

# **UNEQUAL HEALTH OUTCOMES IN THE UNITED STATES**

**RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE TREATMENT AND ACCESS,  
THE ROLE OF SOCIAL AND ENVIRONMENTAL DETERMINANTS OF HEALTH,  
AND THE RESPONSIBILITY OF THE STATE**

## **EXECUTIVE SUMMARY**

**Submitted by the CERD Working Group  
on Health and Environmental Health**

**January 2008**

**A Report to the Committee on the Elimination of Racial Discrimination**

## Submitted by:

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The Opportunity Agenda—Poverty & Race Research Action Council—National Health Law Program—Center for American Progress—Center for Reproductive Rights—New York Lawyers for Public Interest—Families USA—Physicians for Human Rights—Alliance for Healthy Homes—Center for Social Inclusion—Summit Health Institute for Research and Education, Inc. (SHIRE)—Community Catalyst—Lawyers Committee for Civil Rights Under Law—Out of Many, One—National Economic & Social Rights Initiative—Uplift International—Generations Ahead—Natural Resources Defense Council—Policy Link—The Praxis Project—Kirwan Institute for the Study of Race and Ethnicity— Ipas— Kellogg Health Scholars Program—Medical-Legal Partnership for Children at Boston Medical Center— Environmental Justice Resource Center at Clark Atlanta University

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\* Scholars submit this report in their individual capacities. Academic affiliations are provided for identification purposes only. Organizations and scholars submitting this report do not necessarily endorse every assertion made herein.

## Executive Summary

**The “persistent disparities” in health in the United States that were noted by the Committee on the Elimination of Racial Discrimination in its 2001 “Concluding Observations” have not significantly abated.**

Of particular concern are widening disparities in infant mortality between black and white populations, and continuing disparities in cancer mortality, diabetes, heart disease and overall life expectancy. The US government has also failed to collect data on racial disparities in health care as required by CERD, or to provide adequate resources to federal agencies charged with monitoring compliance.

Racial and ethnic disparities in health outcomes in the U.S. are caused not only by structural inequities in our health care systems, but also by a wide range of social and environmental determinants of health. The Convention recognizes and encompasses this dual analysis in the area of public health. Article 5 of CERD provides that “States Parties undertake to prohibit and to eliminate racial discrimination in all its forms” in enjoyment of the right to “public health” and “medical care.” Public health has been interpreted by the Special Rapporteur on the Right to Health to include not only health care systems but also the underlying social and environmental factors affecting health.<sup>1</sup>

The disproportionate lack of health insurance among minority families and children is a critical element contributing to these disparities; moreover, a substantial body of evidence demonstrates that racial and ethnic minorities receive a lower quality and intensity of health care than white patients, even when they are insured at the same levels and present with the same types of health problems.<sup>2</sup> This results, in part, from basic differences in quality of care in white vs. minority communities, inequitable distribution of health care resources, absence of a regular source of medical care for many families of color, and language barriers and cultural obstacles in the clinical encounter. Factors affecting health disparities in the social and physical environment are closely related to patterns of racial and economic housing segregation (which, as discussed in greater detail in the shadow reports on structural racism and housing segregation in the U.S., are in turn influenced by state policy). For instance, racial and

<sup>1</sup> Paul Hunt, *Report of the Special Rapporteur*, U.N. ESCOR, 59th Sess., Provisional Agenda Item 10 ¶ 23, U.N. Doc. E/CN.4/2003/58 (2003) (reporting on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health)(emphasis added), available at <http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/9854302995c2c86fc1256cec005a18d7>.

<sup>2</sup> INST. OF MEDICINE, *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* (2003).

ethnic minorities in the U.S. are more likely than whites to live near commercial hazardous waste facilities and other sources of air and water pollution, and to live in areas with lower quality housing, higher crime levels, lower quality public education, and limited access to healthy nutrition choices. There is also increasing evidence that race-based discrimination itself is not only emotionally hurtful, but also physiologically damaging to minority Americans, thereby leading to unique adverse health impacts.

Federal and state governments have contributed directly to health care disparities, through both historic and present day policies. Racial segregation and discrimination in health care in the United States was historically a matter of government policy, endorsed in the 1896 Supreme Court's *Plessy v. Ferguson* decision upholding the constitutionality of state and local "Jim Crow" laws requiring the separation of the races. Laws such as the 1946 Hill-Burton legislation, which provided federal funding for construction of racially exclusionary hospitals, produced grossly unequal services subsidized with tax dollars, leaving a legacy of segregated health care.

Recent government policies have further perpetuated disparities in health care access for many racial and ethnic minorities. Although the government funds Medicaid and other health insurance safety net programs, recent federal laws such as the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), i.e. welfare reform, and the Deficit Reduction Act of 2005 (DRA) have negatively affected the health insurance status of low-income people of color. Rather than increasing access to health care for racial minorities, these policies have restricted access and are exacerbating racial disparities in health care, particularly for women and children.

The Periodic Report largely fails to address the intersection between racial and gender discrimination, contrary to the Committee's General Recommendation No. 25. For example, women of color in the United States fare significantly worse than white women in every aspect of reproductive health. African American women are nearly four times more likely to die in childbirth than white women and 24 times more likely to be infected with HIV/AIDS. These disparities result from a range of government actions and inactions, from the failure to address high rates of uninsured women of color to restrictions on public funding for sexual and reproductive health services.

U.S. environmental policies have also failed to address racial disparities in health. 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 a 2001 decision (*Alexander v. Sandoval*), and

Congress has not yet responded to repair the law. In addition, the federal Environmental Protection Agency has failed to implement the 1994 Executive Order on Environmental Justice, and its own internal complaint system for adjudicating race-based complaints is ineffective.

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