that accompanies a spending bill can be a very powerful strategy to encourage a federal agency to act. For example, report language suggested the creation of an interagency task force on viral hepatitis. Even though direct funding may not be provided, when Congress expresses support for something via report language, an agency director will closely look at that language and parcel out funding for the project. Report language can therefore be a powerful tool.

A

Workshop Agenda

Ten Years Later: How Far Have We Come in Reducing Health Disparities?

Roundtable on the Promotion of Health Equity and the
Elimination of Health Disparities

National Academies Keck Center Room 100
500 Fifth Street, NW
Washington, DC

April 8, 2010

Objectives of meeting

- To assess progress to date in addressing health disparities since 2000
- To consider the scope and effectiveness of efforts to address social determinants in reducing disparities
- To determine what we still need to learn about efforts to address social determinants, reduce disparities, promote health equity, and move successful models to scale

8:30 – 8:45 a.m. Welcome and Introductions
William Vega, *Chair, Roundtable*

8:45 – 9:00 a.m. Remarks
Howard Koh, Assistant Secretary for Health,
U.S. Department of Health and Human Services
Cara James, Moderator

- 9:00 – 10:30 a.m. Keynote Panel: What Progress Has Been Made in Reducing Health Disparities? A Historical Perspective
- David Williams**, Harvard School of Public Health
Brian Smedley, Joint Center for Political and Economic Studies
Steven Woolf, Virginia Commonwealth University
William Vega, Moderator
- 10:30 – 10:45 a.m. Break
- 10:45 a.m. – 12:00 p.m. Panel: Federal Perspectives on Reducing Health Disparities
- John Ruffin**, National Institutes of Health
Carolyn Clancy, Agency for Healthcare Research and Quality
Mildred Thompson, Moderator
- 12:00 – 1:00 p.m. Working Lunch
- 1:00 – 1:20 p.m. Current Programs Addressing Social Determinants at the National Level
- Susan Sher**, Office of the First Lady
- 1:20 – 2:15 p.m. Current Programs Addressing Social Determinants at the Local Level
- Mildred Thompson**, PolicyLink
Mary Lou Fulton, The California Endowment’s Building Healthy Communities Program
- Questions and Discussion
- 2:15 – 2:30 p.m. Break
- 2:30 – 3:45 p.m. What Do We Still Need to Learn About Reducing Health Disparities?
- Paula Braveman**, University of California, San Francisco
Anne Beal, Aetna Foundation
Dennis Andrulis, Texas Health Institute, Austin
- Questions and Discussion

- 3:45 – 5:00 p.m. Health Care Reform Legislation and Health Disparities: Where Are We Now?
Kelly Whitener, Senate Committee on Finance
Craig Martinez, Senate Health, Education, Labor, and Pensions Committee
Bernardette Arellano, Office of Congressman
Mike Honda
- 5:00 p.m. Adjourn

B

Speaker Biographical Sketches

Dennis P. Andrulis, Ph.D., M.P.H., is a senior research scientist at the Texas Health Institute in Austin, where he oversees and conducts research and other work concerning vulnerable populations, the safety net, and urban health, with a special focus on racial/ethnic disparities, cultural competence, and language assistance. Prior to his current appointment, he served as the associate dean for research and director of the Center for Health Equality in the Drexel University School of Public Health, where he assisted in guiding the research agenda for the school and led the work of the center. Before these appointments he held the position of research professor, State University of New York/Downstate Medical Center/Brooklyn, where he conducted research and other activities related to health care for racially/ethnically diverse patients and communities, social and health conditions in the nation's largest cities and suburbs, and the health care safety net. Recent work includes a book entitled *Managed Care in the Inner City: The Uncertain Promise for Providers, Plans and Communities*, creation of a cultural competence self-assessment tool for health care organizations, and a national conference series called "Quality Health Care for Culturally Diverse Populations." He has also developed a compendium and analysis of national data sources on the nation's 100 largest cities and their surrounding areas entitled *Social and Health Landscape of Urban and Suburban America*. His most recent projects include creation of a national consensus panel and the National Resource Center on Diversity and Preparedness and tracking of health care reform legislation and its implications for racially/ethnically diverse patients and populations. He holds a Ph.D. in educational-community psychology from the University of Texas at Austin

and a master's of public health from the University of North Carolina at Chapel Hill.

Bernardette Arellano has worked for Congressman Mike Honda more than 6 years, first as a senior field representative and caseworker and currently as a legislative assistant. During her time with the Honda office, she has handled a wide variety of issues, including health, transportation, labor, agriculture, Social Security, women's issues, the Temporary Assistance for Needy Families Program/welfare, Native American issues, environmental issues, and civil rights. Currently, she is primarily responsible for health, transportation, labor, and the labor/health and human services component of the congressman's work on the Committee on Appropriations Labor, Health and Human Services, and Education Subcommittee. She is originally from Gilroy, California, and graduated from Princeton University in 2002.

Anne Beal, M.D., M.P.H., is president of the Aetna Foundation, the independent charitable and philanthropic arm of Aetna Inc. The foundation helps build healthy communities by promoting volunteerism, forming partnerships, and funding initiatives that improve the health and quality of life across the United States. As a physician who specializes in pediatric care and public health, Beal brings to the foundation a unique combination of clinical and policy experience. Beal joined the foundation in July 2009 from The Commonwealth Fund, where she directed the fund's program to improve health care quality for low-income and minority patient populations. Prior to that, she was an attending physician at Massachusetts General Hospital and on the faculty at Harvard Medical School.

Beal earned an A.B. degree in biology from Brown University in 1984, a doctorate in medicine from Cornell University Medical College in 1988, and a master's in public health from Columbia University in 1993.

She is a recognized authority in health disparities, quality of care, and children's health, topics on which she has published several articles in the medical literature as well as a book titled *The Black Parenting Book: Caring for Our Children in the First Five Years*. Beal has been a pediatric commentator and medical correspondent for *Essence* magazine, the *American Baby Show*, ABC News, and NBC News.

Paula Braveman, M.D., M.P.H., is professor of family and community medicine and director of the Center on Social Disparities in Health at the University of California, San Francisco (UCSF). She received a degree in medicine from UCSF and a degree in epidemiology from the University of California, Berkeley, and practiced medicine in a range of settings serving diverse, disadvantaged populations. For more than two decades, Braveman has studied and published extensively on social disparities in health and

health care and actively engaged in bringing attention to this field in the United States and internationally. Her research has focused on measuring, documenting, and understanding socioeconomic and racial/ethnic disparities, particularly in maternal and infant health and health care. During the 1990s she worked with World Health Organization staff in Geneva, Switzerland, to develop and implement a global initiative on equity in health and health care. Throughout her career, she has collaborated with local, state, federal, and international health agencies to see research translated into practice with the goal of achieving greater equity in health. She was elected to the Institute of Medicine of the National Academies in 2002.

Carolyn Clancy, M.D., was appointed director of the Agency for Healthcare Research and Quality (AHRQ) on February 5, 2003. Prior to her appointment, Clancy served as the agency's acting director and was previously director of AHRQ's Center for Outcomes and Effectiveness Research. Clancy, who is a general internist and health services researcher, is a graduate of Boston College and the University of Massachusetts Medical School. Following clinical training in internal medicine, Clancy was a Henry J. Kaiser Family Foundation Fellow at the University of Pennsylvania. She was also an assistant professor in the Department of Internal Medicine at the Medical College of Virginia, before joining AHRQ in 1990. Clancy holds an academic appointment at the George Washington University School of Medicine (clinical associate professor, department of medicine) and serves as senior associate editor of *Health Services Research*. She has served on multiple editorial boards and is currently on the board of the *Annals of Family Medicine*, the *American Journal of Medical Quality*, and *Medical Care Research and Review*. She is a member of the Institute of Medicine and was elected a master of the American College of Physicians in 2004. In 2009, Clancy was chosen as the most powerful physician-executive by readers of *Modern Healthcare* and *Modern Physician* magazines. She was also awarded the 2009 William B. Graham Prize for Health Services Research. Her major research interests include improving health care quality and patient safety and reducing disparities in care associated with patients' race, ethnicity, gender, income, and education. As director of AHRQ, she launched the first annual report to Congress on health care disparities and health care quality.

Mary Lou Fulton is a program officer overseeing communications and media grant making at The California Endowment, the state's largest health-focused foundation. She moved to the foundation world in 2009 after a 20-year career in journalism and digital media. Fulton started out as a reporter for the Associated Press and then joined the *Los Angeles Times*, where she was a reporter and editor for 6 years. She moved to the online

world in 1995, joining the *Washington Post*, where she helped to launch washingtonpost.com and served as the site's managing editor. Fulton went on to hold senior management positions at a number of online companies, including AOL, GeoCities, and HomePage.com, before returning to the newspaper world in 2003 at the *Bakersfield Californian*. In Bakersfield, she created a new product development team that was nationally recognized for its participatory media initiatives, including the first citizen journalism publication to be started by a U.S. newspaper. A native of Yuma, Arizona, and a second-generation Mexican American, Fulton holds a bachelor's degree in journalism from Arizona State University and a master of public administration degree from Harvard's Kennedy School of Government. She blogs at <http://mediaoptimist.wordpress.com>.

Howard Koh, M.D., M.P.H., serves as the 14th assistant secretary for health for the U.S. Department of Health and Human Services (HHS), after being nominated by President Barack Obama and confirmed by the U.S. Senate in 2009. As the assistant secretary for health, Koh oversees the HHS Office of Public Health and Science, the Commissioned Corps of the U.S. Public Health Service, and the Office of the Surgeon General. He also serves as senior public health adviser to the secretary. At the Office of Public Health and Science, he leads an array of interdisciplinary programs. Koh previously served as the Harvey V. Fineberg Professor of the Practice of Public Health, associate dean for public health practice, and director of the Division of Public Health Practice at the Harvard School of Public Health. At Harvard, he also served as the principal investigator of multiple research grants. He was also director of the Harvard School of Public Health Center for Public Health Preparedness. He has published more than 200 articles in the medical and public health literature. Koh served as commissioner of public health for the Commonwealth of Massachusetts (1997-2003), after being appointed by Governor William Weld. Koh graduated from Yale College (where he was president of the Yale Glee Club) and the Yale University School of Medicine. He completed postgraduate training at Boston City Hospital and Massachusetts General Hospital, serving as chief resident in both hospitals. He has earned board certification in four medical fields, internal medicine, hematology, medical oncology, and dermatology, as well as a master of public health degree from Boston University. At Boston University Schools of Medicine and Public Health, he was professor of dermatology, medicine, and public health as well as director of cancer prevention and control. He is an elected member of the Institute of Medicine of the National Academies. President Bill Clinton appointed Koh as a member of the National Cancer Advisory Board (2000-2002). Other awards include being named to the K100 (the 100 leading Korean Americans in the first century of Korean immigration to the United States), the Boston University

School of Public Health Distinguished Alumni Award (the highest award of the school). The Boston Red Sox designated him a Medical All Star (2003), which included the opportunity to make the ceremonial first pitch at Fenway Park.

Craig Martinez, M.P.H., is a health policy adviser in the Majority Health Policy Office of the Senate Health, Education, Labor, and Pensions (HELP) Committee, first under the chairmanship of Senator Edward M. Kennedy and currently under the chairmanship of Senator Tom Harkin. His legislative portfolio on the HELP Committee includes issues relating to public health, prevention, health disparities, and public health preparedness. Martinez is a candidate for a doctorate in public health degree in child and adolescent health at the Johns Hopkins Bloomberg School of Public Health, where he examines the effects of acculturation on Mexican American youth. He also holds a master of public health degree from Johns Hopkins and a bachelor's degree from Stanford University. Martinez has more than 10 years of experience working with a number of nonprofit organizations and health care providers that offer community and clinical preventive services to predominantly low-income communities of color in the San Francisco Bay Area and the greater Washington, DC, region.

Diana Ross is the collaborative director of the Mid-City Community Advocacy Network (Mid-City CAN) in the San Diego, California, community of City Heights. Mid-City CAN is a community collaborative of over 200 organizations, government agencies, faith-based organizations, and residents. Mid-City CAN's mission is to promote a safe productive and healthy community through collaborative efforts. For 8 years, Ross has worked with collaboratives that serve diverse communities in Southern California. She worked with the Los Angeles Refugee Immigrant Training Employment program collaborative in Los Angeles, US-Mexico Bilateral Safety Corridor Coalition (a binational anti-human trafficking collaborative), and the San Diego Refugee Forum in City Heights. In addition to her work with collaboratives, she is a former director of Refugee Employment Services in City Heights. Ross began her career coordinating medical camps for Rotary International's Polio Plus program in Ethiopia and Nigeria. Later, while working as director of refugee employment services in City Heights, she pioneered a social enterprise model to help health care providers and law enforcement agencies comply with Title VI of the 1964 Civil Rights Act. This program grew to provide translation and interpretation services in more than 72 languages and cultural competency consultation and training. The county of San Diego hailed the Refugee Employment Services program as Best of the Best in client participation at its annual Best Practices Provider Seminar in 2006, and Ross was a featured presenter at the state of

California Annual Refugee Summit. She has college honors and a bachelor's degree in sociology and international development from the University of California, Los Angeles (UCLA), where she was also awarded the Riordan Fellowship at UCLA's Andersen School of Management. Ross has college honors and a master's degree in nonprofit leadership and management from the University of San Diego. She is a former Rotary International Ambassadorial Scholar at the American University in Cairo, Egypt, and speaks English, Arabic, and Spanish.

John Ruffin, Ph.D., is director of the National Institute on Minority Health and Health Disparities (NIMHD). He oversees the NIMHD budget of approximately \$210 million. In addition, he provides leadership for the minority health and health disparities research activities of the National Institutes of Health (NIH), which constitutes an annual budget of approximately \$2.8 billion. He has served as associate director for minority programs, Office of Minority Programs, and associate director for research on minority health, Office of Research on Minority Health. Under his leadership, NIH convened its first summit on health disparities, the NIH Science of Eliminating Health Disparities Summit, in December 2008. He has received an honorary doctor of science degree from Spelman College, Tuskegee University, the University of Massachusetts in Boston, North Carolina State University, Morehouse School of Medicine, and Meharry Medical College. He has been recognized by the National Medical Association, the Society for the Advancement of Chicanos and Native Americans in Science, the Association of American Indian Physicians, the Hispanic Association of Colleges and Universities, the Society of Black Academic Surgeons, and the National Science Foundation. The John Ruffin Scholarship Program is an honor symbolic of his legacy for academic excellence bestowed by the Duke University Talent Identification Program. Ruffin has also received the Martin Luther King, Jr., Legacy Award for National Service, the Samuel L. Kountz Award for his significant contribution to increasing minority access to organ and tissue transplantation, the NIH Director's Award, the National Hispanic Leadership Award, the Beta Beta Beta Biological Honor Society Award, the U.S. Department of Health and Human Services Special Recognition Award, and the U.S. Presidential Merit Award. He received a B.S. in biology from Dillard University, an M.S. in biology from Atlanta University, and a Ph.D. in systematic and developmental biology from Kansas State University and completed postdoctoral studies in biology at Harvard University.

Susan Sher, J.D., is assistant to the president and chief of staff to First Lady Michelle Obama. In this role, Sher works closely with the First Lady

and her staff on various issue areas with a focus on military families, national service, childhood obesity, and healthy living. In addition to her role in the Office of the First Lady, Sher works on Jewish Outreach for the White House. Her first position in the Obama administration was in the White House Counsel's Office, where she served as associate counsel to the President, until taking over as the First Lady's chief of staff in June 2009. Before coming to Washington, D.C., in January 2009, Sher worked as vice president for legal and governmental affairs and general counsel of the University of Chicago medical center and was responsible for all legal, government, regulatory, and community affairs at the medical center. She also worked on governance and many other board-related issues. From 1993 through 1997, she was the corporation counsel for the city of Chicago, the city of Chicago's chief lawyer, reporting to the mayor and responsible for representing the mayor, city departments, boards, and commissions on all legal matters. She was the first assistant corporation counsel from 1989 to 1993. Previously she was associate general counsel of the University of Chicago and earlier was a partner at Mayer Brown & Platt, specializing in labor and litigation. She is a cum laude graduate of the Loyola University of Chicago School of Law. She has served on many boards, including vice chair of the Board of Trustees of Mt. Sinai Hospital Medical Center and Schwab Rehabilitation Hospital and Care Network, the board of directors of High Jump, and the board of directors of YWCA of Greater Chicago. She is past chair of the University of Chicago Laboratory Schools and of The Chicago Network. She is on a variety of task forces and committees involving not-for-profit corporations and health care, including the Illinois Hospital Association, the attorney general's Charitable Advisory Task Force, and the Donor's Public Trust Task Force.

Brian D. Smedley, Ph.D., is vice president and director of the Health Policy Institute of the Joint Center for Political and Economic Studies in Washington, DC. Formerly, Smedley was research director and cofounder of a communications, research, and policy organization, The Opportunity Agenda (www.opportunityagenda.org), whose mission is to build the national will to expand opportunity for all. Prior to helping launch The Opportunity Agenda, Smedley was a senior program officer in the Division of Health Sciences Policy of the Institute of Medicine (IOM), where he served as study director for studies culminating in the IOM reports *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce* and *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, among other reports on diversity in the health professions and minority health research policy. Smedley came to the IOM from the American Psychological Association (APA), where he worked on a wide

range of social, health, and education policy topics in his capacity as director for public interest policy. Prior to working at APA, Smedley served as a congressional science fellow in the office of Congressman Robert C. Scott (D-VA), sponsored by the American Association for the Advancement of Science. Among his awards and distinctions, in 2004, Smedley was honored by the Rainbow/PUSH Coalition as a Health Trailblazer award winner; in 2002, he was awarded the Congressional Black Caucus's Healthcare Hero award; and in August 2002, he was awarded the Early Career Award for Distinguished Contributions to Psychology in the Public Interest by APA.

Mildred Thompson, M.S.W., is senior director and director of the PolicyLink Center for Health and Place and leads PolicyLink's health team. As part of her work, she conducts research focused on understanding community factors that affect health disparities and identifies practice and policy changes needed to improve individual, family, and community health. She has authored several reports and journal articles focused on reducing health disparities, increasing awareness about social determinants of health, and effective ways to bring about policy change. Prior to joining PolicyLink, she was director of community health services for the Alameda County Public Health Department; director for Healthy Start, a federal infant mortality reduction program; and director of San Antonio Neighborhood Health Center. Thompson has degrees in nursing and psychology and an M.S. in social work from New York University. She has also taught at Mills College and San Francisco State University and has worked as an organizational development consultant. She speaks frequently on health and place issues and serves on several boards and commissions, including The Zellerbach Family Foundation and the Institute of Medicine's Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

Kelly Whitener, M.P.H., completed her M.P.H., specializing in health policy, at the University of California, Los Angeles. Upon graduation, she was recognized for her scholastic achievement, personal integrity, and dedication to social justice with her induction into the Iota Chapter of Delta Omega, the honorary public health society, and the Ruth Roemer Social Justice award. Prior to moving to Washington, DC, Whitener worked as a case manager in community mental health clinics in Los Angeles. As part of her graduate work, Whitener evaluated the treatment modalities and program goals of a mental health clinic and presented the findings to the executive leadership team of a hospital system for consideration. After the preliminary evaluation, she identified areas for continuous quality improvement and assessed the effectiveness of new evidence-based treatment strategies for the identified patient population. After finishing her undergraduate work at the University of Michigan, she joined the United States Peace Corps and was

invited to serve in Ecuador. At the beginning of her service, she worked as an urban youth development volunteer in Quinindé, a small urban center in the Afro-Ecuadorian province of Esmeraldas. After fulfilling 2 years of service, Whitener was asked to relocate to the capital city of Quito to work as a cotrainer for the incoming group of volunteers and as liaison between volunteers in the field and the headquarters office. Whitener describes her Peace Corps experience as fulfilling and formative, leaving her committed to improving the health of disadvantaged populations. She currently works with the Senate Committee on Finance in the office of Chairman Max Baucus, which gives her an exceptional opportunity to witness the intersection of policy and politics while striving to enact meaningful and comprehensive health reform.

David R. Williams, Ph.D., M.P.H., is the Florence and Laura Norman Professor of Public Health at the Harvard School of Public Health and professor of African and African American studies and of sociology at Harvard University. His first 6 years as a faculty member were at Yale University, where he held appointments in both sociology and public health. The next 14 years were at the University of Michigan, where he served as the Harold Cruse Collegiate Professor of Sociology, a senior research scientist at the Institute of Social Research, and a professor of epidemiology in the School of Public Health. He holds a master's degree in public health from Loma Linda University and a Ph.D. in sociology from the University of Michigan. He is the author of more than 150 scholarly papers in scientific journals and edited collections; and his research has appeared in leading journals in sociology, psychology, medicine, public health, and epidemiology. He has served as a member of the editorial board of eight scientific journals and as a reviewer for more than 50 others. According to ISI Essential Science Indicators, he was one of the top 10 most cited researchers in the social sciences during the decade from 1995 to 2005. The *Journal of Black Issues in Higher Education* ranked him the second most cited black scholar in the social sciences in 2006. In 2001, he was elected to the Institute of Medicine of the National Academies. In 2004, he received one of the inaugural Decade of Behavior Research Awards, and in 2007, he was elected to the American Academy of Arts and Sciences. He has served on the U.S. Department of Health and Human Services National Committee on Vital and Health Statistics and on six panels for the Institute of Medicine. He has held elected and appointed positions in professional organizations such as the American Sociological Association, Academy Health, and the American Public Health Association. Currently, he is a member of the MacArthur Foundation's Research Network on Socioeconomic Status and Health. His current research includes the health of black Caribbean immigrants in the

United States, examining how race-related stressors can affect health and assessing the ways in which religious involvement is related to health.

Steven Woolf, M.D., M.P.H., is professor at the Departments of Family Medicine, Epidemiology, and Community Health at Virginia Commonwealth University. He received an M.D. in 1984 from Emory University and underwent residency training in family medicine at Virginia Commonwealth University. Woolf is also a clinical epidemiologist and underwent training in preventive medicine and public health at the Johns Hopkins University, where he received an M.P.H. in 1987. He is board-certified in family medicine and in preventive medicine and public health. He has published more than 100 articles in a career that has focused on evidence-based medicine and the development of evidence-based clinical practice guidelines, with a special focus on preventive medicine, cancer screening, quality improvement, and social justice. From 1987 to 2002, he served as science adviser to, and then member of, the U.S. Preventive Services Task Force. Woolf edited the first two editions of the *Guide to Clinical Preventive Services* and is author of *Health Promotion and Disease Prevention in Clinical Practice*. He is associate editor of the *American Journal of Preventive Medicine* and served as North American editor of the *British Medical Journal*. He has consulted widely on various matters of health policy with government agencies and professional organizations in the United States and Europe and in 2001 was elected to the Institute of Medicine.