

September/October 2005

Volume 14: Number 5

This special issue of Poverty & Race was sponsored and largely compiled by the Health Policy Institute at the Joint Center for Political & Economic Studies. We are grateful to Institute Director Dr. Gail Christopher and to Joint Center consultant Michael Wenger for their help. The Health Policy Institute is committed to igniting a "Fair Health" movement that gives people of color the inalienable right to equal opportunity for healthy lives—including equal access to quality healthcare as well as freedom from social and environmental disparities that influence poor health outcomes. The Joint Center for Political and Economic Studies is a Washington, DC-based think tank founded in 1970 by black intellectuals and professionals to provide training and technical assistance to black elected officials throughout the United States. PRRAC is also pleased to be working with the Health Policy Institute on a new national directory, "Organizing to Address Minority Health Disparities: A Directory of State and Local Initiatives" (see box on page 7).

Towards a "Fair Health" Movement

by Gail Christopher

This nation has the resources to assure that all of its citizens have an equal opportunity to live healthy lives. If the rights to life, liberty and the pursuit of happiness are inalienable, then surely the right to an equal opportunity for health and well-being is comparable. Persistent health disparities are a result of a lack of leadership and political will to address the well-documented social conditions, inequalities and discriminatory practices that contribute to poor health outcomes. Indeed, our nation's relatively poor health standing in comparison to many other developed nations is also a consequence of this leadership void. America ranks poorly in several key health indicators, including infant mortality—despite the fact that it has the world's highest per-person medical expenditures. This conundrum—high investments in medical technology and persistent disappointing outcomes, coupled with seemingly intrac-

table gaps in health between minorities, the poor and the more advantaged—demands fresh new approaches to the most fundamental challenge that our nation faces. The health and well-being of all the people should be the primary concern of leaders in a democratic society.

The future health of the nation will be determined to a large extent by how effectively we work with communities to reduce and eliminate health disparities between non-minority and minority populations experiencing disproportionate burdens of disease, disability and premature death. (*Guiding Principle for Improving Minority Health, Centers for Disease Control – Office of Minority Health*)

Healthy People 2010, a set of official HHS health objectives for the nation to achieve over the first decade of the new century, is designed to achieve

two overarching goals: 1) increase quality and years of life; 2) eliminate health disparities. This bold govern-

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ment assertion, a goal to eliminate health disparities, recognizes that the right to the equal opportunity to live healthy lives is embodied in the fundamental freedoms of a democratic society. It also reflects a more pragmatic realization of demographic trends. Groups currently experiencing poorer health status—racial and ethnic minorities—are expected to grow as a proportion of the total U.S. population; therefore, the future health of America as a whole will be influenced substantially by success in improving the health of these groups.

Despite these stated public sector goals and demographic imperatives, racial and ethnic health disparities are not being eliminated. In fact, some disparities, such as infant mortality, are increasing. Historically, human and civil rights for minorities have been gained through social action of movements. From civil rights for African Americans to voting rights for women, freedoms required concerted action before fairness or equality became possible.

What would it take to truly eliminate racial and ethnic health disparities? Like all social injustices that have a disproportionate impact on the poor and minorities, health inequalities are a result of a set of laws, practices, policies and discriminations that benefit some while burdening others. The Institute of Medicine study, *Unequal*

Poverty and Race (ISSN 1075-3591) is published six times a year by the Poverty & Race Research Action Council, 1015 15th Street NW, Suite 400, Washington, DC 20005, 202/906-8023, fax: 202/842-2885, E-mail: info@prrac.org. Chester Hartman, Editor. Subscriptions are \$25/year, \$45/two years. Foreign postage extra. Articles, article suggestions, letters and general comments are welcome, as are notices of publications, conferences, job openings, etc. for our Resources Section. Articles generally may be reprinted, providing PRRAC gives advance permission.

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Treatment, provides irrefutable documentation of patterns of disparate treatment and service delivery, based on race and ethnicity. While some resist the idea that caregivers' behaviors and decisions are racially motivated, the evidence of discriminatory pattern—different treatment—is well established.

While there is no direct evidence that provider biases affect the quality of care for minority patients, research suggests that healthcare providers' diagnostic and treatment decisions, as well as their feelings about patients, are influenced by patients' race or ethnicity. (From Institute of Medicine, *Unequal Treatment*)

Some racial and ethnic health disparities, such as infant mortality, are increasing.

Is there a right to health? Under international law, there is a right not merely to healthcare but to a much broader concept of health. The 1948 Universal Declaration of Human Rights, proclaimed by the United Nations General Assembly as a common standard for all humanity, provides the legal foundations for the right to health. The right to access the conditions, resources and services conducive to health and well-being is as fundamental in a viable democracy as the right to freedom from bondage and discrimination and the right to vote.

Translating that international legal standard into an actualized reality in this country will require a "Fair Health" movement. Eliminating health disparities requires the same energy that is required for eliminating other outrageous social injustices. Communities must become mobilized and coordinated in countering the laws, policies, conditions, practices and perceptions that encourage health disparities. History has taught us that democratic tenets and assertions of human and/or civil rights is not enough. Realization of equality, or some of its promises, has required persistent, or-

ganized, directed action by diverse organizations and like-minded groups. These efforts involved politics, activism, litigation, education, research, national and local mobilization, and perhaps more than anything, vision.

What would constitute a "Fair Health" movement? The "Fair Housing" movement offers some valuable lessons. The Fair Housing movement emerged during a period in U.S. history—1940s and 1950s post-war era—in which minorities had made significant sacrifices for the country and, upon their return home, could more effectively assert their right to equality in voices that the nation's political elite could not ignore. This movement was based on the assertion of a fundamental right of a democratic society. The right to own and transfer property was considered to be crucial to the political and economic viability of the country. Advocates claimed that to prevent certain groups from acquiring property was to deny them full citizenship. Advocates also argued that it was time that the country abide by the principles established in the Civil Rights Act of 1866, which stated:

All citizens of the United States shall have the same right in every state and territory, as is enjoyed by white citizens thereof to inherit, lease, sell, hold and convey real and personal property.

They further argued that segregation was wrong, that it had negative social and economic effects, and that America would be a truly democratic society when all races lived in one community.

Proponents of a "Fair Health" movement can make similar assertions concerning the right to equal opportunity for health, and can call for the nation to indeed abide by the levels and principles of the Civil Rights Act of 1964, particularly Title VI. Title VI prohibits discrimination on the basis of race, color or national origin by programs and activities that receive federal financial assistance. Title VI administrative enforcement procedures

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The Contribution of Black-White Health Differences to the Academic Achievement Gap

by Richard Rothstein and Tamara Wilder

The health characteristics of African Americans and their access to good healthcare are systematically poorer than those of white Americans. These systematic differences begin before birth, continue through early childhood and school years, and continue into adulthood.

These health and healthcare differences partially explain the inability of black students to achieve academically at levels comparable to whites. Because there has been so little research on the topic, including a failure to conduct feasible experiments, we can't say how much of the black-white test score gap is attributable to health and healthcare differences. Health disparities themselves may stem from inferior schooling for black students—for example, if black students have less adequate physical education, or if inferior education in the prior generation led to greater adult economic insecurity which, in turn, causes poor health for both parents and children today.

Yet despite our inability to be precise about causal relationships between poor health and the academic achievement gap, the poorer health and access to care of African Americans certainly contributes to the gap. Children with more exposure to toxins (children with lead poisoning, for example) or more nutritional inadequacies (iron deficiency anemia, for example) have inferior cognitive ability—lower IQs. Children with poorer vision cannot read as well; children less likely to be immunized and more likely to be ill have higher school absenteeism rates; children with more discomfort, from ear infections or toothaches, or with labored breathing from asthmatic attacks, are less able to pay attention to classroom lessons. Parents in poor health are less able to care for their children and less likely to guide their children to good health habits. Each

of these average statistical health differences between black and white children and their parents may make a tiny contribution to the achievement gap, but their cumulative effect is bound to be significant.

In what follows, we describe some of these differences, in life cycle sequence, beginning before a child's

Health and healthcare differences partially explain the inability of black students to achieve academically at levels comparable to whites.

birth, and continuing into adulthood. In each case, data are from the most recent year available, which may vary from indicator to indicator.

Pregnancy, Childbirth and Neonatology

Inequality begins shortly after conception. One indicator of a child's healthy birth, making other lifetime outcomes more likely to be successful, is whether mothers get early medical attention during pregnancy. Twenty-five percent of black mothers get no prenatal care during the first trimester, while 11% of white mothers get none. For black mothers, 6% get no prenatal care at all (or get it only during the last trimester, when it is almost too late), but only 2% of white mothers, one-third the number of blacks, get no or too-late care. These data, describing only care during pregnancies that end with live births, probably underestimate the disparity.

We have no good data on unsuccessful pregnancies, but it is probable

that black women also miscarry more frequently than whites. Data on neonatal deaths strengthen this conclusion. For black newborns, there are 9 deaths within the first month for every 1,000 live births. For whites, there are only 4 such deaths. Considering infant mortality during the first year of life, there are 14 deaths for blacks and 6 whites. Adequate prenatal care could have prevented some of these.

Infant mortality and morbidity are continuous, so the higher rate of black infant mortality suggests a similarly higher rate of black infants who survive with unhealthy conditions that make school and lifetime success more difficult.

These differences in pregnancy and childbirth are reflections of *racial inequality* itself and are not eliminated by controlling for maternal education. For black mothers who are high school drop-outs, 15 of every 1,000 live births die within the first year; for white drop-outs, 9 do so. For mothers who graduated from high school but got no further education, infant deaths are 13 for blacks and 6 for whites. And for mothers with at least one year of college, infant deaths are 12 for blacks and 4 for whites.

Racial differences in pregnancies and live births are paralleled by differences in birthweight. Low birthweight predicts special education placement, lower academic achievement, emotional maladjustment and

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We dedicate this issue of *P&R* to Constance Baker Motley, who died on September 28 at the age of 84, and to her extraordinary and extraordinarily diverse career as a civil rights activist and federal judge (the first black woman to be so appointed).

likelihood of criminal behavior. For blacks, 3% of newborns have very low birthweight (less than 1,500 grams—3 lbs., 5 oz.), the condition most likely to lead to adverse educational and lifetime outcomes. For whites, the rate is only one-third as great. For low birthweight (less than 2,500 grams—5½ lbs.), a condition still putting children at risk, 13% of black babies have low birthweight, versus 7% of whites.

Again, these disparities narrow only slightly after controlling for education. For black mothers who are high-school drop-outs, 15% of live births are low birthweight; for white dropouts, it is 9%. For mothers who graduated from high school but got no further education, 14% of live births are low birthweight for blacks and 7% for whites. And for mothers with at least one year of college, the rates are 12% for blacks and 6% for whites.

Black mothers are less likely than whites to follow practices recommended for the best infant outcomes. For example, 54% of black mothers breastfeed their infants in the early postpartum period, compared to 73% of white mothers. When infants are six months of age, the relative disparity is even greater: 19% of black mothers breastfeeding, compared to 36% of white mothers. At one year of age, the rates are 12% and 21%, respectively.

Some of these indicators are more important than others. For example, if we closed the gap in prenatal care, the low birthweight gap might, at least partly, solve itself. Nonetheless, we can roughly summarize the overall black disadvantage in pregnancy, childbirth and neonatology. The summary requires two oversimplifying assumptions: that each indicator we've mentioned describes normally distributed characteristics, and that each is equally important. We can then say that the average black experience with healthy pregnancy, childbirth and neonatology is at the 37th percentile of the experience of all U.S. mothers and babies, while the average white experience is at the 53rd percentile.

This distribution is only somewhat

more equal than that of black and white test scores in elementary school. In an average of black and white fourth- and eighth-grade student performance on the most recent administrations (in all subjects) of the National Assessment of Educational Progress, black students are at the 28th percentile of achievement, while white students are at the 60th percentile. Certainly other factors besides pregnancy, childbirth and neonatal experiences are involved, but life's earliest experiences of inequality are not easily overcome.

Access to Health Care

Partly, racial inequalities in pregnancy and infancy stem from inequalities in health insurance. For children under 18, 14% of blacks lack health insurance, including Medicaid or CHIP (federally-subsidized children's insurance), whereas for whites, 7% lack coverage.

Children with poorer vision cannot read as well.

These numbers understate inequality—less health insurance for black families is compounded by inaccessibility of primary care physicians, even when families have insurance. In many low-income minority communities, insurance cards in practice confer only the right to wait in lines at clinics or emergency rooms, because few obstetricians, pediatricians or other primary care physicians practice in these communities. We have no national data on this, but a California analysis found that urban neighborhoods with high poverty and concentrations of black and Hispanic residents had one primary care physician for every 4,000 residents. Neighborhoods that were neither high-poverty nor high-minority had one per 1,200.

Black children are thus less likely to get primary and preventive medical care than whites. Eighty-seven percent of black children (under 18) have seen a doctor in the previous year, com-

pared to 90% of whites. Keep in mind that this relatively small disparity does not reflect the much larger disparities in the average number of doctor visits or in the type of medical facility visited. This inequality also has both a racial and socioeconomic aspect. Relatively more poor black children lack medical care than do poor whites, and relatively more non-poor black children lack medical care than do non-poor whites.

Similar inequalities characterize oral health: 69% of black children age 2-17 have seen a dentist in the previous year, compared to 79% of white children.

These inequalities in access to healthcare compound the inequalities of birth outcomes to contribute to differences in health between black and white children that, in turn, contribute to differences in educational and lifelong outcomes. By the age of 35 months, 25% black children have not received standard vaccinations for diphtheria, tetanus, pertussis, polio, measles and influenza. For whites, the non-vaccinated share is 16%.

Ear infections afflict all children, but disadvantaged children are less likely to get prompt treatment. Parents rarely take children to emergency rooms for common ear infections; if primary pediatric care is unavailable, parents are more likely to let the infection take its own course, and it will, most probably, take care of itself. But before then, children with earaches are more likely to miss school, or be inattentive or irritable from pain. Forty-five percent of black children have received antibiotics for ear infections by age 5, compared to 65% of whites.

Again, assuming that each of these indicators reflects normally distributed characteristics and each has equal weight, black children, on average, are at the 43rd percentile in the distribution of children's access to good healthcare, while white children, on average, are at the 56th percentile.

Health of Young Children

Black children get less adequate nutrition—lacking not calories, but

some essential nutrients. For example, iron deficiency anemia, which adversely affects cognitive ability and predicts special education placement and school failure, is more prevalent among black children. In federal programs for low-income children, 19 percent of blacks under the age of 5 are anemic, versus 10% of whites. Iron deficiency anemia also predisposes to lead absorption, further depressing cognitive ability.

Educational inadequacy also results from disparities in vision—not only in near- or farsightedness, but also in poor eye-muscle development, leading to less facility in skills needed for reading, like tracking print, converging and focusing. Optometrists who have tested children in low-income black communities report that as many as 50% of the children may come to elementary school with vision difficulties that impair reading ability, compared to 25% of children in non-poor communities. These difficulties do not always require correction with eyeglasses; eye exercise therapy may suffice, but such therapy is generally unavailable to low-income children.

Disparate rates of lead poisoning also exacerbate the academic achievement gap. Children who live in older buildings have more lead dust exposure that harms cognitive functioning and behavior. High lead levels also contribute to hearing loss. Three percent of black children but only 1% of whites age 1-5 have blood lead levels that are dangerously high.

We have made great progress in eliminating lead from children's blood; 15 years ago, 11% of very young black children had dangerously high lead levels, compared to 2% of whites. The reduction to today's lower levels is mostly attributable to the elimination of leaded automobile fuel, and to a 1978 prohibition on lead-based paint in residential construction. Yet low-income and minority children still today are more likely to live in poorly maintained, pre-1978 buildings with peeling older layers of paint. And the higher lead poisoning levels of only a decade ago still affect the academic potential of children who are now in

the upper grades. Urban children are also more likely to attend older schools, built when water pipes contained lead. New York City, Baltimore and Washington, DC have recently found it necessary to shut off school drinking fountains because lead exceeded dangerous levels.

Other serious diseases are also more common for young black children. Twenty-six of every 100,000 black children under age 2 contract bacterial meningitis; for whites, less than half that number do, 11 of 100,000. Bacterial meningitis is treatable, but requires prompt diagnosis. Although a small number of children, black or white, get the disease, for those who do it can lead to death or, for survi-

100,000 get such infections each year; for whites, only 63 do.

At this early age, racial differences in oral health are relatively small. Twenty-five percent of black children between the ages of 2 and 5 have untreated dental cavities; for whites, it is 23%. As we will see below, however, these small disparities grow large as children mature.

Summarizing these indicators of young children's health, again assuming that each reflects normally distributed characteristics and has equal weight, young black children, on average, are at the 41st percentile in good health characteristics, while young white children, on average, are at the 52nd percentile.

Children less likely to be immunized and more likely to be ill have higher school absenteeism rates.

vors, hearing loss, mental retardation, paralysis and seizures. So it, too, makes a contribution to the academic achievement gap.

Similar inequalities characterize children under 5 for other bacterial diseases, such as pneumonia and ear, blood stream and sinus infections. For black children under 5, 155 of every

Health of School-Age Children

Mentioned above was that black children enter school with a rate of vision difficulty that makes reading difficulty more probable. For children under 18, for the most severe cases of blindness and vision difficulty that cannot be corrected by eyeglasses, the rate for blacks is 2.6%; for whites, 2.3%.

Because the environmental conditions in neighborhoods where disadvantaged children reside contain more allergens, minority and low-income

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PRRAC/Teaching for Change November 12 Oakland Conference

Following up on our joint publication of *Putting the Movement Back Into Civil Rights Teaching*, PRRAC and Teaching for Change, along with several Bay Area co-sponsoring organizations, are holding the first of what we hope will be a series of conferences around the country—this one at Laney College in Oakland, CA on Saturday, Nov. 12. Target audience includes teachers, youth activists, parents, social justice activists, school administrators/school board members.

The aim is in part to influence how the Civil Rights Movement is taught—away from the “dates and heroes” approach, toward the approach of the book: the role of ordinary people in creating and maintaining social justice movements, the role of women, youth, culture. A second aim is to bring current local social justice issues into the classroom, the classroom out into the community, building on the lessons of the CRM.

For more information about the Nov. 12 conference, or to pre-register (attendance will be limited), go to www.civilrightsteaching.org

children are more likely to suffer from asthma. Eighteen percent of black children suffer from asthma, versus 11% of white children. (Because black children get worse primary medical care and are less likely to be diagnosed, these numbers may underestimate the disparity.) Again, this is a racial and socioeconomic disparity; although poor children suffer from asthma more than non-poor children, the disparity for poverty (15% for poor children, versus 12% for non-poor) is smaller than the racial disparity.

Asthma is the single largest cause of chronic school absenteeism. It keeps children up at night, and, if they do make it to school the next day, they are likely to be drowsy and less attentive. Middle-class asthma sufferers typically get treatment for its symptoms, while disadvantaged children get relief less often. As a result, low-income asthmatic children are about 80% more likely than middle-class asthmatic children to miss more than seven days of school a year from the disease. Children with asthma refrain from exercise and so are less physically fit. Irritable from sleeplessness, they also have more behavioral problems that depress achievement.

Perhaps because of environmental factors, asthma increased for children overall by 50% from 1980 to 1996. But it increased twice as rapidly for black children, perhaps partly because their environments are worse, or partly because their low rate of diagnosis is improving. Unequal increases in asthma, with its impact on children's attendance and behavior, will undermine other efforts to raise black student achievement.

We noted above that although lead poisoning has diminished, black preschoolers have three times the rate of whites. Disparities in blood lead levels continue during the school years. There is no clear cut-off between dangerous and safe blood lead levels. Many school-age children have less-than "dangerous" levels that still have subtle depressing effects on cognitive ability. In particular, school-age chil-

dren with levels even half as high as those considered dangerous have lower reading scores, lower math scores, lower non-verbal reasoning scores and less short-term memory. For black and white children age 6 to 16, 22% of blacks have this half-dangerous level, more than three times the white rate of 6%.

Perhaps because of differences in diet, perhaps because of differences in sports and physical activity opportunities, black children are more likely to be overweight than whites. In the elementary school years, 21% of black children are overweight, versus 14% of whites. Including those heavy enough to be seriously at risk of overweight, 35% of black elementary school children are either overweight or at risk of being overweight, com-

Asthma is the single largest cause of chronic school absenteeism.

pared to 29% of whites. In high school, 18% of black students are overweight, compared to 12% of whites; 36% of black high school students are either overweight or at risk of being overweight, compared to 26% of whites.

Black students are more likely to engage in risky sexual behaviors than whites. Nine percent of black high-school students have either been pregnant or gotten someone pregnant, compared to 2% of whites. Although white students are somewhat more likely to use contraception than blacks (mostly because white students are more likely to take birth control pills; condom use is similar for black and white teenagers), most of the difference is attributable to the fact that 49% of black high-school students are sexually active, compared to 30% of whites. As a result, 9% of black and 4% of white high-school students are sexually active without practicing regular contraception.

Black teenagers are diagnosed with new cases of AIDS at nearly 20 times the annual rate of whites—for every million black teenagers, there are 29

new cases; for every million whites, 1.5 new cases.

Another mortal danger is firearms. Each year, of every 100,000 black teenagers (age 15 to 19), 27 are victims of homicide by firearms. For whites, the rate is only 2 per 100,000. Black teenagers are also more likely to be suicidal. Four percent of black high-school students require medical attention annually for a suicide attempt; only 2% of white high-school students require it.

We reported above that black preschoolers are only slightly less likely to have healthy teeth than whites. But by school age, the gap has widened. Seventy-two percent of black children 6 to 17 have healthy teeth (with no untreated dental cavities), compared to 82% of whites. Not only does pain, including toothaches, make it more difficult for children to learn, but their poor oral health makes serious oral diseases more likely when they become adults.

All these add up to overall inequality in the health status of schoolchildren. Black parents report that 74% of their school-aged children are in overall good health, compared to white parents who report that 87% are in good health. These parent-reported data are consistent with what we find from a simple average of the other indicators we've presented on schoolchildren's health.

In a few important respects, the health of black teenagers is superior to that of whites. For example, black high-school students are less likely to engage in substance abuse (smoking, alcohol and drugs) and less likely to die in automobile accidents than whites (perhaps partly because black youths, less likely to consume alcohol, are less likely to drive when under its influence, and perhaps partly because black youths are less likely to own cars).

Notwithstanding these few contrary indicators, if we again assume that children's experiences are normally distributed on each of the indicators of school-aged children's physical and mental health, and weighting each indicator equally, we conclude that black school-aged children, on average, are

at the 47th percentile in a distribution of favorable health characteristics, while white children, on average, are at the 55th percentile.

Health of Adults

Health inequalities, for which foundations are laid in early childhood and the school years, continue and, in some cases, grow for young adults who, then, are less able to care for their own children and pass good health habits on to the next generation. The poor health of parents is, therefore, another determinant of children's lower achievement.

For adults in prime childbearing years, age 18-34, only 68% of blacks are covered by health insurance, compared to 79% of whites.

Of every 100,000 young (age 20-24) black adults, 18 are newly diagnosed each year with AIDS. For whites, there is only 1 such diagnosis per 100,000.

Differences in overweight, established in childhood, continue into adulthood. Sixty-three percent of black young (age 20-39) adults are overweight, compared to 55% of whites. Considering only those who are obese, 36% of blacks and 24% of whites are in this category.

Unequal exercise habits also persist into adulthood. Fifty-one percent of black young (age 18-24) adults engage in the minimal amount of physical activity recommended for good health (including recreational exercise or activity integrated into household work or employment); for whites, 61% of young adults do so. Considering adults from 25 to 34 years old, 44% of blacks engage in the minimal amount of physical activity, compared to 54% of whites.

These data are consistent with adults' overall health conditions. Eighty-one percent of black adults consider themselves to be in excellent or good health, compared to 90% of whites. These subjective reports reflect a reality that black adults are more likely to die prematurely from cardiovascular disease and cancer than

New Health Advocacy Directory Available

We are pleased to announce the release of *Organizing to Address Minority Health Disparities: A Directory of State and Local Initiatives*, a detailed 90-page compilation of over 300 groups working to address the causes and solutions to the health disparities crisis. The directory was sponsored and supported by The Health Policy Institute at the Joint Center for Political and Economic Studies, and prepared by staff at the Poverty & Race Research Action Council, with substantial contributions from two co-sponsoring organizations, The Opportunity Agenda and the Alliance for Healthy Homes.

The directory provides a snapshot of a rapidly evolving community of advocates, organizers and public health professionals working in different ways on the issue of unequal health outcomes for people of color in the U.S., and to establish new connections and networks within and across states. Some of these connections are between researchers and advocates, and others will be among organizations working on different aspects of the health disparities challenge—which involves not just unequal access to quality healthcare, but also a range of social and environmental influences that are beyond the traditional reach of the healthcare “system.”

The Directory will be available for download on the websites of the four participating organizations: www.prrac.org; www.afhh.org; www.jointcenter.org; www.opportunityagenda.org, and is also available in hard copy for \$5 (to order a copy, contact info@prrac.org).

whites. Of every 100,000 black adults age 45 to 54, 181 die from heart disease, more than twice the number (88) of whites who do. Forty-one blacks in this group die of stroke, nearly four times the number (11) of whites. One hundred and eighty-two die of cancer, nearly half again as many deaths as the rate for whites (124).

For blacks and whites to have equal chances of academic and lifetime success, remedying health inequalities must be part of the solution.

Summarizing these adult health indicators, with the same simplifying assumptions used previously, we conclude that black adults, on average, are at the 42nd percentile in a distribution of favorable health characteristics, while white adults, on average, are at the 54th percentile.

As noted at the beginning of this article, it is impossible to say precisely to what extent these inequalities in

health, extending from before birth to adulthood, contribute to black-white educational inequalities, and to what extent educational inequalities perpetuate disparities in health. It would be hard to argue, however, that causality does not run in both directions. For blacks and whites to have equal chances of academic and lifetime success, remedying health inequalities must be part of the solution.

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This article is based on a forthcoming paper for the Campaign for Educational Equity, Teachers College, Columbia University. Full source citations for all of the data presented here, along with explanations of statistical methods employed, will be available in the published paper on the Campaign's website: <http://www.tc.edu/equitycampaign/papers>. □

vest federal agencies with considerable discretion to design, implement and evaluate civil rights enforcement standards and procedures. A complaint must be filed with the appropriate federal agency. Health issues are to be handled by the Department of Health and Human Services' Office of Civil Rights. However, a 1999 report by the United States Commission on Civil Rights concluded that "the timid and ineffectual enforcement efforts of the Office of Civil Rights have fostered, rather than combated the discrimination that continues to infect the nation's healthcare system."

Title VI was silent on the issue of when private individuals who had suffered discrimination could sue, but in *Alexander v. Sandoval* the Supreme Court, in a 5-4 majority decision, held that individuals who allege disparate impact (*de facto*) discrimination under Title VI of the Civil Rights Act of 1964 have no private cause of action to enforce their rights. Now only federal agencies can enforce prohibitions against disparate impact discrimination under Title VI. Thus, an effective battle against healthcare discrimination

will require creative, new litigation strategies and/or must find ways to mobilize Congress to reverse *Sandoval* through legislation.

But healthcare parity is just one aspect of a "Fair Health" movement. Researchers estimate that medical care alone constitutes only 10% of the factors that contribute to health. Broader social determinants and community context will have to be addressed. Chronic diseases, excess mortality and morbidity in minority groups are symptoms of deeper underlying social,

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***Under international law,
there is a right not
merely to healthcare but
to a much broader
concept of health.***

economic and environmental inequalities like housing, joblessness, crime, pollutants and their associated stress.

A successful "Fair Health" movement will require actions on a continuum that moves from community factors to access and quality of care issues. A possible framework is offered here for goals and specific strategies:

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

Where people live determines their

risk for and exposure to disease-inducing factors, as well as their access to care. Ultimately, the realization of Fair Health and the elimination of racial and ethnic health disparities will require place-based accountability systems. Coordination and collaboration across several social and human development movements will also be needed. Child welfare, education, regional equity and family support activists will need to work with housing, economic and community development, criminal justice, civil rights, human rights and health and medical care consumer and advocacy groups.

The lessons from the "Fair Housing" movement are transferable. Fair Health activists must work to influence public opinion and perceptions and foster a sense of urgency and outrage, while appealing to deeply held fundamental principles of democracy. The horrific images from the Gulf Coast post-Katrina may have done more to illustrate racial and ethnic health disparities and the social conditions of poverty and neglect than any social marketing campaign could have ever accomplished.

The challenge facing us now is to clarify and implement the strategies and interventions that are so urgently needed. The challenge is to indeed mobilize an effective "Fair Health" movement.

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New on PRRAC's Website:

Letter to Congress from civil rights organizations on the housing needs of families displaced by Hurricane Katrina (September 23, 2005).

Excerpts from final report of the Third National Conference on Housing Mobility: "Keeping the Promise: Preserving and Enhancing Housing Mobility in the Section 8 Housing Choice Voucher Program."

"The Hurricane and a Right to Housing," by PRRAC Director of Research Chester Hartman

Very Low Birthweight in African-American Infants: The Role of Maternal Exposure to Interpersonal Racial Discrimination

by James W. Collins, Jr., Richard J. David,
Arden Handler, Stephen Wall & Steven Andes

It has long been recognized that African-American infants are more than twice as likely as White infants to die in their first year of life. Reflecting the public health relevance of this phenomenon, the U.S. Department of Health and Human Services' *Health People 2010* calls for the elimination of the racial disparity in infant mortality rates. Infant birthweight is a primary determinant of infant mortality risk. The approximately 1% of births occurring at very low birthweight (VLBW; < 1500 g.—3 lbs. 5 oz.), pathological in all populations, accounts for more than half of the neonatal deaths and 63% of the Black-White gap in infant mortality in the United States.

Chronic stress is a more prominent feature in the daily lives of African-American women than in the daily lives of White women. Although there have been several studies on the relation between chronic stress and infant birthweight, few studies have specifically focused on the relations between women's regular (ranging from a few times per year to nearly every day) exposure to racial discrimination—a nonrandom and race-related source of stress—and infant VLBW. To the extent that population differences in chronic stress from lifetime exposure to interpersonal racial discrimination underlie the observed racial differential in the rate of VLBW infants, one would expect an association between this exposure and VLBW among African Americans.

A causal association between African-American women's exposure to chronic stress from interpersonal racism and infant VLBW is biologically plausible. A 2001 *Maternal and Child Health Journal* study showed that chronic maternal exposure to stress—

through maternal cardiovascular, immune/inflammatory, and neuroendocrine processes—is detrimental to infants' birthweight. Moreover, psychophysiological stress is likely to accelerate the release of corticotropin-releasing hormone, which initiates a cas-

ciated with VLBW births.

African-American mothers delivering at Cook County Hospital and University of Chicago Hospital in Chicago, IL between November 1, 1997, and October 31, 2000, were recruited for this study. These hospitals serve critically ill and healthy infants across a broad range of socioeconomic status. Nevertheless, approximately two-thirds of the participants in the study were Medicaid recipients.

During the accrual period, 117 case subjects and 234 control subjects were potentially eligible. A combination of subjects refusing to be interviewed, failure of some subjects to arrive at scheduled interviews, and death within 72 hours of a few infants reduced interview data to 104 case subjects and 208 control subjects. Trained African-American interviewers administered a structured questionnaire in the hospital.

There were minimal differences between case subjects and control subjects (critically ill and healthy) with respect to marital status, income, Medicaid status, prenatal care usage, number of children and alcohol consumption. A slightly higher percentage of case subjects were found among the older, more educated women, and cigarette smokers. When women older than 30 or those having more than 12 years of education were compared with all others, a significantly increased association with VLBW was found. The distribution of sociodemographic, biomedical and behavioral characteristics did not vary between critically ill and healthy control subjects.

Our study adds to the small but growing evidence of a relation between African-American women's exposure to interpersonal racial discrimi-

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African-American infants are more than twice as likely as White infants to die in their first year of life.

cade of events leading to preterm delivery. Consistent with the larger literature on stress, clinical studies show that exposure to racial stressors leads to physiological reactivity. African-American women who were exposed to what they perceived as racial bias and internalized their responses to unfair treatment had a fourfold greater risk of hypertension. In another study, the viewing of racist situations was associated with a significant rise in blood pressure that correlated with the African-American subjects' responses on the Framington Anger Scale. A 1996 study by D. Jones and colleagues also reported significant changes in heart rate, digital blood flow and facial muscle activity in African-American women who encountered social situations that included blatant and more subtle forms of racism.

Our Case-Control Study

We therefore performed a case-control study among a sample of urban African Americans to determine the extent to which women's reported lifetime and pregnancy exposure to interpersonal racial discrimination is asso-

nation and pregnancy outcomes. We found that African-American mothers who delivered VLBW preterm infants were more likely to report experiencing interpersonal racial discrimination during their lifetime than African-American mothers who delivered NLBW (non-low birthweight) infants at term. Stratified analyses showed that this association persisted across the common risk categories for reproductive health. In multivariate logistic regression models, the adjusted odds ratio of VLBW for African-American mothers who experienced interpersonal racial discrimination in 1 or more and 3 or more (compared with none) categories equaled 1.7 and 2.6, respectively. Interestingly, among African-American women who worked outside the home, those who gave birth to VLBW infants were more likely to report racial discrimination in the workplace than were the working mothers of NLBW infants. These findings provide evidence that greater lifetime exposure to racial discrimination among African-American women contributes to the racial disparity in VLBW infants.

The conventional investigative approach to the racial disparity in the rates of VLBW births has been based on the implicit assumption that there is a set of risk factors that differ in quantity between the races but exert similar effects on African-American and White women. An extensive literature has shown that established risk factors have minimal impact on the rate of VLBW for African-Americans. Moreover, this conceptualization does not take into account the nonrandom, pervasive and multifaceted inequality that is bound up in the historical context of race, nor does it capture its effect on human beings over time. Because African-American women are regularly exposed to unique social risk factors closely related to race, restricting the search for such factors to a sample of African-American women seems reasonable. We used an interviewer-administered closed-ended questionnaire to capture the variability of life-

time exposure to incidents perceived as racial discrimination and describe its association with infant birthweight. The frequency of lifetime-reported incidents of interpersonal racial discrimination in at least one category was 40% among our control subjects. If we take this frequency as an accurate estimate for the general population of urban African-American women, then exposure to perceived racial discrimination is a common risk factor. This estimate is consistent with published prevalence rates.

Greater lifetime exposure to racial discrimination among African-American women contributes to the racial disparity in very low birthweight infants.

Our data show that the magnitude of the association between maternal reported lifetime exposure to racial discrimination and infant VLBW was strongest in the "finding a job" and "at place of employment" categories. Concordant with this phenomenon, working-class African-American mothers of VLBW preterm infants in our sample were more likely to regularly experience specific episodes of interpersonal racism at their primary place of employment than working-class African-American mothers of NLBW term infants. These findings are consistent with the limited literature showing a negative association between pregnant African-American women's psychosocial job strain and infant birthweight. A recent study found that African-American women with high job strain had infants with birthweights 273 grams less than those with low-strain jobs or those who did not work outside the home.

Our study provides empirical evidence supporting the conceptual model proposed by J. Rich-Edwards and colleagues in a 2001 article, in which African-American women's lifetime exposure to interpersonal racism is explicitly included as a chronic stres-

sor. Interestingly, we found no association between maternal self-reported exposure to interpersonal racial discrimination during pregnancy and infant VLBW. However, the prevalence of 1 or more reported incidents during pregnancy among case subjects and control subjects was low; moreover, the prevalence of 3 or more reported incidents during pregnancy among subjects was essentially nonexistent. Given the suspected strong association between reported incidents of interpersonal racial discrimination during pregnancy and VLBW among the subgroup of low-income African-American mothers with high-risk behavioral characteristics, our study did not have sufficient power to address the role of reported incidents during pregnancy.

Study Limitations

Our study had a number of important limitations. First, because the experience of racial discrimination is a complex and multidimensional phenomenon, a more sensitive questionnaire may have led to better ascertainment of the exposure of chronic interpersonal racism. However, the assessment of discrimination in multiple categories and the characterization of regular exposure to discrimination in the workplace are strengths of the instruments used in our study. In addition, the consistency of the elevated point estimates derived from two independently constructed instruments suggests that we accurately assessed exposure to interpersonal racial discrimination. Second, our findings may have stemmed from a recall bias associated with the maternal anxiety associated with the admission of her infant to a neonatal intensive care unit. However, we found no difference in the prevalence of reported racism among control mothers of critically ill NLBW infants (a cohort with anxieties similar to those of case subjects) and the control mothers of healthy NLBW infants. Third, interviewer bias could have also influenced our results. However, the interviewers were trained to collect data using a structured questionnaire

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Reducing Racial and Ethnic Disparities in Medicare

by Ellen O'Brien

Medicare's federal entitlement offers a set of defined health benefits to more than 40 million elderly individuals and persons with disabilities. By virtue of their access to a social insurance program with uniform benefits that cuts across socioeconomic, class, and racial and ethnic groups, Medicare beneficiaries are, in principle, assured access to mainstream healthcare. Hospitals, nursing homes and other medical providers who receive Medicare funds—with the notable exception of physicians—are required by Title VI of the Civil Rights Act to provide care on a nondiscriminatory basis. Medicare's conditions of participation also mandate that care of equal quality be provided to patients regardless of their race and ethnicity.

Despite the promise of access to care that national benefits provide, not all populations fare equally well in Medicare. Numerous studies document that diverse racial and ethnic groups (African Americans, Hispanics/Latinos, Asian and Pacific Islanders, and others) experience greater difficulties than whites accessing care; are more likely to receive inferior care when they are diagnosed with an illness; and suffer worse health outcomes as a result. Elderly black Medicare beneficiaries are seen less often by specialists and receive less appropriate preventive care, lower quality hospital care and fewer expensive technological procedures. These disparities exist across a wide variety of clinical conditions (acute and chronic, and physical and mental illnesses), across healthcare settings (physician offices, hospitals, nursing homes and other healthcare facilities) and services (preventive, diagnostic, rehabilitative, therapeutic). Disparities exist in both fee-for-service (original) Medicare and Medicare-managed care.

Sources of Disparities in Medicare

Although the implementation of Medicare dramatically narrowed income- and race-related disparities in access to care and quality of care, financial access did not guarantee equity in access to and availability of services to all of Medicare's populations. In Medicare, and in the

Medicare beneficiaries are, in principle, assured access to mainstream healthcare.

healthcare system generally, there are several recognized sources of disparities that persist even when beneficiaries have the same insurance coverage:

Poor Neighborhoods: Racial and ethnic disparities in the amount and quality of care that beneficiaries receive arise in part because culturally diverse beneficiaries live in poor and racially segregated neighborhoods. Beneficiaries who are culturally and physically separated from the mainstream may not be willing or able to access the same hospitals and providers as high-income, white beneficiaries. The urban poor are more likely to receive care at public hospitals and other urban safety-net hospitals. Culturally diverse beneficiaries are also more likely than whites to receive care in clinics, hospital outpatient departments and emergency rooms, and have more difficulty getting care from a usual provider at a consistent location. People in poor neighborhoods receive care in segregated and resource-constrained systems, receive less continuous care from a given provider, have more limited access to specialists and are referred less often for intensive procedures. Recent surveys of the physicians who treat culturally diverse patients in Medicare reveal that pri-

mary care physicians treating black and Hispanic/Latino patients have greater difficulty obtaining access for their patients to high-quality sub-specialists, high quality diagnostic imaging and non-emergency admission to the hospital.

Poor People: Racial and ethnic disparities in Medicare persist, in part, because African-American, Hispanic/Latino and other racial and ethnic groups tend to have lower incomes than whites and greater difficulty affording Medicare's required beneficiary cost-sharing. Minority beneficiaries in Medicare have lower incomes on average than white beneficiaries, and are less likely to have private supplemental (Medigap) coverage. They also are more likely to rely on Medicaid as a supplement to Medicare. Although studies of the impact of race and ethnicity generally "control" for income and supplemental coverage, they often do this crudely without accurately accounting for variations in the level of insurance coverage.

Part of the affordability problem can be attributed to financial and non-financial barriers, to barriers to enrollment in Part B (and Part A for certain eligibles), and to the design and implementation of the programs intended to assist poor and low-income beneficiaries with Medicare's cost-sharing responsibilities. Medicaid provides assistance with Medicare's premiums and cost-sharing for certain poor and low-income beneficiaries, but research on enrollment in the Medicare Savings Programs has identified many general barriers to enrollment, including a lack of information about how to enroll, complicated enrollment forms, asset tests, and a lack of one-on-one assistance from a trusted source to help eligible individuals through the enrollment process.

Certain populations face substantial barriers to enrollment in the Medicare Savings Programs—three federal pro-

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grams that help people with low incomes to pay for Medicare coverage. For example, a recent research study shows that the number of eligible American Indian or Alaska Natives (in 15 states with large AI/AN populations) significantly exceeds the number enrolled in Medicare. The research suggests that federal outreach and education for AI/AN populations is inadequate, and that the Part B premium is a substantial barrier to enrollment in Part B for these populations as well. Research on Asian Americans confirms that lack of awareness of eligibility is a significant problem and suggests that Asian-American elderly also have a limited understanding of and limited willingness to enroll in health insurance plans. According to a 2001 study by the Center for Medicare Education: "Cultural background affects people's understanding of the concept of insurance, their attitudes toward government programs, their willingness to trust information about Medicare, as well as their capacity to understand the information they receive." Adminis-

trative barriers—a lack of linguistic and cultural competence at federal, state and county offices where enrollment takes place—are also significant.

Health System Barriers: Disparities in clinical care also arise because culturally diverse populations face unique logistical and cultural challenges dealing with healthcare providers and health systems. Complex medical bills and forms, and complicated processes for obtaining necessary care, may deter patients with low literacy or limited English proficiency from

Not all populations fare equally well in Medicare.

seeking care. Physician practices, medical institutions and healthcare plans may erect systems that create intentional and unintentional barriers to care for racial and ethnic groups. Hispanic/Latino beneficiaries, for example, are more likely than whites to have been uninsured before becoming eligible for Medicare. As a result, they

may be less likely to have the skills needed to navigate a complex healthcare delivery and insurance system, and they may not have access to physicians willing to advocate strongly on their behalf when coverage is denied.

Marginal literacy and limited English proficiency create barriers in access to health information and health services. Recent research has shown that the elderly in Medicare with limited English proficiency are less likely to have a usual source of care, less likely to see a private physician and more likely to use a safety-net provider. In general, according to a 2004 Center on Budget and Policy Priorities paper by Leighton Ku and Glenn Flores, studies show that "LEP patients frequently defer needed medical care, have a higher risk of leaving the hospital against medical advice, are less likely to have a regular medical provider, have an increased risk of drug complications, and are more likely to miss follow-up appointments." A significant part of the explanation for these difficulties rests with the fact that culturally diverse patients often rely on healthcare providers who are not sensitive to cultural differences and are not able to communicate effectively with patients with whom they do not share a common race or ethnicity, language or culture.

Provider Bias: Physician behavior also contributes to racial disparities. In fact, most discussions of disparities in medical care focus not on the disparities that arise because minority patients are disproportionately poorer or less well insured than whites, or disproportionately affected by geographic and other logistical barriers to access. Rather, they focus on the fundamental inequity that arises because patients of color receive different diagnoses and treatments than patients who are white. Race and ethnicity influence providers' beliefs and expectations about patients, how they interpret patients' symptoms and refer for diagnostic tests, procedures recommended, whether and how they provide patient education, and how they assess patients' intelligence and will-

PRRAC Research/Advocacy Grants Again Available

Thanks to a new grant from the Annie E. Casey Foundation, PRRAC is once again able to make grants available for research on the intersection of race and poverty that in turn is designed to support a planned advocacy strategy (community organizing, litigation, legislation, public education, etc.) For a descriptive listing of the 100+ such grants PRRAC has made in the past, see the summary on our website, www.prrrac.org/grants.pdf.

We will give preference to work in the areas of housing, education and health, as well as to work carried out in the cities where the Casey Foundation has its Making Connections sites: Denver, Des Moines, Hartford, Indianapolis, Louisville, Milwaukee, Oakland, Providence, San Antonio, Seattle.

Maximum grant amount is \$10,000 (smaller budgets are appreciated so the available funds can support as many projects as possible). Advocacy groups, researchers, and advocacy/researcher teams are welcome to apply. We also can link researchers to appropriate advocacy groups, advocacy groups to appropriate researchers.

To apply: Send (asap) a brief description of the research and its linked advocacy strategy; the research methodology and qualifications of the researchers; a budget and timeline—to PRRAC's Director of Research Chester Hartman, 1015 15th St. NW, #400, Wash., DC 20005, or email it to chartman@prrac.org. Questions? phone Chester at 202/906-8025.

ingness and ability to adhere to treatment plans. Provider prejudice, bias and stereotyping by physicians and other providers may create disparities in the quality of care provided to white and nonwhite patients.

Patient-Related Factors: Patients, too, may lack the tools they need to obtain needed care. Cultural differences may affect patients' willingness to seek medical attention and follow medical advice, and language barriers may interfere with patient-provider communication and the ability to comprehend and follow medical advice. Racial and ethnic groups, as noted above, may have less experience navigating health systems and may be less assertive in their dealings with physicians than white patients. Although many of the patient-related barriers to receiving timely and appropriate healthcare affect patients of all races and ethnicities, some barriers—lack of time, lack of knowledge, competing demands and uncertainty about the benefits of healthcare—may affect some racial or ethnic groups more than others.

Strategies and Their Impacts

Numerous tools are available to Medicare to reduce or eliminate at least some of the disparities in access to care and quality of care for all of its populations. Recommendations for changes in Medicare tend to focus on: (1) data systems and information feedback; (2) structuring payments systems to limit provider incentives that may promote disparities or to reward providers who reduce disparities; (3) appropriate screening and preventive services and adherence to other evidence-based clinical care protocols; and (4) greater resources for interpretation services, multidisciplinary teams, community health workers and culturally appropriate patient education. Some of these activities and interventions would require legislative changes, some can be accomplished administratively and most could be adopted by innovative managed care plans.

Interventions directed at physicians include efforts to educate physicians about disparities and provide formal training on how to deliver culturally competent care. Cultural competence, in the words of a 2002 Commonwealth Fund study, describes "the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery systems to meet patients' social, cultural, and linguistic needs."

Interventions targeted at culturally diverse communities and patients seek to educate and inform patients by providing culturally appropriate education and outreach about healthcare risks, the role of screening and preventive services, and health risk management. Projects may also seek to reduce financial and logistical barriers to receiving care.

Initiatives targeted at health systems focus on the organization of care and may seek to improve data collection systems (beneficiary race and

Physician behavior also contributes to racial disparities.

ethnicity, primary language preferences, data on providers who may be bilingual, bicultural, or both); address cultural and linguistic barriers by improving access to interpretation; and address beneficiaries' ability to navigate the healthcare system through the use of community health workers or other kinds of interventions to improve patient-provider communication.

Although a range of approaches have been identified and tested in various settings, relatively little is known about the efficacy of alternative approaches to reducing disparities or about the strategies that are effective within various racial/ethnic sub-populations. Some published reviews of these interventions have assessed the evidence of their impact on disparities. These reviews conclude, for example, that physician tracking and reminder systems can be effective in improving preventive care and screening services for racial and ethnic mi-

norities, as are initiatives that bypass the physician, and give responsibility for offering a service to a nurse or nurse practitioner (e.g., standing orders for adult immunizations). Multifaceted provider interventions may also be effective, but interventions that include only a provider education component are not generally found to be very effective in improving care or narrowing disparities.

There is very little evidence yet on the effectiveness of cultural competence training. A few studies found that trainings enhanced providers' knowledge and skills, and attitudes improved, but only a very few studies sought to evaluate the impact on patient outcomes, and those findings were limited to changes in patient satisfaction with care. There were no findings on patient adherence or outcomes.

A recent review of interventions to narrow disparities in cancer care finds that efforts to improve screening participation and adherence are worthwhile goals. For cancers without accepted screening mechanisms, interventions need to address access to primary care. The literature review finds that there are few interventions that address racial/ethnic disparities in the timely completion of all recommended primary and secondary treatments. However, according to a 2003 study by John Capitman and Sarita Bhalotra, a key finding within this literature is that treatment management interventions that draw upon a "knowledgeable and trusted community health worker, serving as a patient navigator, has the potential to increase the share of elders of color who receive the current standard of care."

Conclusions

Medicare's central commitment to fund a consistent set of healthcare for all of the elderly has substantially reduced racial and ethnic disparities for those who would otherwise be unable to obtain affordable healthcare services. However, more can be done to
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assure that those eligible for Medicare and related programs are enrolled in those programs, are able to navigate them effectively, and have access to providers from whom they can receive culturally competent and continuous care, and who will be strong advocates to help them obtain the services they need.

As nearly 40 years of history demonstrates, a national program like Medicare can effectively address diverse groups by doing what it does best: It can assure that resources are distributed in a relatively equitable fashion across the nation; it can improve the quality of care for all beneficiaries; it can assure that federal outreach and education is linguistically and culturally appropriate; and that states and communities have materials and tools they can use to meet local needs.

At the same time, research and practical experience demonstrate that many of the obstacles and solutions vary by region and culture, so there probably will never be one model for care that would work in all communities. Local medical and social cultures vary dramatically across the country, as do the populations receiving care. Local understanding of cultures and barriers can be addressed by community groups and institutions with federal financial assistance. Ideally, a mid-21st century Medicare program will be better able to address the needs of its much more diverse beneficiary population.

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PRRAC Update

- This fall we welcome PRRAC's newest law & policy intern, **Danielle Wilson**, a third-year student at Howard Law School. **Christine Kim**, a second-year student at Georgetown Law School, is continuing her summer internship with us this fall.
- And we say good-bye and thanks to **Alexandra Cawthorne**, our 2005 Bill Emerson Congressional Hunger Fellow—who, we're happy to report, is close by, having joined the staff of the Citizens Commission on Civil Rights, headed by PRRAC Board member Bill Taylor.
- PRRAC Executive Director **Philip Tegeler** has published "The Persistence of Segregation in Government Housing Programs," in *The*

Geography of Opportunity: Race and Housing Choice in Metropolitan America, a new collection edited by Xavier de Souza Briggs and published by Brookings Institution Press.

- On Sept. 26, PRRAC co-hosted (with The Urban Inst., the National Fair Housing Alliance & the George Washington Univ. Dept. of Sociology) a book party, at The Urban Inst., for **James Loewen**'s just-published (and fantastic) book, *Sundown Towns: A Hidden Dimension of American Racism* (New Press).
- We acknowledge with thanks recent financial contributions from **Dylan Conger, Fred & Kathleen Rotondaro, Alan Rabinowitz & Theodore Pearson**.

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in an identical fashion for case subjects and control subjects. They were also blinded to the study hypotheses. Fourth, sample size considerations limited our ability to fully address the association of racism and infant VLBW across the full range of maternal sociodemographic, biomedical and behavioral characteristics. Lastly, the results of our study may be limited by the possible confounding of unmeasured variables closely related to interpersonal racial discrimination. Lifelong exposure to interpersonal racism is unlikely to operate as a risk factor for pregnant women solely at the individual level, but it also expresses the cumulative impact of societal-level (i.e., institutional) racism exposures on birth outcome. Our study suggests that a mechanism by which institutional racism affects female reproductive health is likely to be found in the reported incidents of racial discrimination in the workplace. As such, interventions that target both the reported incidents of racial discrimination in the workplace and the structural issues of

race inequality that place a large percentage of African-American women in conditions of severe income insecurity are needed to narrow the racial disparity in infant VLBW.

In conclusion, the reported lifelong accumulated experiences of interpersonal racial discrimination by African-American women constitute an independent risk factor for infant VLBW.

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Community Health Strategies to Improve the Life Options of Young Men of Color

by Jorielle R. Brown

Minority men (Hispanic/Latino and non-Hispanic who are African-American/Black, American Indian/Alaskan Native, Asian-American, Native Hawaiian/Other Pacific Islander) constitute approximately 30% of the United States male population. Yet this cohort is disproportionately burdened by disease, as evidenced by minority men having a significantly lower life expectancy than all women and white men. Diseases such as hypertension, diabetes, obesity and HIV are particularly high among young minority men ages 25–34. These conditions are known to lead to disability and preventable deaths from various cancers, cardiovascular disease and AIDS. Therefore, they warrant particular attention with regard to young minority males.

On an individual as well as an institutional basis, the health of young men of color has been neglected. Unfortunately, this neglect results in limited research, and therefore an incomplete understanding of effective strategies, optimal prevention and intervention programs, best practices, and estimations of models efficacious for promoting and providing health services for minority men. However, a promising area for the reversal of this trend is the furthering of community health strategies. Community health strategies are defined as promoting community involvement in and ownership of health problems and solutions to improve and strengthen the well-being of community members and their quality of community life. Because young men of color are vital members of the community, the improvement of life options for them will heavily rely on community health strategies. For example, community-based health promotion can facilitate outreach and access to publicly supported health care programs and access to primary and secondary prevention efforts targeted

toward young minority men. Further, adopting a community health perspective requires tailoring the strategies to the community's needs, such as integrating physical and mental health, accessing healthcare professionals who reflect community members' demographics, and addressing areas where young minority men are over-represented (e.g., prison, homelessness).

The health of young men of color has been neglected.

In addressing the health of young men of color, we must consider their issues and health in the context of their experience in the larger society. Improving the life options of young men of color requires a paradigm shift from the present reactive stance which neglects this category of individuals to a proactive posture more holistic in nature. To lead and assist in this paradigm shift will likely require institutional level changes, such as the establishment of an Office of Men's Health in the U.S. Department of Health and Human Services, as there is now an Office of Women's Health.

The Issues

Access to community-based health promotion and treatment services: Men are less likely than women to engage in attention to their health. For instance, women are twice as likely as men to visit a doctor's office for preventive services and annual examinations. In fact, research indicates that, in particular, many black males do not seek routine medical intervention, and these findings hold true for other racial/ethnic minorities.

The demographics and social circumstances (e.g., limited education,

low income, poor employment) of this cohort create barriers to accessing treatment and prevention services. Such barriers may include lack of a telephone or transportation, work schedule inflexibility, limited knowledge of how the healthcare systems function, lack of financial resources, limited healthcare facility hours, or medical mistrust. Without a systematic approach to addressing these and other issues, young minority men are at increased risk of poor health.

Key to community-based health promotion is the development of materials and methods to disseminate information on public health to minority men. This involves creating innovative and practical tools, resources, links and approaches to engaging in health promotion. These materials must be gender-, culture- and age-appropriate. However, due to the dearth of data on young men of color, particularly subgroups of Asian Americans and Hispanic/Latinos, the first essential component in the development of materials is determining the needs and resources present in the community. Such information can be obtained through comprehensive needs assessments. For men of color, it will be particularly relevant to assess cultural and contextual issues, because studies suggest that beliefs about masculinity and cultural norms may lead minority men to either take actions that harm themselves or refrain from engaging in health-protective behaviors. Direct community involvement in designing assessment/evaluation tools is therefore essential to obtaining accurate information on which to base both the promotion materials and the mechanisms for distribution. Primary health, substance use, mental health, social and environmental health are examples of topic areas to be included in a needs assessment.

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Another key to increasing access to community health promotion and treatment for young minority men is the need to remove the barriers that limit well-being, as noted above. Often these barriers are not adequately considered, yet they are important matters, since minority men are often reliant on community health services. Frequently, community health treatment facilities serve the uninsured and the underinsured. Minority men are over-represented in these categories due to over-representation among those who are incarcerated, homeless, unemployed or institutionalized. These conditions marginalize them in the labor force and limit insurance options, often restricting them to use of community health treatment. Thus, community health promotion and treatment is a key component to improvements in the health of young minority men.

The implementation of school-based community health promotion has proven beneficial for adolescent minority males. Evidence suggests that school-based health clinics in high schools can facilitate collaboration with key constituent groups, expand the delivery of healthcare services and improve the health status of students they serve. Areas for increased attention are the feasibility, acceptability and effectiveness of clinics serving younger minority children.

For young men of color, community-based health promotion should focus on both healthy minority males and those at risk. Health promotion needs to reach minority men before they are symptomatic, and at a time when changing health behaviors can prevent illness, disability and death. This will likely require a partnership with educational entities in order to raise health awareness in the early stages of adolescence and encourage lifestyle changes.

Outreach and enrollment in publicly supported healthcare programs: For young men of color over the age of 18 and reliant on publicly supported healthcare programs, the expansion of

Medicaid in the late 1980s did little to improve their insurance status. Instead, the eligibility requirements for many publicly supported programs exclude those over the age of 18.

Among non-elderly men, 46% of Latinos and 28% of African Americans lack health insurance. Men of color are less likely than white men to have job-based insurance, and only 6 to 8% of Latino and African-American men have Medicaid. Regardless of insurance status, men of color are less likely to receive timely preventive services and are more likely to suffer the consequences of delayed medical treatment, such as limb amputations and radical cancer surgery.

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In the United States, care of the uninsured relies significantly on a patchwork system of safety-net providers, including community health centers (CHCs). President Bush recognized the importance of CHCs in his first budget and proposed to double the number by calendar year 2006. While this expansion is much needed, a substantial increase in their budgets is also pivotal. Data suggest that while CHCs are providing primary care services to their uninsured patients, they are often unable to provide much needed diagnostic, specialty and behavioral health services, thus limiting the quality of care offered. Since CHCs are the primary providers of care for young minority men, increased financial assistance to CHCs is mandatory in order to offer the quality of care provided to insured patients.

Access to both primary and secondary prevention, including personal health responsibility and early intervention for treatment: The goal of primary prevention for this group is to target generally healthy young minority males, while the aim of secondary prevention is to address those men with

risk factors for particular diseases or illness. The susceptibility to illness and rates of morbidity in this cohort suggest a need for significant levels of primary and secondary prevention for children and adolescents. While prevention efforts would be expected in the educational system, a large number of younger minority males reside in inner cities where educational systems are often ill-equipped to provide needed services. Further, because young adult males are not considered a priority population, little attention is paid to primary or secondary prevention efforts for this group, especially for young men of color.

Targeted outreach is essential due to the lack of emphasis men place on their health. Yet studies suggest that when health education and awareness are provided in a comfortable and engaging environment, minority men prioritize their health. Thus, campaigns that promote health and wellness, such as outreach, health screenings, gender-specific clinics and other such initiatives are needed.

Integration of physical promotion and behavioral health (mental health and substance abuse) delivery: Mental health and physical health are mutually inclusive issues. Yet there continues to be a stigma associated with mental health. For young minority males, this may be particularly true, because in their communities the perception of mental distress may be intertwined with issues of masculinity. This may lead to denial of emotional problems or adoption of coping styles maladaptive to functioning. Unfortunately, rates of mental illness and substance abuse serve as significant barriers to improved emotional well-being for young men of color. Men generally are less likely than women to recognize, acknowledge and seek treatment for depression. Further, loved ones and physicians may not detect symptoms in men because the presentation is manifested differently. The lack of research in this area limits our understanding of depression in young men of color. With respect to alcohol and drug abuse, rates for males are typi-

cally higher than those for females. African-American men are at greater risk for alcohol-related social and health problems, and this increases the risk of diseases such as hypertension, diabetes, heart disease, and certain types of cancers and malignant neoplasms.

In contrast to females, who are more likely to use relational opportunities (e.g., family, friends, support groups) to manage stress, society has taught men to harbor their issues, which often exacerbates the problem. Moreover, seeking help from the healthcare system may be misconstrued as a sign of weakness. On the other hand, for males, the integration of physical activity as a coping mechanism or intervention for improved mental well-being is a viable and untapped resource.

Discrimination, poor education, limited job opportunities and poverty are realities for many young men of color. Behavioral responses, such as depression, substance abuse and risky sexual behavior are not uncommon. Diagnostically, clinical and non-clinical levels of mental illness are characterized in part by a diminished interest in usual activities. For adolescent and young adult minority males, this may be reflected in a reduction of physical activity, a more normative behavior for this cohort. However, participation in physical activity has been associated with a positive mood, greater self-esteem, and greater physical and psychological well-being. Additionally, participation in physical activity and team sports activities may provide adolescents with a social network that can support and protect them from depression.

Access to health care professionals and services (including mental health) that reflect the cultural, racial and gender composition of the community: As discussed above, access to care is one challenge for young minority males; compounding the challenge is the shortage of healthcare professionals who reflect their culture, race and gender. In 2003, of the approximately 646,000 male physicians, 2% were Black, 3.3% were Hispanic,

More Responses to Justice O'Connor's 25-Year Challenge: The Kirwan Institute

The July/Aug. *P&R* profiled work under way in response to Justice O'Connor's assertion in the 2003 *Grutter* university admissions decision that affirmative action should no longer be necessary in 25 years.

The Kirwan Institute for the Study of Race and Ethnicity, directed by PRRAC Board member John A. Powell, is pursuing its own line of interdisciplinary research and activism in response to Justice O'Connor's challenge. This past spring, the Institute, which is affiliated with Ohio State University, co-sponsored a symposium, "Meeting the Challenge of *Grutter*," where educators, policy leaders and legal scholars participated in helping construct a vision of what is necessary and what schools will look like if we are to meet this 25-year challenge. Writings from this symposium will be published in the *Ohio State Law Journal*, early 2006.

Following the symposium, the Institute has continued the push for equitable public education through a variety of initiatives, such as the Diversity Advancement Project, a collaboration with The Center For Social Inclusion. This project seeks to create a broad public understanding of the importance of racial and ethnic diversity in our institutions, and to persuade the public to support policies and programs, such as affirmative action, that have the power to dismantle structural racism. A conference is also planned for October 31, 2005 at Ohio State, where Judge Robert Carter will discuss the significance and promise of the 1954 and 1955 *Brown* decisions.

More information about the October conference and the Kirwan Institute can be found at www.kirwaninstitute.org. Professor Powell can be reached through Barbara Carter at carter.647@osu.edu.

8% were Asian and less than 1% were Native American/Alaskan Native. Yet research indicates that there is greater satisfaction and adherence to treatment when the patient and provider are of the same race. Unfortunately, in most states, the "diversity ratio"—the degree to which a state's physician composi-

Research indicates that there is greater satisfaction and adherence to treatment when the patient and provider are of the same race.

tion reflects its demographic composition—indicates the need for a substantial increase in the number of minority healthcare professionals.

The lack of access to healthcare and mental health services mirroring the demographics of young minority men

presents many barriers to quality care. Adolescence and young adulthood are periods of self-actualization and growing independence. During these phases, language barriers and poor communication can be impediments to receiving treatment and are related to patient dissatisfaction. In fact, about three in ten Latinos say they have had problems communicating with health providers. For young men of color, limited English proficiency and/or low levels of education likely lead to limited medical literacy, thus hindering possible improvements in their health.

Additionally, medical mistrust is common among minorities. Particularly for young men of color, this may be a learned behavior from historical precedence (such as the role of Tuskegee Syphilis Study). Disclosure of mental and physical health problems and the role of gender are often culturally-specific, thus complicating the

(Please turn to page 18)

patient-provider relationship. An increase in minority healthcare professionals may assist in reversing this negative cycle of ineffective care for young men of color.

The Sullivan Commission in 2003 reported the alarming decrease in rates of minorities in medical, dental and nursing schools. Its report made recommendations on how to diversify our nation's healthcare workforce. These recommendations (e.g., science and math initiatives in high schools) are in the early stages of implementation, yet they show promise.

Additionally, the Institute for Diversity in Health Management, established in 1994, has surmised that even those minorities present in the health care system are not in positions of power. It found that minority workers hold more than 20% of healthcare positions, but less than 1% of top hospital management positions. In response, the Robert Wood Johnson Foundation provided grant support to the Institute designed to create a database to link minority candidates to executive-level health management job openings. In addition, the Institute has several campaigns focusing on increasing the number of minority healthcare professionals.

Access to quality physical and behavioral medical and health services within the criminal justice and juvenile justice systems and foster care system: In 2004, among males age 25 to 29, 12.6% of blacks and 3.6% of Hispanics, compared to about 1.7% of whites, were in prison or jail. Considering the recent trend of more stringent criminal legislation (e.g., zero tolerance, abandoning rehabilitation programs), the incarceration rates for young men of color likely will increase. Their disproportionate representation among the incarcerated population subjects minority men to the disproportionate levels of infectious diseases. Clearly, there is need for adequate healthcare services for those in prison. Unfortunately, there is no federal or state structure to assure such

services. Very few states have an office that oversees healthcare in adult correctional facilities, and no federal mandates exist for juvenile justice facilities. Congress should require that federal, state and local correctional systems (criminal and juvenile justice) adhere to nationally recognized standards of delivery and provide resources to these systems.

Within the foster care system, children of color make up the majority of youth—approximately 42% are African-American and 36% are Hispanic. As a group, children in foster care suffer high rates of serious physical or psychological problems, compared with other children from the same socioeconomic backgrounds. Studies indicate that 50-60% have moderate to severe mental health problems. Given their

A federal Office of Men's Health should be established.

overwhelming and complex needs, foster children require and use health services more than other children.

Foster children receive the same minimum health benefits as children in the Temporary Assistance for Needy Families program. However, these services are not meeting the needs of foster children. Of concern is the constant mobility of foster children, particularly young minority males, who tend to be the most difficult to place. Additionally, healthcare providers often resist serving foster children, due to low payment schedules and stigma. The lack of an infrastructure which systematically attends to the healthcare of foster children impedes improvement in this area. Recommendations include foster care nurses for the healthcare of foster children and increased education and training for foster parents and healthcare providers. Pediatricians and child welfare agencies should work together to ensure that children in foster care receive the full range of preventive and therapeutic services. It also is essential to comply with legal mandates to expeditiously formulate permanency plans for minority males, many of

whom remain in foster care intermittently.

Conclusion

Government entities, researchers, health professionals and activists currently have prioritized the issue of health disparities in America. However, the health of men, and more specifically young minority males, continues to be overlooked. Young men of color are disproportionately impacted by both physical and mental illnesses. Yet this cohort has limited access to healthcare, and research on effective ways to address this problem is woefully inadequate. Implementing community health strategies is one solution to improving the health of young minority males. However, community health strategies require a stable infrastructure to assist and monitor the development and support of effective strategies. Thus, a federal Office of Men's Health should be established.

Congress established the Office of Women's Health in 1991, and there has been marked improvement in the health status of women since then. Legislation now before the House and Senate to create an Office of Men's Health would provide accountability, funding, resources and leadership for improving the health of men generally, and young minority men specifically. Improving the health of young minority men is undoubtedly a considerable undertaking. However, continuing to neglect this population will limit the life options of young men of color, at an untold cost to the society as a whole.

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This article is adapted from a longer, as yet unpublished paper prepared by Dr. Brown for the Dellums Commission of the Joint Center's Health Policy Institute; contact gchristopher@jointcenter.org for publication plans. □

The Right to Health Under International Law and Its Relevance to the United States

by Alicia Ely Yamin

One of the articles in this issue — “The Right to Health Under International Law and Its Relevance to the United States” — was reprinted from the July 2005 *American Public Health Journal*. The permission they granted does not permit posting the piece on a website. For a copy of the article (in its original form, containing the extensive footnoting that we omitted from our reprinted version), contact the author, Alicia Ely Yamin, a human rights attorney who works at the Harvard School of Public Health (ayamin@hsph.harvard.edu).

Readings on Health Disparities:

Applied Research Center & Northwest Federation of Community Organizations, *Closing the Gap: Solutions to Race-Based Health Disparities* (Summer 2005) (<http://www.arc.org/downloads/closingthegap.pdf>)

Auerbach, James, Barbara Krimgold & Bonnie Lefkowitz, *Improving Health: It Doesn't Take a Revolution*, National Policy Association (2003)

Brown, E., Ojeda, V., Wyn, R. & Levan, R., *Racial and Ethnic Disparities in Access to Health Insurance and Health Care*, Los Angeles CA: UCLA Center for Health Policy Research and the Henry J. Kaiser Family Foundation (2000)

Child Welfare League, *Disproportionate Minority Representation: A Statement About Children of Color in the Child Welfare System: Overview, Vision and Proposed Action Steps*, Child Welfare League of America (2001) (<http://www.cwla.org/programs/juvenilejustice/jjdmr.htm>)

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Hillemeirer, Marianne M., John Lynch, Sam Harper & Michelle Casper, *Measurement Issues in Social Determinants Measuring Contextual Characteristics of Community Health*, HSR: Health Services Research 38:6 Part II (December 2003)

Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* 177, Brian D. Smedley et al. eds. (2003)

McDonough, John et al., *A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities*, The Commonwealth Fund (June 2004)

Mullings L., A. Wall, *Stress and Resilience: the Social Context of Reproduction in Central Harlem*, New York, NY: Kluwer Academic Publishers (2001)

National Center for Poverty Law, “Environmental Justice for Children,” *Clearinghouse Review* (May/June 2005)

New England Journal of Medicine: August 18, 2005 issue has 3 major studies on racial health disparities (www.nejm.org)

PolicyLink & Joint Center for Political & Economic Studies, *Community Factors that Impact Health* (2004) (a series of four issue briefs, available at www.policylink.org)

Pritchett, Wendell E. “The Romance of Home: The Fair Housing Movement in the 1950s,” Public Law & Legal Theory Research Paper Series Research Paper No. 8, Univ. of Penn. Law School (Fall 2002)

Rosenbaum, Sara & Joel Teitelbaum, “Civil Rights Enforcement in the Modern Healthcare System: Reinvigorating the Role of the Federal Government in the Aftermath of *Alexander v. Sandoval*,” *Yale Journal of Health Policy, Law and Ethics*, (2003) III 2

Smith, David Barton, *Eliminating Disparities in Treatment*, The Commonwealth Fund (August 2005)

Websites for additional information:

Agency for Healthcare Research and Quality, www.ahrq.gov

Center for Economic and Social Rights, www.cesr.org

Centers for Disease Control and Prevention, www.cdc.gov

Healthy People 2010, www.healthypeople.gov

Howard University National Human Genome Center, www.genomecenter.howard.edu

National Center for Health Statistics, www.cdc/nchs.gov

The Praxis Project, www.thepraxisproject.org

PolicyLink, www.policylink.org

Resources

Most Resources are available directly from the issuing organization, either on their website (if given) or via other contact information listed. Materials published by PRRAC are available through our website: www.prrac.org. Prices include the shipping/handling (s/h) charge when this information is provided to PRRAC. "No price listed" items often are free.

When ordering items from PRRAC: SASE = self-addressed stamped envelope (37¢ unless otherwise indicated). Orders may not be placed by telephone or fax. Please indicate from which issue of P&R you are ordering.

Race/Racism

- “**African Americans and Latinos: The Future of the Middle Class**”: A 23-page transcript of a June 7, 2005 Demos Forum, featuring Thomas Shapiro (Brandeis), Eric Rodriguez (National Council of La Raza) and Javier Silva (Demos), is available (possibly free) from Demos, 220 Fifth Ave., 5th flr., NYC, NY 10001, 212/633-1405, <http://www.demos.org/9530>

- **What's Race Got To Do With It?** (2005) is a 55-minute documentary-in-progress “that will go beyond identity politics, celebratory history & interpersonal relations to articulate the many myths & misconceptions that underlie & obstruct our thinking about race in today’s post-Civil Rights world.” Inf. from Larry Adelman at California Newsreel, la@newsreel.org [9586]

world.” Inf. from Larry Adelman at California Newsreel, la@newsreel.org [9586]

- **New NYC Civil Rights Law:** The NYC City Council has passed, and Mayor Bloomberg has signed, the “Local Civil Rights Restoration Act.” The measure is directed at preventing the City’s Human Rights Law from being interpreted in tandem with the cutbacks in civil rights that have occurred on the federal level in recent years. The new law pointedly requires judges to interpret provisions of the City’s Human Rights Law to best accomplish its “uniquely broad a remedial purposes,” regardless of how “its federal and state counterparts have been construed.” It also provides stronger protection against retaliation for persons who file a discrimination complaint. Further inf. from the Anti-Discrimination Ctr. of Metropolitan NY, 299 Broadway, #1820, NYC, NY, 10007, <http://www.antibiaslaw.com/9589>

- **“Embracing the Opportunities for Increasing Diversity Into the Legal Profession: Collaborating to Expand the Pipeline,”** hosted by the ABA Advisory Council on Diversity in the Profession & The Law School Admission Council, will be held **Nov. 3-5, 2005** at Rice Univ., Houston. Inf. from the ABA Advisory Council, 321 No. Clark St., Chicago, IL 66010-4714, 312/988-5100. [9528]

Please drop us a line letting us know how useful our Resources Section is to you, as both a lister and requester of items. We hear good things, but only sporadically. Having a more complete sense of the effectiveness of this networking function will help us greatly in foundation fundraising work (and is awfully good for our morale). Drop us a short note, letting us know if it has been/is useful to you (how many requests you get when you list an item, how many items you send away for, etc.) Thank you.

- **“No Retreat, No Compromise”** is the US Human Rights Network first bi-annual meeting, **Nov. 11-13, 2005** in Atlanta. Inf. from the Network, 659 Auburn Ave. NE, Unit 205, Atlanta, GA 30312, 404/588-9761, conference@ushrnetwork.org, <http://www.ushrnetwork.org/> [9534]

Poverty/Welfare

- **“Costly Credit: African Americans and Latinos in Debt”** (13 pp., May 2005) is available (possibly free) from Demos, 220 Fifth Ave., 5th flr., NYC, NY 10001, 212/633-1405, <http://www.demos.usa.org/9529>

- **“An Atlas of Poverty in America,”** by Amy Glasmeier, can be accessed at www.emsei.psu.edu/~kolb/amy/Atlas/ [9544]

- **“Welfare Reform in Los Angeles: Implementation, Effects & Experiences of Poor Families & Neighborhoods”** (2005) is available at <http://www.mdrc.org/> [9560]

- **Census Bureau 2004 Poverty Report:** Poverty increased from 2003 to 2004. Study available from 301/763-4636, or www.census.gov/hhes/www/poverty/poverty04.html [9568]

- **“Two Steps Back: African Americans and Latinos Will Lose Ground Under Social Security ‘Reform’,”** by Ross Eisenbrey & William E. Spriggs, a 5-page, July 2005 Economic Policy Inst. report, is available from co-author Spriggs, bspriggs@epinet.org [9577]

Community Organizing

- **“The Midwest Academy”** is holding its Maryland Training Session, **Nov. 14-18, 2005** in Linthicum Heights (nr. BWI Airport — recently renamed for Thurgood Marshall). Inf. from the Academy, 28 E. Jackson Blvd., #605, Chicago, IL 60604, 312/427-2304, mwacademy1@aol.com, <http://www.midwestacademy.com/> [9565]

Criminal Justice

- “Race and Incarceration in Delaware: A Preliminary Consideration,” by Thomas P. Eichler (27 pp., n.d. [2005]), has been published by the Delaware Center for Justice and Metropolitan Wilmington Urban League. Available (possibly free) from the author, teichler@nemours.org [9526]
- “On the Power of Restorative Justice” is the title of a transcript of a May 2005 Drum Major Institute forum featuring long-time San Francisco Sheriff Michael Hennessey and several commentators (including Rev. James Forbes, Jr. of Riverside Church, Kings County District Attorney Charles Hynes & NYC Dept. of Corrections Commissioner Martin Horn). Copies of the 37-page document are available (possibly free) from the Inst., 110 E. 59 St., 28th flr., NYC, NY 10022, 212/909-9663, drummajorinstitute.org [9547]
- “Chicago Communities and Prisoner Reentry,” by Jill Farrell & Christy Visher (2005), is available from The Urban Inst., 2100 M St. NW, Wash., DC 20037, 202/261-5709, http://www.urban.org/ [9553]
- “Prisoner Reentry in Illinois” (2005) is available (likely free) from The Urban Inst., 2100 M St. NW, Wash., DC 20037, 202/261-5709, http://www.urban.org/ [9556]

Economic/Community Development

- *Democratizing Capital: The History, Law, and Reform of the Community Reinvestment Act*, by Richard Marsico, (315 pp., 2005), has been published by Carolina Academic Press, 919/489-7468, <http://www.caplaw.com/> [9531]
- “The Impact of Community Development Corporations on Urban Neighborhoods,” by George Galster, Diane Levy, Noah Sawyer, Kenneth Temkin & Christopher Walker (2005), is available (likely free) from The Urban Inst., 2100 M St. NW, Wash., DC 20037, 202/261-5709, <http://www.urban.org/> [9557]
- “Gentrification: Boon or Bane?” appeared in the July/Aug. 2005 issue of *Shelterforce*, www.nhi.org/online/issues/142/gentrification.html [9563]

Education

- “The Governance Divide: A Report on a Four-State [FL, GA, NY, OR] Study on Improving College Readiness and Success,” by Andrea Venezia, Patrick M. Callan, Joni E. Finney & Michael Usdan (55 pp., Sept. 2005), from the Inst. for Educ. Leadership, the Natl. Ctr. for Public Policy & Higher Educ., and the Stanford Inst. for Higher Educ. Research, is available (no price listed) from the Natl. Ctr., 152 N. Third St., #705, San Jose, CA 95112, 408/271-2699, <http://www.highereducation.org/> [9520]

● “Closing the Gap: Moving from Rhetoric to Reality in Opening the Doors to Higher Education for African-American Students” (17 pp., June 2005) is available (possibly free) from the NAACP Legal Defense and Educational Fund (headed by PRRAC Board member Theodore M. Shaw), and is downloadable at <http://www.naacpldf.org/> [9524]

● *School Resegregation: Must the South Turn Back?*, eds. (PRRAC Board Chair) John Charles Boger & Gary Orfield (2005), has been published by Univ. of North Carolina Press. [9536]

● “Shortchanging Poor and Minority Students: California’s Hidden Teacher Spending Gap” is a 2005 report from Education Trust-West, 155 Grand Ave., #1025, Oakland, CA 94612, 510/465-6444, <http://www.edtrustwest.org/> [9552]

● “Kids Who Move A Lot - A Problem for Rural Districts,” by Karl Schafft, (2005) is available at srdc.msstate.edu [9559]

● “The Role of Education — Promoting the Economic & Social Vitality of Rural America” (2005) has been published by the Southern Rural Development Center, [srdc.msstate.edu/](http://srdc.msstate.edu) [9562]

● “Educational Progress Across Generations in California,” a 2005 report from the Public Policy Inst. of California, focuses on Mexican-American immigrants. Available at www.ppic.org/main/publication.asp?i=402 [9573]

● “Teacher Attrition: A Costly Loss to the Nation and to the States,” a 2005 brief, is available from the Alliance for Excellent Education, (1201 Conn. Ave. NW, #901, Wash., DC 20036, 202/828-0828, Alliance@all4ed.org, www.all4ed.org/publications/TeacherAttrition.pdf [9574]

● **A National Poll Finds Americans Feel High School Improvement More Urgent Than Elementary Education Improvement:** Materials from an Aug. 2005 Alliance for Excellent Education event presenting the results are available at www.all4ed.org.events/NationalPollRelease.html [9575]

● *Postsecondary Education Opportunity* devotes its Aug. 2005, 20-page issue to “Minority Undergraduate Enrollments at Leading Public & Private Colleges & Universities.” Subs. to the monthly are \$164, from PO Box 415, Oskaloosa, IA 52577-0415, 614/673-3401, subscription@postsecondary.org, <http://www.postsecondary.org/> [9578]

● “High School Students Have Parents Too,” a 2005 study by members of the “Youth News Team” in Lexington, KY, is available (possibly free) from the Center for Parent Leadership at the Prichard Committee, 167 W. Main St., #310, Lexington, KY 40507, kgardner@prichardcommittee.org [9581]

● “Full-Day Kindergarten: A Study of State Policies in the United States” (2005?) has been

published by the Education Commission of the States. Inf. from the Foundation for Child Development, harold@fcd-us.org [9583]

● “PK-3: An Aligned & Coordinated Approach to Education for Children 3 to 8 Years Old” (2005?) has been published by the Society for Research in Child Development. Inf. from harold@fcd-us.org [9584]

● “Parent Leaders: An Untapped Resource in Education” is a Dec. 1-2, 2005 informational seminar in San Antonio, sponsored by the Center for Parent Leadership at the Prichard Committee, 167 W. Main St., #310, Lexington, KY 40507, kgardner@prichardcommittee.org [9579]

● “Six Key Strategies for Teachers of English-Language Learners” is a Dec. 7, 2005 breakfast forum (in DC), sponsored by the Alliance for Excellent Education. Inf. from them, 1201 Conn. Ave. NW, #901, Wash., DC 20036, 202/828-0828, Alliance@all4ed.org, www.all4ed.org/events/index.html [9571]

Employment/Jobs Policy

● “Promoting Work in Public Housing: The Effectiveness of Jobs-Plus,” by Howard S. Bloom, James A. Riccio, Nandita Verma & Johanna Walter (263 pp., March 2005), is available (no priced listed) from MDRC, 16 E. 34 St., NYC, NY 10016, 212/532-3200, http://www.mdrc.org/ [9521]

● “The Labor Day List: Partnerships That Work” is a 15-page, Sept., 2005 publication “celebrating successful labor relations strategies in the new economy.” Available (possibly free) from American Rights at Work, 1100 17th St. NW, #950, Wash., DC 20036, 202/822-2127, srbprogram@americanrightsatwork.org, http://www.americanrightsatwork.org/ [9525]

● “Does Making Work Pay Still Pay? An Update on the Effects of Four Earnings Supplement Programs on Employment, Earnings & Income” (2005) is available at http://www.mdrc.org/ [9561]

Families/Women/Children

● “Mississippi Child Care Development Fund: Program Implementation, Evaluation and Impact Analysis” (60 pp., Jan. 2005) is available (possibly free) from the John C. Stennis Institute of Government, Mississippi State Univ., PO Drawer LV, Mississippi State, MS 39762, 662/325-3328, http://www.sig.mssstate.edu/ [9527]

● “Stand Up for Children Now! : State of America’s Children Action Guide” is a 46-page, 2005 Children’s Defense Fund publication, available (likely free) from CDF, 25 E St. NW, Wash., DC 20001, 202/662-3576, www.cdfactioncouncil.org [9537]

● “Childcare Centers and Inter-Organizational Ties in High Poverty

Neighborhoods” is a 3-page, Sept. 2005 Fragile Families Research Brief, available (possibly free) from the Center for Research on Child Wellbeing, Wallace Hall, 2nd flr., Princeton Univ., Princeton, NJ 08544, http://www. fragilefamilies.princeton.edu/ [9538]

● “A Profile of Low-Income Working Immigrant Families,” by Randy Capps, Michael Fix, Everett Henderson & Jane Reardon-Anderson is a 7-page, June 2005 Urban Inst. policy brief, available (likely free) from the Institute, 2100 M St. NW, Wash., DC 20037, 202/261-5709, http://www.urban.org/ [9539]

● “A Look at Low-Income Working Families: Facts and Figures” (2005) is available (likely free) from The Urban Inst., 2100 M St. NW, Wash., DC 20037, 202/261-5709, http://www.urban.org/ [9555]

Health

● “Medicaid Responsiveness, Health Coverage, and Economic Resilience: A Preliminary Analysis” (Sept. 2005) is an 8-page Executive Summary and Implications for Policymakers, available (possibly free) from The Joint Center for Political and Economic Studies, 1090 Vermont Ave. NW, #1100, Wash., DC 20005, http://www.jointcenter.org/ [9523]

● “Know Your Rights: A Handbook for Patients with Chronic Illness” (2005) has been produced by Advocacy for Patients With Chronic Illness.

Ordering inf./description at <http://www.advocacyforpatients.org/> [9535]

● “Income, Poverty & Health Insurance Coverage in the United States: 2004,” a 2005 Census Bureau report, can be found at www.census.gov/prod/2005pubs/p60-229.pdf [9567]

● The Kaiser Family Foundation website has a segment on “Race, Ethnicity & Health Care” - KaiserEDU.org [9587]

● “Knowledge Paths: Racial & Ethnic Disparities in Health” (new 2005 edition) can be found at www.mchlibrary.info/KnowledgePaths/kp_race.html [9588]

Homelessness

● “Report on Hates Crimes and Violence Against People Experiencing Homelessness in 2004,” a 2005 National Coalition for the Homeless report, can be found at www.nationalhomeless.org/hatecrimes/index.html [9566]

Housing

● “Low-End Rental Housing: The Forgotten Story in Baltimore’s Housing Boom,” by Sandra J. Newman (7 pp., March 2005), is available (\$5) from The Urban Inst., 2100 M St. NW, Wash., DC 20037, 877/847-7377, pub@ui.

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urban.org, <http://www.urban.org/> [9522]

- “**Keeping the Promise: Ending Racial Discrimination and Segregation in Federally Financed Housing,**” by (PRRAC Board member) Florence Roisman, appeared in vol. 48 (2005) of the *Howard Law Journal*. It is part of a symposium on the 40th anniversary of the Community Reinvestment Act. Copies of the article are available (free) from mdeer1@iupui.edu [9532]
- **Rural Voices**, the quarterly magazine of The Housing Assistance Council, devoted is Summer 2005, 24-page issue to “Farmworker Housing: Turning Challenges Into Successes.” Contact HAC at 1025 Vermont Ave. NW, #606, Wash., DC 20005, 202/842-8660, hac@ruralhousing.org [9540]
- “**Improving Homeownership Among Poor and Moderate-Income Households,**” by Adam Carasso, Elizabeth Bell, Edgar O. Olsen & C.

Eugene Steurle, a 2005 study from the Urban-Brookings Tax Policy Center, is available at www.urban.org/UploadedPDF/311184_improving_homeownership.pdf [9542]

- “**How to Better Encourage Homeownership,**” by Adam Carasso, C. Eugene Steurle & Elizabeth Bell, a 2005 brief from the Urban-Brookings Tax Policy Center, is available at www.urban.org/UploadedPDF/311193_IssuesOptions_12.pdf [9543]
- “**The Family Permanent Supportive Housing Initiative: Family History & Experiences in Supportive Housing,**” by Clare Nolan, Cathy ten Broeke, Martha R. Burt & Michelle Magee (2005), is available from The Urban Inst., 2100 M St. NW, Wash., DC 20037, 202/261-5709, www.urban.org/url.cfm?ID=311224 [9554]
- “**Less Aid Given for Latino Housing,**” by

Antonio Olivo (2005), is available (likely free) from The Urban Inst., 2100 M St. NW, Wash., DC 20037, 202/261-5709, <http://www.urban.org/> [9558]

- “**The Promises and Challenges of Co-ops**” appeared in the July/Aug. 2005 issue of *Shelterforce*, www.nhi.org/online/issues/142/co-ops.html [9564]

Miscellaneous

- **Advancement Project** has launched a new blog designed to keep people informed “on the latest racial justice issues such as: voting rights, educational opportunities, immigrant rights, criminal justice, economic justice and policing” — <http://www.justdemocracyblog.org/> [9545]
- **The Center for the Study of Political Graphics** is holding a sale on new & vintage posters. They’re at 8124 W. Third St., #211, LA,

CA 90048-4309, 323/653-4662, cspg@politicalgraphics.org, <http://www.politicalgraphics.org/> [9576]

Job Opportunities/Fellowships/Grants

- **The National Low Income Housing Coalition** (headed by PRRAC Board member Sheila Crowley) is seeking an **Organizer** to engage Coalition members in advancing low-income housing policy goals and in voter registration, education and mobilization. Ltr./resume to Deputy Dir., NLIHC, 727 15th St., 6th flr., Wash., DC 20005. [9551]
- **Advancement Project** is hiring a **Staff Attorney** to work primarily on voter protection issues in their “Power & Democracy Program.” Resume/ list of refs. to Tujuana Tell, ttull@advancementproject.org.

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Again Available, see page 12**