

CREATING MORE EQUITY IN HEALTH

A COMPREHENSIVE APPROACH TO HEALTH REFORM



**July 2008
National REACH Coalition**

Introduction

In spite of the outstanding work and advocacy of many organizations across the country and the overwhelming evidence and documentation of the existence of health disparities the issue of health disparities and health equity is largely missing from the national debate on health reform. Health reform has been largely framed in terms of the healthcare crisis and defined by a lack of access to affordable and quality healthcare. The elimination of inequalities in health does not exclude needed reform of the healthcare system, but necessitates a national response and policy based on the broader social determinants of health. Now more than ever, the opportunity arises to increase national attention, broaden the lens and sharply change the debate and the nation's response to this larger health crisis.

To this end, the National REACH (Racial and Ethnic Approaches to Community Health) Coalition to Eliminate Disparities in Health convened a broad range of national health advocacy organizations to develop and advance the following policy analysis and recommendations in an effort to interject the issue of health equity into the national discourse and policy development for health reform. Established in 2004, the National REACH Coalition (NRC) grew out of the national REACH 2010 initiative designed to develop and demonstrate effective strategies and community-based interventions to improve health outcomes. Today, the NRC represents more than 40 communities across the country to provide coordination and leadership for the advancement and translation of community-based participatory research into evidenced-based practices, policies and community empowerment.

The National REACH Coalition would like to thank the following individuals and organizations for their contribution to the preparation of this policy paper

Brian Smedley, Ph.D - Opportunity Agenda

also

Lark Galloway-Gilliam, MPA – Community Health Councils

Deborah Reid - National Health Law

Nicole Laurie, M.D. - RAND

Charmaine Ruddock, MS – Institute for Urban Family Health

Cheza Garvin, PhD, Seattle & King County Public Health

Participating Organizations

American Public Health Association	NHeLP – National Health Law Program
American Psychological Association	The Opportunity Agenda
Asian & Pacific Islander American Health Forum	Institute for Urban Family Health
Black Women's Health Imperative	Joint Center for Political & Economic Studies
Boston Public Health Commission	Families USA
Common Health Action	Genesee County Health Department
Community Health Councils	Kansas City Chronic Disease Coalition
Eastern Band of Cherokee Indians	RAND Corporation
Greater Lawrence Family Health Center	The Satcher Health Leadership Institute
Massachusetts General Hospital	Seattle and King County Public Health
	Society for Public Health Education

Executive Summary

The issues of health disparities and health inequalities have been largely absent from the national discourse on health and health care reform. In this document, we synthesize a large and growing body of scientific and legal scholarship and identify a series of policy strategies that can complement national health care reform proposals to promote equitable health and health care. These health equity strategies include policies that promote equitable health care, but also address issues such as socioeconomic inequality and harmful living conditions. Because scientific research is crucial to advance knowledge and develop new tools to combat health inequality, we include ideas for shaping a new health equality research agenda. Finally, because a variety of policy and legal levers are likely needed to implement these strategies, we discuss judicial remedies to help make the law a more effective tool to combat health inequality.

The key recommendations are as follows:

Social and Community Level Determinants

Racial and ethnic health disparities are caused largely by socioeconomic differences and differences in living conditions. Racial segregation concentrates poverty resulting in reduced access and quality in education, nutrition, physical activity, housing, employment, transportation and economic opportunity. Strategies that mitigate the effects of negative living conditions include:

- Opportunities for good health must take a developmental and intergenerational approach to be effective and range from full access to health and reproductive health services, school based adolescent health and Medi-gap insurance to augment Medicare coverage for seniors.
- Expansion of access to high-quality preschool and other early intervention programs;
- The use of incentives and land use policies to improve food and nutritional options and access in schools and under-resourced communities;
- Aggressive monitoring and enforcement of environmental protection and justice laws;
- Greater coordination between and the adoption of health impact assessment policies by education, housing, employment, transportation and other relevant agencies that can effect social determinants of health;
- Adoption of public policies – including transportation, economic empowerment zones, housing mobility, community reinvestment and zoning to improve and/or reduce geographic barriers to economic opportunity.

Healthcare Equity

Insurance coverage does not necessarily guarantee access to appropriate, high-quality health care, particularly for people of color. Research on health care inequality suggests that health care can be made more equitable by addressing barriers in several domains: access to health care; health care quality; patient education and empowerment; health care infrastructure; and health care policy and program administration. State and federal governments can increase equity in healthcare by:

- Making healthcare affordable through lower out-of-pocket costs, public subsidies to buy healthcare coverage, sliding scales for premiums and limits on co-payments for those at the lowest income levels;
- Ensuring that all state residents have a medical home by expanding and promoting Community Health Centers and other publicly-supported healthcare institutions;
- Promoting cultural and linguistic competence in health care settings by more widespread adoption of the federal CLAS guidelines and recommended standards;
- Promoting diversity among health professionals and increasing the incentives for health care professionals to practice in underserved communities by additional funding for tuition-for-service agreements with underrepresented healthcare professions students, graduate medical education programs that focus on underserved communities and tuition reimbursement and loan forgiveness programs for service in professional shortage areas ;
- Improving and streamlining enrollment procedures for public health insurance programs.
- Requiring public and private health systems to collect, monitor and report racial/ethnic, primary language, education and/or income-based health care disparities.
- Encouraging the adoption of quality improvement programs that consider the health care challenges and needs of underserved communities.
- Developing and funding patient education, the training and use of community health workers and prevention programs.
- Providing financial resources and other support to safety net hospitals and community health centers serving poor and ethnic minority communities; and instituting measure to ensure that the funds meet their intended use;
- Reviving and improving community health planning through demonstration programs, certificate of need policies;
- Implementing health equity as a performance measurement and financial policy.

Research to Eliminate Racial and Ethnic Health Disparities

While federal health research has made great strides toward the development of new tools to combat illness and improve health, it has disproportionately benefited wealthy communities. The majority of federal research funds continue to be expended on genetic and biological research, or research to improve individual health behavior, to the relative exclusion of research to study how social and community environments affect health. Therefore, greater priority and

resources should be given to federally-supported health disparities research with an emphasis on:

- Social and community research
- Community-based participatory research
- Research translation

Judicial Remedies

The key federal civil rights law addressed to “unintentional” racial disparities in government programs (Title VI of the Civil Rights Act of 1964) was recently rendered unenforceable by the U.S. Supreme Court in the 2001 *Alexander v. Sandoval* decision in its ruling that individuals do not have the right to sue to enforce the Title VI disparate impact regulations. To remedy this legislation is needed to:

- Ensure that every statute protecting civil rights specifically authorizes individuals to bring civil suits in federal court to redress violations of the law.
- Clarify the legal right of Medicaid recipients to force state compliance with the Medicaid Act.

It is our hope that these strategies will be vigorously debated. They are offered to help advance the national discussion on health and health care reform and to center equity as a fundamental objective in the presidential candidates’ health proposals.

CREATING MORE EQUITABLE HEALTH IN THE UNITED STATES

Health care reform is again a high priority for voters in the current election cycle, and many political leaders have offered proposals designed to expand access to health insurance, improve health care quality, and contain rapidly rising health care costs. Few of these efforts, however, have focused attention on the problem of *inequality* in health and health care. Millions of people in the United States – principally racial and ethnic minorities, immigrants, and those who aren't proficient in English – have greater difficulty accessing health care services and tend to receive a lower quality of health care, even when they present with the same illnesses, health insurance, and ability to pay for care as whites.¹ These problems persist despite the fact that many communities of color, particularly African Americans, American Indians and Alaska Natives, Pacific Islanders, and some Asian American and Hispanic subgroups, suffer from disproportionately high rates of illness and disability. And while the age-adjusted death rate declined by 3.4 percent nationwide between 2003 and 2004, racial and ethnic differences in mortality are stubbornly persistent.²

Health disparities such as these are complex and stem from many causal factors. Part of the gap stems from racial and ethnic differences in health insurance coverage and access to high-quality health care. But public health experts agree that the most significant underlying causes of health inequality are socioeconomic inequality and inequitable living conditions. These problems arise largely from residential segregation and discrimination and powerfully shape a range of health risk and protective factors, such as individual behavioral health choices (e.g., improving diet or seeking health care). These conditions, however, *can and must be remedied*. Health and health care inequality exact a huge human and economic toll on the nation. Their persistence means that millions of Americans and their families suffer needlessly from a high burden of illness and mortality. Health inequality leaves these Americans less able to contribute to the nation's economy and productivity, and to participate fully in social, civic, and political affairs in their communities. And with projections indicating that nearly 1 in 2 people living in the United States by mid-century will be a person of color, the nation's health status clearly depends on our ability to improve the health and living conditions of our fastest-growing communities.

For these reasons, we believe that the presidential candidates must confront the problem of health and health care inequality. These issues, however, have been largely absent from the national discourse on health and health care reform. In this document, we synthesize a large and growing body of scientific and legal scholarship and identify a series of policy strategies that can complement national health care reform proposals to promote equitable health and health care. These health equity strategies include policies that promote equitable health care, but also address issues such as socioeconomic inequality and harmful living conditions. Because scientific research is crucial to advance knowledge and develop new tools to combat health inequality, we include ideas for shaping a new health equality research agenda. Finally, as a variety of policy and

legal levers are likely needed to implement these strategies, we discuss judicial remedies to help make the law a more effective tool to combat health inequality.

It is our hope that these strategies will be vigorously debated. They are offered to help advance the national discussion on health and health care reform and to center equity as a fundamental objective in the presidential candidates' health proposals.

Policies to Eliminate Inequities in Social and Community-Level Determinants of Health

While largely outside of the purview of health care “reform” proposals, any effort to reduce racial and ethnic health status gaps must address factors that lie outside of the health care arena. As noted above, racial and ethnic health disparities are caused largely by socioeconomic differences and differences in living conditions. Racial segregation concentrates poverty and excludes and isolates communities of color from the basic and/or quality resources needed for socio-economic equality and health. African Americans are more likely to reside in poorer neighborhoods than whites of similar economic status. For example, African Americans of all incomes are 36 times more likely than whites of all incomes to live in high-poverty communities. Similarly, poor African Americans are 7.3 times more likely to live in high poverty neighborhoods as poor white Americans; poor Latinos are 5.7 times more likely than poor whites to live in high poverty neighborhoods.³ These rates have doubled since 1960.

Segregation affects health in many direct and indirect ways:

Economic Opportunity Segregation restricts socioeconomic opportunity by channeling non-whites into neighborhoods with poorer public schools, fewer employment opportunities, and smaller returns on real estate. These limits on economic opportunity have a significant indirect impact on health as evidenced by the strong and well-documented correlation between wealth and health.

Nutrition and Physical Activity The behavioral choices people make are constrained by the choices people have. One study revealed that black Americans are five times less likely to live in census tracts with supermarkets than white Americans.⁴ Nationally, 50% of black neighborhoods lack access to a full service grocery store or supermarket.⁵ It's more challenging to eat right in neighborhoods where fast-food joints, liquor stores and convenience stores proliferate while supermarkets and other sources of affordable, nutritious food are hard to find. The fruit and vegetable intake of Black residents increased an average of 32% for each supermarket in their census tract.⁶ Black and Latino neighborhoods also have fewer parks, green spaces and recreational options than white neighborhoods, including fewer gyms, recreational centers, swimming pools and safe places to walk, jog, bike or play. Their neighborhoods are less likely to be walk-able (homes near stores and jobs) and more likely to have streets that are not safe after dark. Cautious parents in poor neighborhoods keep their children indoors after school – where

they are more likely to watch TV, play video games and eat – rather than allow them out to play on unsafe streets. These characteristics of place all contribute to higher obesity, diabetes and cardiovascular disease rates among people of color, especially poor people of color.

Environmental Justice Dozens of empirical studies over the past 40 years have determined that low-income communities and communities of color are more likely to be subjected to environmental degradation and exposed to environmental hazards. For example, 56% of residents in neighborhoods with commercial hazardous waste facilities are people of color even though they comprise less than 30% of our population.⁷ The promise of economic benefits and new job opportunities is often in direct conflict with exposure to hazards including lead, toxic waste, air pollution, and pesticides. These exposures are associated with a variety of ailments including asthma, birth defects, and cancer.

Housing Crowded, substandard housing, elevated noise levels, decreased ability to regulate temperature and humidity, and exposure to lead paint and allergens such as mold and dust mites are all more common in poor, segregated communities, as are asthma rates, sleep disorders and lead toxicity.⁸ Lack of affordable housing often leads to unsafe overcrowding conditions and the diversion of limited financial resources from other basic needs such as food and health. In addition, organization of neighborhoods has been shown to have an effect on mental and physical health, educational achievement and the prevalence of violence and crime.

Education: There is a profound correlation between educational opportunities and health, even life expectancy. Minority students, however, remain highly concentrated in poorly-performing, high-poverty schools, despite five decades of effort since the landmark 1954 *Brown v. Board of Education* decision to desegregate them. Poor and minority school districts receive less funding, have larger class sizes, worse physical infrastructure and more non-credentialed teachers than higher-income and majority-white districts. Fifty years after the *Brown* decision, the re-segregation of our schools continues throughout the country. According to a 2007 Harvard Civil Rights Project study, “The children in United States’ schools are much poorer than they were decades ago and more separated in highly unequal schools. Black and Latino segregation is usually double segregation, both from whites and from middle class students.”⁹

The “Poverty Tax.” According to a Brookings Institution study, not only do poor neighborhoods have fewer parks, fewer supermarkets, worse schools, more environmental hazards, higher crime and neglected public spaces, residents pay more for the exact same consumer products than those in higher income neighborhoods— more for auto loans, furniture, appliances, bank fees, and even groceries. And homeowners get less return on their property investments.¹⁰ Sociologists call this “the poverty tax.” The “tax,” adding up to hundreds, even thousands of dollars, further impoverishes those who are already poor.

Despite the challenges that racial segregation present for eliminating health inequality, solutions exist which can both mitigate the negative effects of segregation and inequitable living conditions, as well as increase housing mobility and improve opportunities for people to live in the community of their choice. Strategies that mitigate the effects of negative living conditions should:

- *Take a developmental and intergenerational approach* by recognizing that improving the opportunity for good health can begin before birth, and by responding to the health needs of older Americans. The nation can make a profound investment in population health by addressing the health and living conditions of future mothers. Adolescent and young women in communities of color should have full access to health and reproductive health services. The development of culturally-responsive health promotion and prevention programs for adolescents of color is crucial,¹¹ and school-based services are often the most efficient and effective way to reach young women in need of services. For example, in a study of an alternative school-based program for adolescent females, program participants were more likely to have higher education aspiration, better reproductive health outcomes, and higher contraceptive use.¹² In addition, any attempt to address health disparities should address the often-greater health needs of minority American elders. Older adults of color suffer disproportionately from illness (diabetes, heart disease, most types of cancer) and mortality. Low income and limited access to medical care, such as being able to afford Medi-gap insurance to augment Medicare coverage, is only part of the challenge that these populations face. For example, it is also more difficult for them to maintain their safety, independence and a high quality of life.
- *Improve opportunities for healthy infant and child development.* Expanding maternal and infant nutrition programs can also offer significant long-term savings, as can home nurse visitation programs for new mothers. Nurse home visitation programs like the Nurse-Family Partnership have worked to improve the health, well-being, and self-sufficiency of low-income families. For high-need communities, these programs bring essential services that provide positive outcomes to pregnancies by helping women improve their prenatal health, improve their child's health and development, and improve their parental life course. Evidence has shown that nurse-visited women had fewer subsequent pregnancies and births, and used less welfare. Nurse-visited children demonstrated higher intellectual functioning and fewer behavioral problems and over time, a reduction in antisocial behavior.^{13 14}
- *Expand access to high-quality preschool and other early intervention programs.* When a child receives a high-quality preschool education, the personal, social and economic impact over-time is long-lasting for both them and their families. Early intervention programs such as the Perry Preschool Project and the Abecedarian Project support disadvantaged, at-risk children by providing them with a rich academic curriculum and essential social services. With a societal economic return of seven dollars per dollar invested, children involved in these programs have achieved higher educational attainment and performance. Participants earn significantly higher scores on intellectual and academic measures as young adults,

- attained significantly more years of total education, and were more likely to attend a 4-year college. Additionally, they have shown a reduction in teenaged pregnancy, higher adult wages, rates of employment and home ownership when compared with preschool controls.^{15 16}
- *Improve food and nutritional options in schools and communities*, by providing incentives for major grocery chains and “farmer’s markets” to locate in communities with limited or poor food options, regulating and limiting the citing of fast-food restaurants and liquor stores, and providing a healthier range of food options in schools while limiting access to harmful foods such as sodas and other high-fat, high-sugar products.
 - *Develop effective, sustainable, multi-disciplinary community-based strategies and interventions* in collaboration with and that respond to the specific needs of each community as seen in the Racial and Ethnic Approaches to Community Health (REACH) 2010 programs nationwide funded under the Centers for Disease Control and Prevention (CDC). The strategies must address health disparities in each stage of life: pre-natal, infancy, childhood, adolescence, adulthood, and older adulthood. The approaches should improve health in communities, health care settings, schools, after-school programs, work sites, and other social structures.

Other interventions can improve the quality of living conditions in communities by addressing the built environment, reducing the threat of environmental contaminants, and improving the ability of government to assess and predict the health impacts of policies and program in areas such as transportation and housing. These include:

- *Aggressive monitoring and enforcement of environmental protection and environmental justice laws.* Executive Order 12898, signed by President Clinton in 1994, directs all federal agencies to review policies and procedures for responding to environmental health threats that disproportionately affect communities of color. The Office of the Inspector General of the EPA, however, has concluded that EPA had failed to integrate environmental justice into its daily operations, it had failed to identify low-income and minority populations, and it had failed to establish criteria for defining disproportionate impact.¹⁷ EPA (and other federal agencies having jurisdiction over environmental justice issues) should issue a final Title VI guidance on processing Title VI complaints and methods to improve permitting programs, and should conduct an independent analysis of adverse disparate impacts in order to determine if they are present in a given community. EPA should also establish a guideline for its state funding recipients that incorporate an inclusive definition of adverse disparate impact, and should conduct Title VI compliance reviews where periodically EPA would review the number and type of Title VI complaints and ensure their funding recipients are complying with their Title VI obligations.¹⁸
- *Improve coordination of relevant agencies that should address social determinants of health* (e.g., education, housing, employment). Agencies that seek to reduce social and economic gaps are inherently engaging in health equity work. Almost all aspects of education, transportation, housing, commerce, and criminal justice policy influence health, and can have a disproportionate impact on marginalized communities. Federal and state governments should take steps to

- coordinate the work of agencies that impact health disparities to reduce duplication of effort, increase efficiency, and more effectively address health outcome disparities.
- *Adopt Health Impact Assessment (HIA) policies.* HIA attempts to ensure that all government programs and initiatives in and outside of the health care delivery sector – such as transportation, housing, and environmental protection – are assessed to determine their potential impact on the health status of affected communities.¹⁹ HIA is used extensively as a policy and planning tool in Europe and other countries, and is used increasingly in the United States. The San Francisco Department of Public Health, for example, has developed and implemented the Healthy Development Measurement Tool to identify and assess community health needs and understand how land use and development projects can complement public health goals. And King County in Washington State is developing and preparing a process to utilize an impact assessment tool that focuses on health equity and social justice in the adoption and implementation of County policies and decisions.

In addition to these efforts to mitigate the negative health problems that are disproportionately found in poor and minority communities, the federal government can also take steps to improve housing mobility and increase investment in segregated communities:

- *Housing mobility* strategies are a promising approach to reducing health inequities and expanding opportunity. Research suggests that helping poor people of color relocate to lower poverty neighborhoods can improve health outcomes. Although research is needed to understand how, under what conditions and which types of programs will work best, portable rent vouchers and tenant-based assistance have been the most common housing mobility strategies. However, legal efforts that challenge residential and school segregation and targeted development of affordable housing in high opportunity areas have also produced results.
- *Employment and Economic Development:* Many communities, as noted above, are segregated from opportunity in ways that ultimately harm the health of their residents. To address these problems, policies should be examined that reduce geographic barriers to opportunity. For example, new job creation is increasingly taking place in suburban and exurban communities, far from segregated communities of color in urban cores and inner-ring suburbs²⁰; many of the residents in these communities don't have cars or other opportunities to get to these jobs. A range of public policies – including public transportation, economic empowerment zones, housing mobility, community reinvestment and zoning – can improve economic opportunities in distressed communities and reduce the distance between people and employment opportunities. Most of these policies require regional planning and coordination across local jurisdictions, and can be supported by state and federal incentives.

Policies to Achieve Equitable Health Care

Research on health care inequality suggests that health care can be made more equitable by addressing barriers in several domains: access to health care; health care quality; patient education and empowerment; health care infrastructure; and health care policy and program administration.

We begin with a fundamental issue – **improving access to health care**. The most important step to improve access for all is to develop a mechanism to provide health insurance coverage for all who live in the United States. This is important not just for the uninsured, but also for those who currently have insurance. The presence of a large number of uninsured people in the population contributes to escalating health care costs, the shifting of costs, and inefficiency in the delivery of care. This policy statement is agnostic on how universal coverage is achieved, since the major presidential candidates already have well-established positions on whether they believe universal coverage is an important policy goal, and if so, how they would achieve it. But insurance coverage does not necessarily guarantee access to appropriate, high-quality health care, particularly for people of color. We, therefore, discuss below how characteristics of insurance coverage, as well as other factors, can influence health care access among people of color, and offer policy solutions.

Access to Health Care

Myriad factors contribute to how and whether people can access needed health care; lacking health insurance is one of the most important factors.²¹ Individuals with affordable and comprehensive health insurance coverage have fewer barriers to health care, are more likely to see a physician on a regular basis, and experience better health outcomes. Insurance coverage also reduces out-of-pocket costs and shields individuals and their families from the economic hardships that an unexpected injury or illness can create.²² But racial and ethnic minorities are more likely to lack health insurance coverage or to be underinsured compared to non-Hispanic whites: while people of color make up about 30% of the U.S. population, they comprise over half of the nation's 47 million uninsured individuals.²³

In addition to coverage barriers, racial and ethnic minority and language-minority groups face other well-documented problems accessing health care. Predominantly minority communities have fewer health care resources, such as hospitals, primary and specialty care providers, outpatient clinics, and nursing home facilities. The health care services that are available to them are often of lower quality than those in more advantaged communities. And even among minorities who have insurance, many face cultural and/or linguistic barriers to accessing care.²⁴

The literature suggests that state and federal governments can expand health care access for disparity populations by:

- *Making health care affordable.* Minorities and people with low incomes are more likely than whites and people with higher incomes to report not accessing care when needed because of a lack of health insurance and/or high out-of-pocket costs. Insurance coverage expansions and efforts to reduce out-of-pocket costs can therefore improve access to care.²⁵ Policymakers should be sensitive, however, to the potential effect of such strategies on health insurance coverage and health care access among communities of color. Policymakers should also take into account and attempt to minimize the disproportionate impact that health care costs may have on health care access and utilization among currently underserved groups. These include public subsidies for those with low incomes to purchase health insurance, sliding fee scales for premiums, limits on co-payments and other out-of-pocket costs such that those at the lowest income levels will face only nominal charges, and efforts to study and respond to potential unintended effects of cost-sharing on utilization.
- *Ensuring that all state residents have a medical home.* Having a “medical home”—a health care setting that enhances access to providers and timely, well-organized care—is associated with better management of chronic conditions, regular preventive and early diagnostic screenings, and better primary care. Racial and ethnic minorities are less likely to report having a medical home, but when they do, health care access gaps are significantly reduced.²⁶ The federal government should expand and promote the development of medical homes in Community Health Centers and other publicly-supported health care institutions.
- *Assessing how policies to expand insurance coverage – such as affordability standards and mandates requiring individuals to purchase insurance – may differentially affect communities of color, immigrants, and low-income populations.* Several health care reform proposals require individuals and families to purchase health insurance, and/or are exploring standards of affordability to determine premium or cost-sharing contributions. The impact of an individual mandate and definitions of affordability may vary across racial and ethnic groups, even at the same income level, as these groups vary in wealth and access to resources. In addition, the challenges of enforcing an individual insurance mandate across different communities are significant. Some legal immigrants, for example, may be reluctant to apply for public health insurance programs, even if eligible, as a result of anti-immigrant rhetoric and policies, and might therefore be slower to comply with a mandate. Policymakers that are considering such strategies should monitor insurance take-up among the previously uninsured by race, ethnicity and immigration status, and take steps to correct policies that might have a disproportionate impact.
- *Reducing “fragmentation” of the health insurance market* by promoting equal access to the same kinds of health care products and services, regardless of coverage source. A potentially significant source of racial and ethnic health care disparities among privately insured populations lies in the fact that minorities are likely to be disproportionately enrolled in “lower-tier” health insurance plans. Such plans tend to limit services, offer fewer covered benefits, and have relatively small provider networks. These limitations can harm access to quality care.²⁷ Policymakers can take steps as part of coverage expansion proposals to improve

access to the same health care products and services, regardless of coverage source.

- *Improving and streamlining enrollment procedures* for public health insurance programs. Racial and ethnic minorities and immigrants are underrepresented, relative to eligibility rates, in public health insurance programs. Policymakers can achieve greater success in increasing minority participation in public programs if they develop and sustain aggressive outreach programs and take steps to improve and streamline enrollment, with particular attention to the needs of cultural and language-minority groups.²⁸
- *Consistently evaluating outreach to and enrollment of underserved groups in public health insurance programs.* Measurement of public insurance take-up rates in low-income communities and communities of color is an important step to ensure that health care expansion efforts reach underserved groups. The Centers for Medicare and Medicaid Services should regularly conduct such evaluations to assess the impact of outreach programs on coverage rates among eligible populations.²⁹
- *Promoting cultural and linguistic competence in health care settings.* Health care providers and systems must be culturally and linguistically competent to improve health care access and quality for an increasingly diverse U.S. population.³⁰ The federal Culturally and Linguistically Appropriate Services (CLAS) standards identify over a dozen benchmarks that have been widely accepted and increasingly adopted by health systems and providers.³¹ Federally-funded health care organizations are mandated to meet four of the standards, but the federal government can take steps to encourage more widespread adoption of the guidelines and recommended standards. These include providing incentives that encourage and reward health care organizations that implement the CLAS standards.
- *Promoting diversity among health professionals.* Racial and ethnic diversity among health care professionals is associated with improved access to and satisfaction with care among patients of color.³² Federal programs have stimulated greater diversity among health care providers for over three decades, but congressional support for these programs is waning. These programs should be evaluated and, where they demonstrate success, should be expanded, for example by increasing funding for tuition-for-service agreements with underrepresented health care professions students.

Quality of Care

Health care reform initiatives increasingly address health care quality in general, as well as access. However, many people of color experience a lower quality of care relative to whites, even when they are able to access care. According to the Agency for Healthcare Research and Quality's National Healthcare Disparities Report, African Americans receive poorer quality of care than whites for about two-thirds of health care quality measures, and Hispanics receive a lower quality of care than non-Hispanic whites for half of quality measures. Policymakers can establish mechanisms for promoting equity and

accountability by promoting the collection of data on health care access and quality by patients' race, ethnicity, income or education level, and primary language, and by publicly reporting this information. These evaluations should focus on reducing health care quality gaps, to achieve "quality equality." In addition, government can provide incentives for quality improvement, such as pay-for-performance programs, performance measurement, and report cards. But quality improvement efforts that fail to take into account the different challenges and needs of underserved communities, and the health care institutions that serve them, can unintentionally worsen health care quality gaps.³³

The federal government can establish mechanisms for quality equality and accountability by:

- *Requiring public and private health systems to collect and monitor racial/ethnic, language status, and income-based health care disparities.* Currently, data collection efforts with regard to health care disparities are uneven. CMS does not currently require Medicare providers to collect and report data. Some states require recipients of state funding (e.g., Medicaid managed care organizations) to collect and report health care access and quality data by patient demographic factors, but many other states fail to utilize their leverage as regulators, payers, and plan purchasers to encourage all health systems to collect and report data using consistent standards.³⁴ And given that the federal government and some states have non-discrimination laws that apply to health care settings and require diligence to enforce, requirements to collect and report standardized data are an important benchmark for state efforts to reduce health care inequality.
- *Publicly reporting health care access and quality disparities.* Once CMS has obtained health care access and quality data by patient demographic data, this information should be publicly reported, to promote greater public accountability, to allow consumers to make more informed decisions about where to seek care, and to assist state efforts to monitor disparities and take appropriate action to investigate potential violations of law.³⁵
- *Encouraging the adoption of quality improvement programs that consider the health care challenges and needs of underserved communities.* Health care quality improvement efforts, such as pay-for-performance or performance measurement, are gaining increasing attention. But because underserved communities are typically sicker and face greater barriers to treatment compliance, performance measurement can inadvertently dampen provider enthusiasm for treating low-income communities or communities of color. Quality improvement efforts should take into account the challenges and needs of underserved communities and reward efforts that reduce disparities and improve patient outcomes relative to baseline measures, perhaps by focusing on health care process measures.³⁶ In addition, quality improvement incentives can be targeted to safety net institutions and other providers that disproportionately serve communities of color.

Patient Education

Patients should be empowered to make decisions about their health care and to insist that care be delivered consistent with their needs, preferences, and values. These issues are particularly relevant for racial and ethnic minority and immigrant patients, who may face significant health literacy and cultural gaps in U.S. health care settings.³⁷ These concerns can be addressed by:

- *Developing and strengthening patient education programs* that are well-researched and are tailored to the need of underserved communities. Patient education programs, such as health literacy programs, commonly seek to help patients understand how to best access health care services, participate fully in treatment plans, and better understand and manage illness. Such efforts to empower patients can help reduce health care disparities by providing patients with skills to effectively navigate health care systems and ensure that their needs and preferences are met. An excellent example of the effectiveness of patient education programs can be found in the REACH 2010 initiative. The proportion of American Indians from REACH communities who began to take medication to manage high blood pressure increased from 67% in 2001 to 74% in 2004, surpassing the national rate for the American Indian population. In 2002, Hispanics from REACH communities were less likely to be screened for high blood cholesterol levels than were those in the national Hispanic population and even wider when in comparison to the overall national population. By 2006, the cholesterol screening rate for Hispanics from REACH communities surpassed that for the national Hispanic population, and the gap between the rate for Hispanics from REACH communities and the overall national average was closing and continues to improve.³⁸
- *Supporting training and reimbursement for community health workers.* Community health workers, also known as lay health navigators or *promotoras*, are trained members of medically underserved communities who work to improve community health outcomes. Several community health worker models train individuals to teach disease prevention, conduct simple assessments of health problems, and help their neighbors access appropriate health and human resources.³⁹ In health care contexts, they serve as a liaison between patients and health systems. Using lay health workers to improve rates for cervical cancer screening among Vietnamese American women, 48% of the Vietnamese American women who had never had a Papanicolaou's (Pap) test received the test after meeting with lay health in the REACH 2010 program in Santa Clara County, California. The overall rate increased by 15% in two years. Community health worker models are rapidly spreading, as research and practice indicate that such services can improve patients' ability to access care and understand how to manage illness. The federal government can stimulate these programs by providing grants, seed funding, or other resources to help stimulate their promulgation.

Health Care Infrastructure

As noted above, the disproportionate lack of health insurance among racial and ethnic minorities is associated with fewer health care resources (e.g., practitioners, hospitals and health care centers) in communities of color. Even if the United States achieves universal

health insurance coverage, communities of color will still require investments to improve their health care infrastructure. The federal government can ensure that the community-level health care infrastructure needs of racial, ethnic, and language minority patients are better addressed by:

- *Supporting “safety net” hospitals and community health centers, and reducing the financial vulnerability of health care institutions serving poor and minority communities.* People of color and low-income individuals are more likely than other populations to access health care in safety net institutions, such as public hospitals and community health centers.⁴⁰ In many cases, these institutions face financial vulnerability because of low Medicaid reimbursement rates and/or the costs of providing uncompensated care to uninsured individuals.⁴¹ These institutions may fare better in states where near-universal health insurance coverage proposals are enacted and where health insurance expansions are realized, but they will likely continue to face financial vulnerability until universal coverage is achieved. In addition, the survival of safety net institutions depends on the manner in which health insurance expansions are carried out. If the financing of these programs draws resources away from safety net institutions, they could suffer significant budget shortfalls. State and local subsidies provide about 39 percent of the cost of unreimbursed care that public hospitals provide, but state and local safety net financing varies considerably across jurisdictions; over 15 percent of public hospitals receive no state or local support, and for an additional third of public hospitals, state and local subsidies represent less than 10 percent of net revenues.⁴² The federal government should provide additional financial resources or other support to safety net institutions, and assess the impact of health insurance coverage expansion programs on these institutions.
- *Creating and/or improving incentives for health care professionals to practice in underserved communities.* Low-income and minority communities often have the most pressing need for health care services, but they are served by a dwindling number of providers and institutions that lack resources to expand and improve services.⁴³ The federal government can address this imbalance by expanding incentives, such as funds for graduate medical education programs that focus on underserved populations, tuition reimbursement and loan forgiveness programs that require service in health professional shortage areas.
- *Requiring cultural competency training for health care professional licensure.* Most communities are experiencing rapid growth in the population of racial and ethnic minority and language-minority residents. Already, four states and the District of Columbia are “majority minority,” and nearly one in two U.S. residents will be a person of color by mid-century. These demographic changes require that the health professions keep pace by training future and current providers to manage diversity in their practice.⁴⁴ Some states have taken action to address this need—as of 2005, for example, New Jersey required that all physicians practicing in the state must attain minimal cultural competency training as a condition of licensure.

Program and Policy Infrastructure

The federal and state governments can improve their capacity to plan for and address the health care policy challenges and needs of minority communities by adopting or strengthening existing policies such as:

- *Community health planning*, as a means of gaining community input and better aligning health care resources with community needs. Community health planning has a long history, but its promise as a tool to reduce health care disparities has yet to be fully realized. Community health planning seeks to strengthen communities to play a greater role in their own health, actively involving residents in the planning, evaluation, and implementation of health activities in their communities. The National Health Planning and Resource Development Act of 1974 sought to create and support a network of community Health Systems Agencies (HSAs), but a lack of funding, enforcement powers, and effective mechanisms for community input to shape health policy has led to a decline of HSA power and influence.⁴⁵ Some states, such as New York, are examining strategies to reinvigorate HSAs and to include disparities reduction efforts as part of the mission of these planning agencies. The federal government should revive and improve community health planning through demonstration programs and other strategies.
- *Certificate of Need assessments*, as a tool to reduce geographic disparities and reduce the “fragmentation” of the health insurance market. Historically, the purpose of the Certificate of Need (CoN) process has been to provide state governments with a tool to control health care costs and ensure that capital and technology investments in the health care industry reflect community needs. In most states that employ CoN, the process has required hospitals or other health care institutions that seek to establish or expand services to submit proposals so that state boards can evaluate projects to eliminate unnecessary duplication of services and ensure that investments strategically address health care needs. But the process has met significant resistance and criticism for its failure as a cost-containment measure. The CoN process, however, has great potential to encourage a better distribution of health care resources, reflecting community and statewide need.⁴⁶ States should re-evaluate, and in some cases reinvigorate CoN through new policies that ensure accountability for the use of public funds, and the federal government should provide resources to stimulate states to adopt strong CoN policies.
- *Health Equity as a performance measurement and financial policy*. Medicare and Medicaid funding are significant drivers for quality improvement and cost containment. Federal policy is needed to both measure, report and expand reimbursement to include state and local performance in reducing health disparities and achieving health equity.

Research to Improve Understanding of and Strategies to Eliminate Racial and Ethnic Health Disparities

The federal health research enterprise has made great strides toward the development of new tools to combat illness and improve health. Most of the gains, however, have disproportionately benefited wealthy communities. And while federal research efforts to address health inequality have expanded significantly in the two decades since the 1986 Heckler report which found shocking inequality in health status among U.S. racial and ethnic groups, the majority of federal research funds continue to be expended on genetic and biologic research, or research to improve individual health behavior, to the relative exclusion of research to study how social and community environments affect health. Federally-supported health disparities research should provide greater emphasis on:

- *Social and Community Research.* Given the importance of “upstream” determinants of health such as neighborhood living conditions, federal health disparities research should increasingly emphasize understanding how social and physical environments contribute to health inequality. Research should examine both direct effects, such as the cognitive and health impacts of exposure to violence, as well as indirect effects, such as how neighborhoods shape access to food and nutrition resources.
- *Community-Based Participatory Research* as a model for program development. CBPR produces field-based, rigorous research through active partnerships with community members, who help establish research priorities and objectives, serve as research resources and consultants, and share in the interpretation of research findings.
- *Research Translation.* Research addressing health inequality should be translated for policy consumption; doing so requires the active participation of key stakeholders, as above.

Restoring Judicial Remedies

The key federal civil rights law addressed to “unintentional” racial disparities in government programs (Title VI of the Civil Rights Act of 1964) was recently rendered unenforceable by the U.S. Supreme Court in the 2001 *Alexander v. Sandoval* decision, and Congress has not yet responded to repair the law.⁴⁷ In *Sandoval* the U.S. Supreme Court ruled that individuals do not have the right to sue to enforce the Title VI disparate impact regulations, because the statute did not specify a private right of action. The next President should support legislation in Congress that would ensure that every statute protecting civil rights specifically authorizes individuals to bring civil suits in federal court to redress violations of the law.⁴⁸ Similarly, The President should support legislation that would clarify the legal right of Medicaid recipients to force state compliance with the Medicaid Act.⁴⁹

- ¹ Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academies Press, 2003.
- ² Centers for Disease Control and Prevention, National Center for Health Statistics – 2004 Death Rates.
- ³ Poverty and Race Research Action Council with Nancy Denton and Bridget Anderson, analysis of U.S. Census Bureau data, 2005.
- ⁴ Kimberly Morland, PhD, Steve Wing, PhD, and Ana Diez Roux, MD, PhD The Contextual Effect of the Local Food Environment on Residents' Diets: The Atherosclerosis Risk in Communities Study *Am J Public Health*. 2002 November; 92(11): 1761–1768.
- ⁵ R. Flournoy, "Regional Development and Physical Activity: Issues and Strategies for Promoting Health Equity," PolicyLink, Oakland, CA, November 2002, p.10
- ⁶ Kimberly Morland, PhD, Steve Wing, PhD, and Ana Diez Roux, MD, PhD The Contextual Effect of the Local Food Environment on Residents' Diets: The Atherosclerosis Risk in Communities Study *Am J Public Health*. 2002 November; 92(11): 1761–1768.
- ⁷ ROBERT D. BULLARD ET AL., TOXIC WASTES AND RACE AT TWENTY: 1987-2007 (2007) (report prepared for the United Church of Christ Justice and Witness Ministries).
- ⁸ David R. Williams & Chiquita Collins, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health*, 116 *PUB. HEALTH REP.* 405, 405-16 (2001).
- ⁹ G. Orfi eld and C. Lee, *Historic Reversals, Accelerating Resegregation, and the Need for New Integration Strategies* (Cambridge, Mass.: The Civil Rights Project, Harvard University, August 2007).
- ¹⁰ From Poverty, Opportunity - Putting the Market to Work for Lower Income Families The Brookings Institution Metropolitan Policy Program 2006
- ¹¹ Guthrie, Barbara J., Special issue: Healthcare disparities. *Journal for Specialists in Pediatric Nursing*, 2006 Vol 11(1):1.
- ¹² Ruhul Amin, et al. A study of an Alternative School for pregnant and or parenting teens: quantitative and qualitative evidence. *Child and Adolescent Social Work Journal*, 2006 23(3): 172-195
- ¹³ David L. Olds, PhD et al. Effects of Nurse Home-Visiting on Maternal Life Course and Child Development: Age 6 Follow-Up Results of a Randomized Trial. *Pediatrics* 2004114 (6): 1550-1559.
- ¹⁴ David Olds, PhD et al. Long-term Effects of Nurse Home Visitation on Children's Criminal and Antisocial Behavior 15-Year Follow-up of a Randomized Controlled Trial. *Journal of the American Medical Association*, 1998, 280(14) 1238-1244.
- ¹⁵ Frances A. Campbell, et al. Early Childhood Education: Young Adult Outcomes From the Abecedarian Project *Applied Developmental Science*, 2002, 6 (1):42–57
- ¹⁶ Schweinhart, Lawrence J. Crime prevention by the High/Scope Perry Preschool Program. *J.; Victims & Offenders*, 2007 2(2):141-160.
- ¹⁷ OFFICE OF THE INSPECTOR GEN., U.S. ENVTL. PROT. AGENCY, EVALUATION REPORT: EPA NEEDS TO CONSISTENTLY IMPLEMENT THE INTENT OF THE EXECUTIVE ORDER ON ENVIRONMENTAL JUSTICE, REPORT NO. 2004-P-00007 (2004), available at <http://www.epa.gov/oig/reports/2004/20040301-2004-P-00007.pdf>.
- ¹⁸ USCCR 2003, *supra* note 164, at 77-78.
- ¹⁹ Dannenberg AL, Bhatia R, Cole BL, et al, Growing the field of health impact assessment in the United States: an agenda for research and practice, *American Journal of Public Health*, 2006, 96(2):262-70.
- ²⁰ U.S. Department of Housing and Urban Development, Moving to Opportunity for Fair Housing Demonstration Program: Interim Impacts Evaluation, 2003,
- ²¹ Kaiser Family Foundation, op. cit.
- ²² Eugene Lewit, Courtney Bennet, and Richard Behrman, "Health Insurance for Children: Analysis and Recommendation," *The Future of Children* 13 (1), Spring 2003, pp. 5-29.
- ²³ U.S. census Bureau, *Income, Poverty, and Health Insurance Coverage in the US: 2006*, August 2007.
- ²⁴ Institute of Medicine, *Unequal Treatment*, 2003.
- ²⁵ For example, see: Doty MM and Holmgren AL, *Health care disconnect: gaps in coverage and care for minority adults. Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2005*, Issue Brief. New York: The Commonwealth Fund, 2006; Hargraves JL, and Hadley, J, The contribution of insurance coverage and community resources to reducing racial/ethnic disparities in access to care, [*Health Services Research*](#), 2003, 38(3):809-29; Lillie-Blanton M, and Hoffman C, The role of health insurance coverage in reducing racial/ethnic disparities in health care, *Health Affairs*, 2005, 24(2):398-408;

Weinick RM, Byron SC, Bierman AS. Who can't pay for health care? *The Journal of General Internal Medicine*, 2005, 20(6):504-9.

²⁶ Beal AC, Doty MM, Hernandez SE, Shea KK, and Davis K, *Closing the Divide: How Medical Homes Promote Equity in Health Care*, The Commonwealth Fund, June 2007, available at http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=506814, accessed December 11, 2007.

²⁷ Institute of Medicine, *Unequal Treatment*, 2003.

²⁸ Brach C et al., Who's enrolled in the State Children's Health Insurance Program (SCHIP)? An overview of findings from the Child Health Insurance Research Initiative (CHIRI), *Pediatrics*, 2003, 112(6):e499; Ross DC, Hill IT, Enrolling eligible children and keeping them enrolled, *Future Child*, 2003, 13(1):81-97; Morreale MC, English A, Eligibility and enrollment of adolescents in Medicaid and SCHIP: recent progress, current challenges, *Journal of Adolescent Health*, 2003, 32(6):25-39;

²⁹ Shone LP et al., The role of race and ethnicity in the State Children's Health Insurance Program (SCHIP) in four states: are there baseline disparities, and what do they mean for SCHIP?, *Pediatrics*, 2003, 112(6):e521.

³⁰ Brach C, Fraser I, Reducing disparities through culturally competent health care: an analysis of the business case. *Quality Management in Health Care*, 2002, 10(4):15-28.

³¹ Office of Minority Health, U.S. Department of Health and Human Services, *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, available at <http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf>, accessed July 23, 2007.

³² Institute of Medicine, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*. Washington, DC: The National Academies Press, 2004.

³³ Siegel B, Regenstein M, Jones K, *Enhancing Public Hospitals' Reporting of Data on Racial and Ethnic Disparities in Care*, The Commonwealth Fund, January 2007, available at http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=452681, accessed July 10, 2007.

³⁴ Perot RT and Youdelman M, Racial, ethnic and primary language data collection in the health care system: An assessment of federal policies and practices, The Commonwealth Fund publication number 492, September 2001, available at http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=221295, accessed September 2, 2007; Watson SD, Equity measures and systems reform as tools for reducing racial and ethnic disparities in health care, The Commonwealth Fund publication number 776, August 2005, available at http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=289303, accessed August 23, 2007.

³⁵ Perot and Youdelman, 2001; Institute of Medicine, *Unequal Treatment*, 2003.

³⁶ Casalino PL and Elster A, Will Pay-For-Performance and quality reporting affect health care disparities?, *Health Affairs*, 26(3):w405-414; Hood RG, Pay-For-Performance—Financial Health Disparities and the Impact on Healthcare Disparities, *Journal of the National Medical Association*, 2007, 99:953-958.

³⁷ Institute of Medicine, 2003.

³⁸ Centers for Disease Control and Prevention. REACHing Across the Divide: Finding Solutions to Health Disparities. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2007.

³⁹ Freeman HP, Patient navigation: a community centered approach to reducing cancer mortality, *J Cancer Education*, 2006 21(1 Suppl):S11-4; Steinberg ML et al., Lay patient navigator program implementation for equal access to cancer care and clinical trials: essential steps and initial challenges, *Cancer*, 2006 107(11):2669-77

⁴⁰ Kaiser Commission on Medicaid and the Uninsured, Stresses to the Safety Net: The Public Hospital Perspective, June 2005, available at <http://www.kff.org/medicaid/7329.cfm>, accessed August 12, 2007; Hadley J, Cunningham P, Hargraves JL, Would safety-net expansions offset reduced access resulting from lost insurance coverage? Race/Ethnicity differences, *Health Affairs*, 2006, 25(6):1679-1687.

⁴¹ Andrulis DP, Duchon LM, Hospital care in the 100 largest cities and their suburbs, 1996-2002: Implications for the future of the hospital safety net in metropolitan America, SUNY Downstate Medical Center, August 2005, available at <http://www.rwjf.org/pr/product.jsp?id=14910>, accessed July 13, 2007.

⁴² Kaiser Commission on Medicaid and the Uninsured, 2005.

⁴³ Cunningham P, Mounting pressures: physicians serving Medicaid patients and the uninsured, 1997-2001, Center for Studying Health System Change Tracking Report No. 6, December 2002, available at <http://www.hschange.com/CONTENT/505/505.pdf>, accessed May 17, 2007; Cunningham P, and May J, Medicaid patients increasingly concentrated among physicians, Center for Study Health System Change Tracking Report No. 16, August 2006, available at <http://www.hschange.com/CONTENT/866/>, accessed July 8, 2007.

⁴⁴ Taylor SL, Lurie N, The role of culturally competent communication in reducing ethnic and racial healthcare disparities, *American Journal of Managed Care*, 2004 10 Spec No:SP1-4

⁴⁵ Conrad DA, Community care networks: linking vision to outcomes for community health improvement, *Medical Care: Research and Review*, 2003, 60(4 Suppl):95-129; Sofaer S, Community health planning in the United States: a postmortem, *Family & Community Health*, 1988 10(4):1-12; [Weech-Maldonado R, Benson KJ, Gamm LD](#), Evaluating the effectiveness of community health partnerships: a stakeholder accountability approach, *Journal of Health and Human Services Administration*, 2003, 26(1):58-92; Landrum LB, Health Planning is Alive and Well, American Health Planning Association, undated, available at <http://ahpanet.org/files/ALIVE%20AND%20WELL.pdf>, accessed September 3, 2007.

⁴⁶ Smith DB, *Eliminating Disparities in Treatment*, The Commonwealth Fund, August 2005, available at http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=289279, accessed September 2, 2007.

⁴⁷ *Alexander v. Sandoval*, 532 U.S. 275, 293 (2001) (“Neither as originally enacted nor as later amended does Title VI display an intent to create a freestanding private right of action to enforce regulations promulgated under § 602. We therefore hold that no such right of action exists.”) (footnote omitted). The case involved a Title VI challenge to Alabama state policy that administered driver’s license examinations in English only. *Id.* at 275.

⁴⁸ WILLIAM L. TAYLOR ET AL., CITIZENS’ COMM’N ON CIVIL RIGHTS & CTR. FOR AM. PROGRESS, *THE EROSION OF CIVIL RIGHTS: DECLINING CIVIL RIGHTS ENFORCEMENT UNDER THE BUSH ADMINISTRATION* 9 (2007).

⁴⁹ Jane Perkins, *Health Care: The Civil Rights Rollback: It’s Bad for Your Health*, in *AWAKENING FROM THE DREAM, CIVIL RIGHTS UNDER SIEGE AND THE NEW STRUGGLE FOR EQUAL JUSTICE* 179 (Denise C. Morgan et al., eds. 2006).

For more information on this policy report or the National REACH Coalition contact:
National REACH Coalition
c/o Community Health Councils
www.chc-inc.org
(323) 295-9372