Mayor's Task Force Blueprint

A plan to eliminate racial and ethnic disparities in health

The Disparities Project

Boston Public Health Commission

Mayor Thomas M. Menino

The Disparities Project is an initiative of Mayor Thomas M. Menino and the Boston Public Health Commission.

Its goal is to reduce disparities in health based on race and ethnicity.

This edition was printed June 2005.
Visit **www.bphc.org/disparities** for electronic copies of this and other reports.

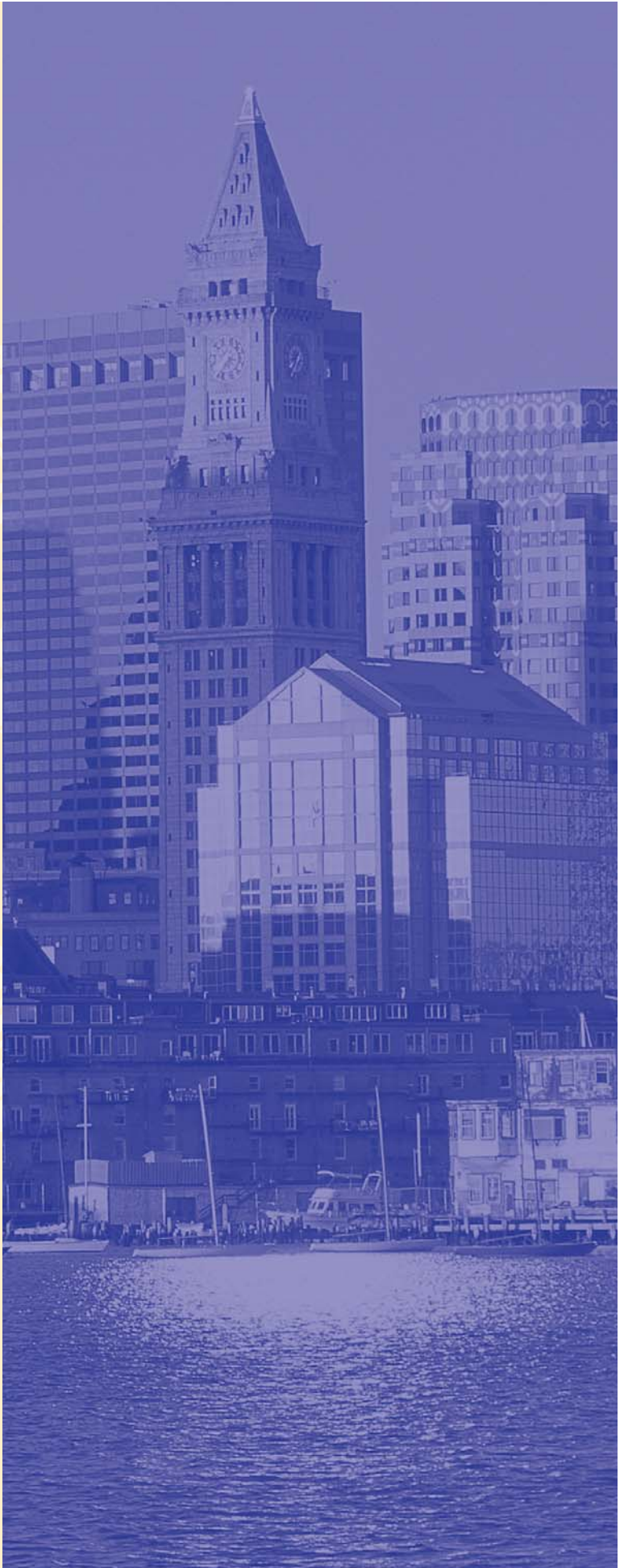
Other reports released by the Boston Public Health Commission as part of the Disparities Project:

Hospital Working Group Report
Action steps and recommendations for Boston hospitals

Data Report
A presentation and analysis of disparities in Boston

The goal of these reports is to bring the City's institutions and organizations together to promote fairness, equality and good health for all Boston's residents.

Design by Boston Public Health Commission, Communications Department.



Dear Fellow Bostonians,

I am proud to present the Blueprint to Eliminate Racial and Ethnic Health Disparities, a document that represents the conclusion of a two year process by members of the Mayor's Task Force. I established this group last year and chose as my co-chairs, Deborah Jackson, the CEO of the American Red Cross of Massachusetts Bay, and Dr. Gary Gottlieb, President of Brigham and Women's Hospital. Members were leaders from multiple sectors – business, community coalitions, health centers, higher education, hospitals, and insurance – and charged with developing a comprehensive blueprint to eliminate racial and ethnic health disparities.

The Blueprint tries to shed light on the existence of racial and ethnic health disparities within Boston and offer recommendations on how to ameliorate them. It is part of an effort that has produced three publications. In addition to this one, readers are encouraged to review the Project's Data Report and the Recommendations of the Hospital Working Group. Both contribute to the elucidation of the issue – one by summarizing what we know about the inequitable health outcomes themselves and the other by indicating the potential for hospitals to be agents of positive change in the battle against unnecessary illness and death.

The Task Force members worked diligently to produce the recommendations, which were informed by several roundtables with community members and organizations that serve our diverse neighborhoods. Their voices and concerns shaped the development of the recommendations and ensured that we addressed both health care and environmental factors which contribute to disparities we see among our Asian, Black and Latino Bostonians.

We hope that you find this report along with the Hospital Working Group and Data Report to be useful in advancing the work to improve the health of all Bostonians, but particularly those who are in greatest need due to the magnitude of the challenges they face.

Sincerely,

Thomas M. Menino

Thomas M. Menino
Mayor

Dear Fellow Bostonians,

When Mayor Menino asked us to chair his Task Force to Eliminate Racial and Ethnic Health Disparities about eighteen months ago, we were eager to support such an important effort, knowing that a number of health problems have resulted in many preventable illnesses and premature deaths. We strongly believe that health and human services must be available to all, regardless of race, ethnicity or income, and this Blueprint is a starting point for improving the health of all Bostonians.

We were delighted that Mayor Menino decided to lead this effort personally. The Mayor appointed an impressive array of local leaders and experts and all pledged their support for implementing the Task Force's recommendations. The Task Force was instructed to examine the full range of causes of health disparities, including such areas as racism and poverty, which are sometimes overlooked when the lens is too narrowly focused. A very important commitment was made to develop an immediate action plan to mobilize resources to implement the recommendations. As a sign of the strength to this commitment, more than $1 million was raised during the Task Force's deliberations to fund its recommendations. Some of the City's leading institutions including Blue Cross-Blue Shield, the Boston Foundation, Brigham and Women's Hospital, Harvard Pilgrim Health Care Foundation, Massachusetts General Hospital, and the Boston Public Health Commission, gave generously to this cause.

Of course, no single effort, not even one as well supported as this, will eliminate the causes of the disparities. In order to end this problem, many different sectors will need to make a long-term commitment to address the multiple contributing factors that cause health disparities. We believe that the work of the Mayor and the Task Force demonstrates that meaningful progress can be made. Our efforts represent the first steps of a collective, city-wide effort to combat this problem. We encourage you to take the Blueprint and its recommendations to heart and join with us in the struggle to improve the health of all Bostonians, regardless of race or ethnicity.

Sincerely,

Deborah Jackson
American Red Cross of Massachusetts Bay

Gary Gottlieb, MD, MBA
Brigham and Women's Hospital

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Acknowledgements

This report is the culmination of the hard work and commitment of many people. Foremost, are the members of the Mayor's Task Force who are listed on page two.

Additionally, many local experts in Boston contributed their knowledge and expertise throughout the deliberations of the Task Force including ***Kate Bennett,*** *Boston Housing Authority;* ***Sharon Callender,*** *Mattapan Community Health Center;* ***Jim Glauber, MD, MPH,*** *Neighborhood Health Plan;* ***Lilliam Hebbert,*** *Jamaica Plain Asthma Initiative;* ***Deandrea Houston, LPN,*** *Dimock Community Health Center;* ***Margaret Reid, RN,*** *Asthma Prevention and Control Program, Boston Public Health Commission;* ***Bridgette Wallace,*** *Whittier Street Community Health Center.*

Northeastern University contributed immensely in providing the initial research and background to support the recommendations developed by the Task Force members. This dedicated team was led by ***Hortensia Amaro, PhD,*** *Director, Institute on Urban Health Research, Distinguished Professor, Bouve College of Health Sciences, and included* ***Andrea Acevedo, MS,*** *Program Manager,* ***Jean Flatley McGuire, PhD, Lorraine Snell*** *Visiting Professor, and* ***Matthew D. McHugh, CRNP, PhD, MPH,*** *Bouve Fellow.*

Boston Public Health Commission staff and consultants were instrumental during the process and the writing of the report. They are ***Maia BrodyField, MPH, Lisa Costanzo, Philip DeChavez, MD, MPH, Chuck Gagnon, Jessie R. Hood, MPH, Kristin O'Connor Golden, Ijeoma Mbamalu, MPH, Debra Paul, Christine R. Robinson and Lisa Scarlett.***

About the Mayor's Task Force Blueprint

The Mayor's Task Force Blueprint provides two necessary final components to the Disparities Project. One of these is a thoughtful, well-researched chapter that summarizes what is known about the causes of these health disparities. Armed with evidence-based arguments it debunks some of the more popular myths regarding the differences between the health of people of color and that of white people, such as the notion that such differences are largely a reflection of genetic composition or of individual behavioral choice. And it explains the necessity of extending one's vision beyond what occurs within the doctor's office to encompass the important roles that poverty, segregation and racial and ethnic prejudice play in health outcomes.

The second component of the Blueprint is its heart and soul, the list of recommendations for action steps to eliminate racial and ethnic health disparities. This compilation of twelve recommendations — 8 with a health care focus, 4 with an environmental or societal focus — is offered as a guide both for the short-term and for the long-term. Each of the twelve includes a sweeping goal which we believe must be addressed in order to eliminate disparities. It is then followed by a few places to begin. This latter category was considered necessary so that we are not overwhelmed by the enormity of our tasks. We believe that we must begin the struggle against disparities both aware of the scope of the problem and confident that initial, small steps can improve conditions. There are many ways to begin this work and these short-term and intermediate steps are not intended to be exhaustive. Rather, they highlight action steps that can be started with the resources that are available. This section of the Blueprint will be utilized as a guide in the release of a $1 million Request for Proposals in the near future.

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Introduction

Over the past 20 years, a growing number of studies have shown that White people are healthier than people of other races and ethnicities. The effect of these disparities on our population has become the number one public health concern for the City of Boston. This report reviews the many facets of this concern and lays the foundation for a series of recommendations on how to address it.

Although people of color generally have fewer economic advantages than Whites and often live in less healthy environments, income and environment alone do not explain their poorer health. Nor are disparities simply a function of unhealthy behaviors or inappropriate utilization of health care services. In fact, recent studies show that people of color actually get worse treatment within the health care system, even when they have equal access to health insurance and services. "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," the groundbreaking 2002 report from the National Academies' Institute of Medicine (IOM), clearly documented the health care system's role in producing and perpetuating health inequalities. Alan Nelson, former president of the American Medical Association and the chairperson of the IOM committee that wrote the report, said:

> *"Disparities in the health care delivered to racial and ethnic minorities are real and are associated with worse outcomes in many cases, which is unacceptable. The real challenge lies not in debating whether disparities exist, because the evidence is overwhelming, but in developing and implementing strategies to reduce and eliminate them."*[1]

Since that report was released, researchers have done more studies to better understand and address both these inequalities in care and the underlying inequities that make certain populations less healthy in the first place. Federal agencies, foundations, health insurers, and hospitals have funded new research. Medical, public health, nursing, and dental associations have held conferences on racial and ethnic disparities in health. Community-based organizations and community health centers have organized providers and residents to advocate for change. Other initiatives were already under way at the federal[2] and local level, including the Boston Healthy Start Initiative's efforts to decrease infant mortality among Black women; community coalitions under the CDC's Racial and Ethnic Approaches to Community Health (REACH) initiative have focused on eliminating racial and ethnic disparities in cancer, AIDS, cardiovascular disease, and diabetes.

Together, the Mayor of Boston and the Boston Public Health Commission imagined ways that a city—especially one that is a center of medical research and practice—could marshal its resources to address these issues. The Mayor's Task Force to Eliminate Racial and Ethnic Disparities in Health is a product of this vision.

The Disparities Project ultimately hopes to develop strategies that will close the health gap between White residents and residents of color in Boston. The Task Force recognizes that health care is only partly responsible for the health of the population: social factors such as the environment, housing, poverty, stress, racism, and neighborhood infrastructure (including residential segregation) play a large role. That is why our recommendations address housing agencies, public safety officials, educators, business leaders, health care institutions, elected officials, health insurers, and others. These recommendations form the backbone of this report.

To illustrate the context in which the Task Force developed its recommendations, we will review the social history of race and ethnicity in American society and explain how race shapes the social, environmental, and economic conditions that affect health. Then we will discuss how race affects people's experiences in the health care system and, finally, offer a case study focusing on one neighborhood and one disease.

What are Race and Ethnicity?

On its face, race might seem to be a biological concept, since people of different races do look physically different. These differences led physical anthropologists in the 18th century to divide humankind into different racial groups based on skin color, physical characteristics, and region of origin. Over time, the idea of discrete racial groups has become part of American society.

We now know, however, that physical differences between so-called races are not based on genetic differences.[3,4,5] In fact, scientists have found remarkable genetic similarity between so-called races.[6,7] The physical differences that we see are mostly the products of environment. For example, people who originated and stayed near the equator maintained darker skin to protect them from the damaging rays of the sun. People who migrated north evolved lighter skin to capture sunlight and produce vitamin D. The racial groups that we have come to accept—White, Black, Asian, and Indian—are not biologically valid categories.

Moreover, racial classifications vary considerably according to time and place.[8] For example, some people who are considered Black in United States might be considered White in Brazil and "Colored" in South Africa. And the racial categories we use in this country—including the categories used by the U.S. Census—have evolved over the generations.[9] These facts show why race is considered a *social construction.*[10] This expression means that the concept of "race" is *built* by individual societies, which determine its meaning and impact.

The way people were assigned to the racial categories we know in the United States reflected unexamined assumptions that darker-skinned people were innately inferior to lighter-skinned people. These were the same assumptions behind slavery, behind Jim Crow laws, and behind the institutionalized practices of discrimination whose effects are still felt today.

Ethnicity, too, is not a biological category. Ethnicity refers to shared ancestry, geography, historical experiences, and heritage, often expressed through similar customs, symbols, social norms, and language.[11,12] But the populations that make up an ethnic group may also be very different from one another. For example, in the U.S. "Latino" and "Hispanic" are ethnic labels, but these categories include a wide range of people from places such as Puerto Rico, Cuba, Mexico, the Dominican Republic, and South and Central America. Moreover, people labeled Latino or Hispanic might also consider themselves to belong to a racial group like Black, White, or Asian. Similarly, the term "Asian" encompasses people from South Asia, East India, China, Japan, Korea, and Indonesia, and elsewhere.

Such a broad category hides important differences between groups that have different histories, experiences, and resources.

In short, people of color do not have different genes or different biological characteristics that are inherent in the genes. So innate physical differences cannot explain why they are less healthy than White people. Rather, race and ethnicity determine the social conditions in which people live, and those conditions affect their health. In societies where people of certain races are discriminated against, they will often be less healthy because they have less access to health care and economic opportunities, and may live in unhealthier conditions.

What Are Health Disparities?

In 2000, the National Institutes of Health (NIH) of the U.S. federal government defined health disparities as "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States."[13]

When these differences are apparent even after other factors are accounted for, we can conclude that some inequity between population groups is responsible for them.

Despite the national and local progress that has been made toward explaining and addressing these disparities, it is clear that their underlying causes are complicated and many. The specific racial and ethnic health disparities best documented in Boston today, and some of the social factors that may account for them, are detailed in the Data Report that has been developed as a part of the Disparities Project.

What Is Racism and How Does It Affect Health?

When most people hear the word "racism," they envision cruel acts of discrimination and violence against Black people, as in the Deep South 50 years ago or in South Africa as recently as 20 years ago. But racism is not always so extreme or visible; it encompasses all beliefs, attitudes, institutional arrangements, and acts that denigrate individuals or groups because of their physical characteristics or ethnic group affiliation.[14]

At the *institutional level*—where it is embedded almost invisibly in social structures, laws, and customs—racism affects access to goods, services, and opportunities,[15] including health care and many of the factors that make up a healthy environment. At the *interpersonal level*—the level of prejudice and discrimination[16]—racism affects the way people are treated by others, both intentionally and unintentionally.

And at the *internal level*, racism affects people's own beliefs about who they are and what they can do,[17] sometimes leading to self-destructive behaviors such as drug abuse or interpersonal violence.[18]

Racism in the delivery of health care has a long and disturbing history in the United States that has certainly harmed the health of racial and ethnic minorities.

Medical care provided to Black slaves was segregated, inferior, and exploitative.[19] Even after slavery ended, separate and unequal medical care was the only care available to African-Americans. Well into the mid-1900s, most U.S. medical schools did not accept Black or Latino applicants.

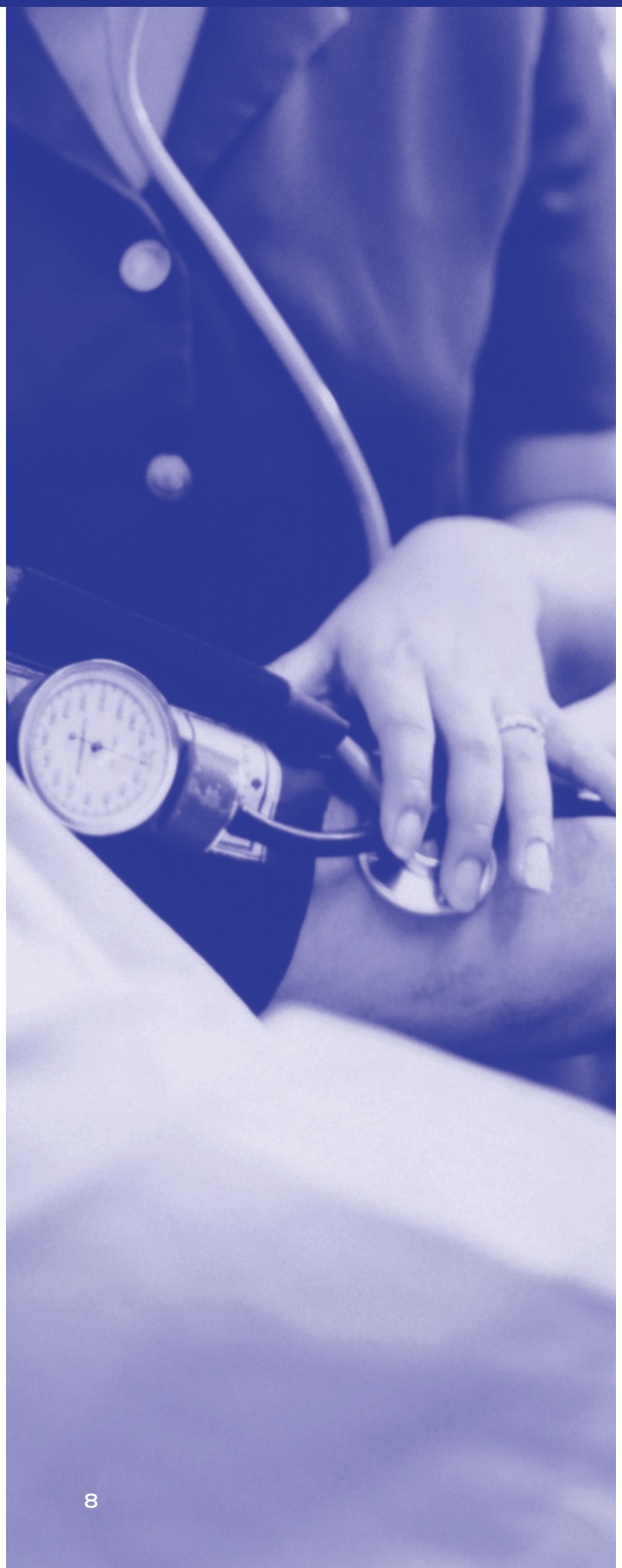
Worse, the U.S. government has committed documented atrocities against Black and Latino people.

From 1932 to 1972 the U.S. Public Health Service sponsored the Tuskegee Syphilis Study, a shameful example of human experimentation: Black men with syphilis were denied knowledge of their diagnosis and left deliberately untreated.[20] Government and medicine also colluded in forced sterilization and other eugenic practices intended to control the growth of minority and immigrant populations in Puerto Rico: between the 1930s and the 1970s approximately one-third of Puerto Rican women of childbearing age were sterilized.[21,22] Partly because of this history, many people of color distrust the health care system. This can make it harder for them to seek care.

Even today, many African-Americans and Latinos feel discriminated against in the health care system.

In Boston, Black residents are more than four times as likely as White residents to say they have felt discriminated against based on their race when seeking health care. Latino residents are two times as likely as Whites to report such perceptions.[23]

Of course, racism and perceptions of racism also persist outside the health care system. In Boston, a much higher proportion of Black residents (20.8%) and Latinos (18.1%) than Whites (2.9%) feel that they have been treated worse than others in the workplace because of their race.[24] Wherever it occurs, perceived discrimination affects both mental and physical health.[25] Studies have found that people who feel that they have been discriminated against have higher levels of distress,[26,27] depression[28,29] stress,[30,31,32,33,34,35,36,37] and anxiety.[38] Discrimination has been associated with increased mortality,[39,40] very low birth weight,[41,42] and worse cardiovascular health, including hypertension.[43,44] People who experience discrimination have reported disproportionately higher rates of smoking[45] and alcohol and drug use and dependence.[46,47] They also rate their health as poorer than those who have not felt discriminated against.[48]



Socio-economic Status

Socio-economic status refers to a group or person's position in society as measured by income, education, and occupation.[49,50,51]

It helps determine access to power, privilege, and resources that are associated with health; all across the world people with higher socio-economic status are healthier than those with lower status.[52,53,54] Poor people are more likely to be affected by smoking, lack of exercise, poor diet, chronic stress, inadequate social support, hazardous workplaces, unsafe and crowded housing conditions, lack of health insurance, and other factors that can compromise health.[55]

This dynamic is evident in Boston. Based on analysis done by the Boston Public Health Commission, compared with residents of the four highest-income neighborhoods, residents of the four lowest-income neighborhoods are less healthy. The death rate from all causes is 30% higher in the poor neighborhoods; residents are two and a half times as likely to die from diabetes, four times as likely to die of HIV/AIDS, and twice as likely to die from injuries.

People of color are more likely to be poor, but this socio-economic disparity does not fully explain the disparities we seen in health. Even when researchers control for socio-economic status, racial and ethnic health disparities remain:[56,57] Blacks in the United States are less healthy than Whites even when they have the same income. For example, the disparity in infant mortality between Blacks and Whites is greater for college-educated women than for high-school-educated women.[59] In fact, the infant mortality rate among White women who have not completed high school is lower than the rate among Black women who have graduated from college.[60]

Residential Segregation

As in most communities in the United States, racial and ethnic groups are distributed unevenly throughout Boston. According to the 2000 U.S. census, about 92% of Boston's Black population lives in seven neighborhoods—Roxbury, Dorchester, Mattapan, Hyde Park, Jamaica Plain, the South End, and Roslindale. These same neighborhoods are home to about 63% of the city's Latino residents; another 17% of Latinos live in East Boston.[61] Boston is so segregated that 76% of Blacks and 60% of Latinos would have to move before racial and ethnic groups were evenly distributed.[62]

Surveys show that compared with Whites, African-Americans and Hispanics are more interested in living in non-segregated neighborhoods.[63] But persistent racial and ethnic discrimination in housing keeps residential segregation in place.[64]

David Williams, Ph.D., a national expert in racial disparities, has explained the relationship between segregation and health this way:

"Residential segregation, a product of long-standing institutional and individual racism, represents a fundamental cause of racial disparities in health because it perpetuates racial disparities in poverty, education, and economic opportunity that, in turn, drive disparities in health.

The social and spatial marginalization associated with segregation reinforces substandard housing, underfunded public schools, employment disadvantages, exposure to crime, environmental hazards, and loss of hope, thus powerfully concentrating disadvantage."[65]

Research shows that residential segregation is associated with myriad health risks. For example:

- Segregated neighborhoods have higher levels of air pollution and other environmental hazards.[66]
- Segregated neighborhoods have less access to recreation space and large supermarkets, which makes it more difficult for residents to exercise[67] and buy healthy, affordable food.[68,69]
- Segregation has been associated with higher crime and homicide rates.[70]
- Segregation can increase people's exposure to behavioral risks. Tobacco and alcohol advertising is rampant in communities of color, which also have more liquor stores than less segregated areas.[71,72]
- Segregation has been linked to higher infant mortality rates and higher adult mortality rates.[73,74,75]

Neighborhood segregation tends to reflect differences in income,[76] but the link between segregation and health is not due to income alone. In fact, the United States is more segregated by race and ethnicity than it is by income. And segregation affects health even when socio-economic factors have been accounted for. One study found that after adjusting for family income, residential segregation was associated with increased mortality risk for Blacks aged 25 to 44.[77] Segregation is also associated with higher risks of tuberculosis,[78] cardiovascular disease,[79] teenage childbirth,[80] and homicide[81] for people of color.

Neighborhood Environment

Poor neighborhoods and highly segregated ones often suffer the worst liabilities of the urban environment: pollution, crime, low-quality and crowded housing.[82,83,84] More generally, decaying neighborhoods—those with vacant or boarded-up houses, graffiti, and abandoned cars on the block—have higher rates of premature death, even when socio-economic status is taken into account.[85]

One major health risk has to do with what has been called "environmental racism."[86] Owing to their relative lack of political power, minority and lower-income neighborhoods in Boston and around the country are more likely to be home to waste sites and other facilities that expose residents to environmental toxins.[87,88,89,90,91,92]

Of the 22 waste sites in Boston, half are in the predominantly Black and Latino neighborhood of Roxbury. In 2004, of the city's 902 auto-body shops (which can produce volatile organic compounds that are harmful to human health and the environment), 29% were in Dorchester and 10% were in Roxbury.[93]

Other risks have to do with poor housing. Children who live in poorly maintained housing are more likely to be injured—for example, by falling from a window. Older houses with deteriorating paint may also expose children to lead poisoning, which can cause brain damage and developmental delay.

Lead poisoning is concentrated in Boston neighborhoods that are predominantly communities of color: Dorchester, Mattapan, and Roxbury.[94]

So is asthma, which can be triggered by mold (more common in leaky houses or apartments) or household pests like cockroaches and rodents. In Boston, asthma is more common among people of color. Boston's Black and Latino children are hospitalized for asthma at higher rates than White or Asian children, and Black adults are more likely than White adults to have asthma.[95]

Diet and Exercise

Diets that are high in sugar and saturated fat have been linked to heart disease, stroke, cancer, obesity, and diabetes.[96,97,98,99,100,101] On the other hand, diets that are high in fruits and vegetables have been found to protect against those same diseases.[102,103,104] Yet healthier foods often cost more. Since Black and Latino communities are more likely to be poor, people in those communities may have particular difficulty affording healthy foods.[105]

A related problem is that Black neighborhoods have fewer supermarkets than White neighborhoods do.[106] Segregated and poorer areas have more corner shops, convenience stores, and smaller supermarkets than larger supermarkets,[107,108,109] but these stores tend to have less variety and charge higher prices. Residents who depend on public transportation may have to take multiple buses or trains to reach a major supermarket.

Others may rely on costly taxis to get to the grocer. Several studies have shown that the foods recommended for diabetic, in particular, are less likely to be available in non-White neighborhoods.[110,111,112]

When members of the REACH 2010 Breast and Cervical Cancer Coalition and Women Health Ambassadors (WHA) compared urban and suburban grocery stores as part of their Community Mapping Project in Boston, they did not find that prices varied much. However, they found that the urban stores were not as attractive or well maintained, had poorer-quality food, and provided less nutrition information and customer service.[113] Like eating a nutritious diet, getting enough exercise can help people stay healthy but is harder to do in many minority neighborhoods. Regular exercise is easier in safe and walkable neighborhoods with adequate green space.[114,115,116] If neighborhood residents do not feel safe or do not think the police will respond promptly to their needs, then they are less likely to exercise outdoors. In Boston, fewer than 30% of Black, Asian, and Latino adults report that they get the recommended amount of exercise, compared with 42% of Whites. Black, Asian, and Latino high school students are also less likely than their White counterparts to get enough exercise. Lack of exercise is a strong risk factor for overweight and obesity; 64% of Black residents and 56% of Latino residents are overweight, compared with 43% of Whites.[117]

Health Care Access and Quality

Factors such as socio-economic status, environment, education, and nutrition probably play a bigger role in health than does the health care system itself. Nonetheless, access to medical care is critical, especially for managing the chronic diseases that disproportionately affect people of color. Both access to health insurance and quality of care can be problems for racial and ethnic minorities.

Nationally, people of color are much less likely to have insurance than non-Hispanic Whites. In 2000, 32% of Hispanics lacked insurance, compared with 9.7% of non-Hispanic Whites. About 18% of Blacks and Asians/Pacific Islanders were also uninsured.[118] Even among the poor, insurance rates differed by race and ethnicity. For example, 43% of poor Hispanics were uninsured, compared with 25% of poor non-Hispanic Whites.[119]

In Boston, 11.7% of all residents are uninsured.[120] One in 7 Latinos and 1 in 9 Blacks are uninsured, compared with 1 in 15 Asians and 1 in 18 Whites.[121] More Boston residents of color, especially Asians and Latinos, report that they could not afford to see a doctor when they needed one in the previous year.[122]

Whether or not people of color have insurance, the quality of care they receive may suffer.

The 2002 study by the Institute of Medicine found that when differences in socio-economic status, payment source, and severity of illness, are not a factor, patients of color are less likely to get acceptable treatment for various illnesses.[123]

Some examples of inequality in care:

- African-American patients who need advanced cardiovascular procedures are less likely to get them than their White counterparts, regardless of insurance. In one study of about 86,000 Medicare patients,Whites were four times as likely to receive coronary artery bypass graft surgery as African-American patients.[124]

- African-Americans and Hispanics are significantly less likely than Whites to receive cardiovascular procedures, even after adjusting for primary diagnosis, age, gender, insurance type, income, and other factors that might have explained the differences.[125]

- Latinos are less likely than non-Latinos to have a regular health care provider (68.5% versus 84.1%) or a regular place for receiving health care (93.4% versus 96.2%), according to one study.[126] The Latino respondents were also more likely than non-Latinos to report that they needed medical care during the previous year but could not get it (6.5% versus 5%). Latinos were significantly less likely to have received several preventive measures in the preceding year, including screening for high blood cholesterol; screening for breast, cervical, and colorectal cancers; pneumococcal vaccination; and influenza vaccination.[127]

- Among men with prostate cancer, aged 50 to 69, Blacks were less likely to undergo prostatectomy. For all age groups, twice as many Blacks as Whites received no treatment for prostate cancer.[128]

- Only 47.7% Cambodians surveyed reported having ever had their blood cholesterol checked, compared with 70% of all U.S. Asians and 77.4% of the general U.S. population.[129] Cambodian and Vietnamese women were less likely to have had Pap tests (64.2% and 65.5%, respectively) than women in the total Asian and general U.S. populations (74.5% and 85.8%, respectively). About 19% of Cambodians and 40% of Vietnamese over 65 years old reported ever having had a pneumococcal vaccine, compared with 63.4% of all Asians and 61.8% of the general U.S. population.[130]

- People of color who need pain medication are less likely to get it. For example, African-Americans with cancer are less likely to receive pain treatment than Whites.[131] One study in an emergency department found that Hispanic patients with bone fractures were twice as likely to go without pain medication as non-Hispanic Whites with similar injuries.[132]

The Institute of Medicine Committee that wrote the 2002 report attributed such disturbing differences in quality of care to unconscious stereotypes and assumptions that lead physicians to prescribe different treatment for people of color. The researchers concluded that these biases are essentially invisible to institutions and providers unless they constantly gather and analyze data about treatments according to the race and ethnicity of the patients. Patient satisfaction surveys might also miss these differences if they are not analyzed by race and ethnicity.

As we noted before, discrimination is a barrier to care,[133] and a much higher proportion of Boston's Black (8.3%) and Latino (4%) residents than White (1.9%) residents say they have been treated worse than others because of their race when they seek health care.[134] Patients of color are acutely aware of differences in treatment and often report insensitivity by White providers. In a series of meetings with community coalitions, the Boston Public Health Commission heard repeated complaints about insensitive racial comments from providers, inadequate treatment of pain, and unwillingness to communicate important information to patients. Surveys support this finding.

One reason for this insensitivity is that people of color are severely underrepresented in medicine, nursing, and dentistry. The lack of diversity in the health care system creates an institutional climate that can seem hostile to the needs of people from minority communities. Although African-Americans, Latinos, and Native Americans represent more than 25% of the U.S. population,[135] they make up about 6% of physicians[136] and 8% of nurses.[137] Recent reports by the Sullivan Commission,[138] the Institute of Medicine,[139] and the Massachusetts-based Health Care for All[140] underscore the need for better representation of racial and ethnic minorities in the health care workforce.

Among the benefits of a more diverse system:

- Health care professionals from racial and ethnic minority groups are more likely than their White counterparts to work with minority and medically underserved communities, and this might improve access to care for people of color.[141,142,143]

- A more diverse workforce could help give immigrant populations access to the care they need. A recent study found that about 40% of Hispanic patients consider the physician's ability to speak their language a significant factor in choosing a doctor, even when controlling for the doctor's location.[144]

- African-American and Hispanic patients whose doctors share their ethnicity are more satisfied with their medical appointments, rate the quality of their health care higher, are more likely to feel treated with respect, and feel more satisfied with their care than those who have doctors of a different ethnic group.[145,146,147,148]

Better hiring practices will not be enough to change the face of the health care workforce, these reports conclude. Rather, the pipeline of minority students entering the health professions must itself be increased.

CASE EXAMPLE: ASTHMA IN ROXBURY

To illustrate how these different factors come together to affect health and how to think about racial and ethnic disparities in a particular neighborhood, we present the example of asthma in Roxbury. We chose Roxbury because it is an ethnically diverse, low-income community in Boston. We chose asthma because it is a chronic disease affecting both adults and children, its symptoms can be triggered by numerous irritants in the environment, and there are clear guidelines about how it should be treated.

Roxbury is disproportionately affected by asthma, especially among children. Between 1998 and 2002, Roxbury children under the age of five were nearly twice as likely to be hospitalized for asthma as children in all other neighborhoods of Boston (14.6 hospitalizations per 1,000 children in Roxbury, compared with 7.9 for the rest of Boston). Hispanic and Black children were 50% more likely to be hospitalized for asthma than Whites in this neighborhood.[149]

Compared with Boston as a whole, Roxbury has a larger Black and Latino population: it is 53% Black, 22% Latino, 15% White, and 5% Asian.[150] Roxbury is also among the poorest of Boston's neighborhoods. As of the 2000 census, 29% of Roxbury's population was below the poverty level, compared with 20% of Boston's overall population.[151]

Also, 29% of Roxbury's population had less than a high school education or GED, compared with 21% of Boston's overall population.[152] A study in 2002 showed that Roxbury's median monthly rent consumed 70% of neighborhood residents' median income.[153]

Roxbury's poverty fosters an environment that can trigger asthma or make it worse. For example, as of the 2000 census just 23.7% of Roxbury's Black residents, 11.7% of Asian residents, and 10.7% of Hispanic residents owned their homes, compared with 43.7% of non-Hispanic White residents.[154]

Renting instead of owning a home gives people less control over their home environment.[155,156] Poor housing conditions can give rise to dust and household pests, two well-established asthma triggers.[157,158] These triggers are highly concentrated in poor neighborhoods and often even more highly concentrated where poor Blacks and Hispanics live.[159] Roxbury also has a disproportionate number of garbage disposal sites, which generate dust and invite infestation by rodents and insects.

Poverty puts particular pressure on families whose children have a chronic illness. Children with asthma may require multiple prescriptions, each with its own co-pay; families that are strapped for money may have to choose which prescriptions to fill and which to save for later. When children unexpectedly get sick or need to see a doctor, parents may have to miss work, which reduces their badly needed earnings and threatens their employment. This is a special challenge for single parents. Poverty also increases stress for families, which in itself can worsen a chronic illness.

Behavioral risk factors for asthma are also more prevalent in Roxbury. For example, smoking or being exposed to secondhand smoke can trigger or exacerbate asthma symptoms. Roxbury has the second-highest rate of smoking during pregnancy among all Boston neighborhoods (7.3% of all births, compared with 4.5% for Boston as a whole). In part this reflects the tobacco industry's targeted marketing to racial and ethnic minorities. In a study of tobacco advertising in the Boston area, Roxbury residents were exposed to about six times as many brand advertisements as they were to No Smoking signs. Beacon Hill residents, on the other hand, were exposed to only about 1.6 and 1.2 times as many brand advertisements. Advertising to youth, especially, increases their likelihood of smoking.[164,165]

Evidence suggests that safe, supervised exercise improves asthma among children, but high school surveys show that Black and Latino adolescents get less exercise than their peers. Part of this disparity may have to do with neighborhood safety and walkability. Though the media image of Roxbury as a crime center may be unfairly exaggerated, Roxbury did have a homicide rate of 14.1 deaths per 100,000 in 1999–2002, the fourth-highest rate among all neighborhoods (the figure for Boston as a whole was 7.2).[166] Concern for safety may dissuade families from sending children outside to play, and neighborhood surveys show that Roxbury has proportionately fewer supervised recreation facilities than more affluent parts of the city.

Finally, access to health insurance and quality health care is critical for managing asthma. Although data on the actual prevalence of asthma are inadequate, the rate at which children of color are hospitalized for asthma suggests that they are not receiving the most effective care. Massachusetts is fortunate in that all children are eligible for some form of insurance, regardless of their family's ability to pay. Nonetheless, certain children's insurance programs severely limit prescription coverage, and multiple co-pays and out-of-pocket expenses stress families' limited economic resources.

Closing the Black-White gap in asthma complications will require a broad range of specific interventions. But some general conclusions that emerged from this example are applicable to many other health disparities.

For example:

- We need better data to evaluate racial disparities.
- Environment and health are inextricably linked.
- Housing plays a major role in health and health disparities.
- Addressing residential segregation can help reduce health disparities.
- Poor communities need more economic opportunity.
- Safe neighborhoods are essential to promoting exercise and recreation.
- Access to affordable health insurance and health care makes a big difference for poor people and people of color.
- Community-based organizations must educate patients to help them prevent and manage disease.

These programs must be culturally competent—in other words, care providers should be familiar with the communities they serve and refrain from stereotyping or making inaccurate assumptions about patients of color.

Community Assets

Strong in human assets and spirit, the Roxbury community has already responded to some of these needs. The many passionate organizations, churches, and individuals devoted to the community have worked to keep its residents well. The community health centers in Roxbury—Whittier Street, Dimock, and Roxbury Comprehensive Community Health Center—provide vital services that are sensitive and responsive to the needs in their neighborhoods. They form the front line of asthma treatment in the community.

Community coalitions, health centers, community-based organizations, city agencies, churches, health care providers, and businesses have devoted time and resources to the problem of asthma in Roxbury.

For example:

- Resident-guided community-development initiatives such as the Roxbury Action Program have addressed housing issues in Roxbury.
- The Boston Urban Asthma Coalition has brought together a broad range of community partners in Roxbury, Jamaica Plain, and Dorchester.
- Health insurers such as Neighborhood Health Plan and Harvard Pilgrim Health Care have developed disease-management to help control asthma symptoms among their patients.
- The Neighborwalk, Steps to Wellness, and Kids with Asthma Can Swim programs launched by the Boston Public Health Commission encourage physical activity in Roxbury and other neighborhoods.
- The Boston Public Health Commission's Asthma Prevention and Control Program works with the community to improve housing conditions. It offers help with pest management and air-quality testing, and provides a Healthy Homes guide online.[167]
- Boston now restricts smoking in city workplaces. The smoking ban means that people with asthma will be exposed to much less secondhand smoke when they go to work or visit a restaurant or public space.

These measures are important steps toward reducing racial disparities in asthma for Roxbury residents, but they are only a start toward reducing health disparities in Boston as a whole. The recommendations that follow were developed as a guide for eliminating racial and ethnic disparities in health without regard to neighborhood or specific disease condition. They are not meant to derail or supplant current initiatives. Rather, they are meant to engage a much broader community in the short- and long-term work of achieving health equality in Boston. Addressing racial and ethnic health disparities is more than just the leading public health enterprise for the city; it is the core of building a stronger community and a better Boston.

A comprehensive, multi-level strategy is needed to eliminate disparities in health. Since research shows that people of color tend to receive a lower quality of health care than Whites, attention must be focused on needed changes in virtually all sectors of the health care industry. However, the health of people of color is also affected by conditions outside of the health care field – such as the quality of housing, employment opportunities, the availability and affordability of healthful food, access to parks and recreational facilities, and the safety of the environment.

There are a total of twelve recommendations that have been divided into two major segments, those specifically germane to the health care field and those related to larger societal factors and circumstances. In developing these recommendations, we have tried to include concrete action steps that a broad range of stakeholders should take in City-wide efforts to eliminate health disparities. Health care organizations, insurers, public officials, community-based organizations, foundations and businesses can each play a role in implementing the proposed recommendations.

We have attempted to address two separate and distinct needs. Our first aim is to provide a series of overarching recommendations. These are broader, longer-term objectives for change. They include ambitions like the elimination of barriers to employment and a major change in the racial and ethnic composition of the healthcare workforce. Our Task Force and the Boston Public Health Commission can work towards the achievement of these outcomes, but our influence is limited and the time frame for accomplishment is long. Yet, to exclude these larger goals would minimize the deep societal changes that are needed to ensure that health disparities are eliminated.

Our second aim is to develop short-term and intermediate action steps, ones that can be reached in the next few years with the dedication of available resources and the prioritization of activities. These suggested action steps are not intended as the only ones needed to overcome health disparities. Rather, these are offered as examples to highlight that meaningful changes are within our grasp. Without such efforts, we run the risk that the Blueprint will fail to improve conditions for local residents in the near future, a compelling need given the daily suffering caused by preventable illness and premature death.

Section 1 – Health Care and Public Health

B1-1 Health Insurance:

Ensure that all residents have access to universal, affordable, high quality, and comprehensive health insurance, regardless of income and residency status. Insurance should cover a range of services that may help end disparities — such as reimbursement for interpreter services and community health workers — and should avoid payment mechanisms that may increase disparities, such as excessive co-payments.

Short-term/Intermediate Action Steps:

a. Actively participate in the current State debate about the retention and expansion of insurance and retention of the Free Care Pool.

b. Promote coverage for all racial and ethnic groups and expand the range of reimbursable services in the current advocacy efforts. Such efforts should include the development of a cost/benefit analysis of the recommended coverage.

B1-2 Data Collection:

Require that all health care organizations and insurers gather uniform data on the race, ethnicity, preferred language, and socioeconomic status of patient/member populations. These same organizations should use these data to identify and reduce disparities in clinical practice and outcomes, incorporating them into performance assessment and quality improvement activities.[168, 169]

Short-term/Intermediate Action Steps:

a. Implement standard data collection on the race, ethnicity, preferred language, and highest level of education of patients in all acute care hospitals and a subset of community health centers.[170]

b. Collect and analyze information on access, utilization, and treatment by race and ethnicity at a subset of hospitals and community health centers to promote an internal process of monitoring performance, and identifying and addressing disparities in treatment.

B1-3 Patient Education:

Develop programs that build the skills of community members to become better informed and equipped patients, able to effectively navigate through the health care system. Such efforts should include the use of population-specific and/or disease-specific training and educational tools and should expand access to English for Speakers of Other Languages (ESOL) programs.[171]

Short-term/Intermediate Action Steps:

a. Develop and assess the efficacy of several model programs that build on the skills of patients and community members.

b. Encourage additional resources for English of Speakers of Other Languages (ESOL) programs to include patient/clinician encounters as part of the curricula.

c. Prioritize the design of model programs for the elderly, women of childbearing age, young men, and other segments of the populations for whom disparities are the greatest.

Cross reference
The Hospital Working Group Report has more detailed recommendations that hospitals can follow to improve data collection. The recommendations are listed in Chapters 1 and 2 and are available on-line at **www.bphc.org/disparities.**

B1-4 Health Systems:

Develop programs that identify and address specific obstacles to overcoming disparities. Such components should include mechanisms for patient input and feedback, specialized outreach and patient support efforts.

Short-term/Intermediate Action Steps:

a. Develop and implement model patient ombudsperson programs in order to investigate and achieve solutions to patient complaints regarding their care; mechanisms like patient satisfaction systems should be available in multiple languages to allow feedback regarding the quality of health care provided.
b. Support the work of community educators, outreach workers and/or patient navigators in order to increase their ability to reach and follow up with patients.

B1-5 Cultural Competence:

Provide cultural competence education and training, including educational components on racism and other social determinants of health, as part of the training of all health professionals (undergraduate, graduate, and continuing). Training should focus on eliminating health disparities and pay particular attention to eliminating invalid assumptions that lead them to provide different treatment for people of color.

Short-term/Intermediate Action Steps:

a. Identify a common set of educational objectives for cultural competence training, develop an inventory of available curricula and training materials, and identify gaps in training.
b. Expand cultural competence training options for hospital and community health center staff.[172]
c. Advocate for training and education in cultural competence as a condition of licensure.[173]

B1-6 Workforce Diversity:

Increase resources to recruit, train, retain, and graduate persons from underrepresented groups of color in the health care field. Such efforts should include the use of specialized outreach and mentorship programs, the expansion of scholarships and other financial assistance and the commitment to increase the racial and ethnic diversity of educational faculty.

Short-term/Intermediate Action Steps:

a. Identify and promote promising practices in workforce development to diversify the pool of health professionals. Programs could include those that promote creative outreach and incentive efforts and career ladders.
b. Investigate the feasibility of creating a subsidized, seven-year joint BS/MD program, to expand access to medical school education for students of color and those with limited financial resources.[174]
c. Build partnerships between health professions schools/ health care organizations and the Boston Public Schools health career academies to provide students with opportunities for academic enrichment in math and sciences and enhanced access to health career training.

Cross reference
Read the Hospital Working Group Report for more detailed recommendations on workforce diversity (Chapter3) and cultural competence (Chapter 4). The report is also available on-line at **www.bphc.org/disparities**.

B1-7 Public Health Programs:

Establish and/or strengthen state and local government health agency offices to help guide the efforts to eliminate health disparities.[175] Non-health-oriented agencies involved in activities that have a significant impact on the health and well-being of communities of color should designate personnel to focus on this issue.

Short-term/Intermediate Action Steps:

a. Secure additional funding to strengthen the capacity of local and state offices on the health of people of color.

b. Strengthen core public health functions such as monitoring and evaluation that are linked to efforts to reduce health disparities.

B1-8 Research Needs:

Conduct research to determine the causes of and solutions to health disparities. Such research should include examination of the link between social and environmental factors and health outcomes as well as the impact of positive and negative practices within the health care field.[176] Researchers and public officials should promote community-based participatory research to eliminate health disparities.

Short-term/Intermediate Action Steps:

a. Evaluate programs funded under the Boston Disparities Project.

b. Identify existing promising practices by reviewing available data and supporting those programs that yield positive results.[177]

c. Monitor research findings as hospitals and health centers incorporate racial and ethnic data into their quality improvement efforts.

Section 2 — Environmental and Societal Factors

B2-1 Neighborhood Investment:

Undertake efforts to eliminate the disproportionate health risks in neighborhoods of color in order to make them healthier places to live. Such efforts should include the reduction of exposure to certain environmental hazards, the improvement of public safety conditions, the elimination of discriminatory practices, and the promotion of recreational activities and access to healthy foods.

Short-term/Intermediate Action Steps:

a. Offer cultural competence, anti-racism, and anti-discrimination trainings to health care and community-based organizations.[178]

b. Review the administrative policies, activities, and programs of key City agencies to examine their potential of having a positive impact on the health of communities of color.

c. Support neighborhood and community participation in public policy, public decision-making, and the regulatory process.

B2-2 Jobs and Economic Security:

Eliminate the disproportionate barriers to employment faced by residents of color. Whenever possible, jobs should include opportunities for promotion, training and comprehensive health insurance benefits.

Short-term/Intermediate Action Steps:

a. Support efforts to increase access to jobs that offer comprehensive health insurance and sufficient income to cover employees' health care needs.

b. Partner with higher education and workforce development organizations to identify and replicate successful job training and placement programs.

c. Review and adapt hiring and employment practice such as current CORI policies to promote diversity at all levels of employment.

d. Provide job training and career development programs for incumbent employees of color to enhance their skills and professional development.

B2-3 Public Awareness:

Increase the awareness of all Boston residents about the impact of health disparities and related social justice issues. Specialized educational efforts should be undertaken for policy and decision makers.

Short-term/Intermediate Action Steps:

a. Create a public information campaign to raise awareness among the general public about health disparities and the recommendation of the Boston Disparities Project.

b. Meet with key policy and decision-makers about the importance of eliminating disparities and about the recommendations of the Boston Disparities Project.

B2-4 Promotion of Key Community Institutions:

Enhance the ability of local community organizations and neighborhood residents to effectively address issues that have an impact on health disparities. Local practices with demonstrated positive outcomes should be identified, nurtured, and replicated in other neighborhoods or communities.

Short-term/Intermediate Action Steps:

a. Build the capacity of existing coalitions and organizations with positive track records of mobilizing and educating community members.

b. Encourage neighborhood-based non-health-related institutions – such as faith-based organizations, neighborhood associations and local businesses – to become more active in promoting environmental conditions that eliminate health disparities.

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