status report

UNIVERSITY OF PITTSBURGH
Institute of Politics

Health Disparities in America: Challenge and Opportunity

by Bruce Barron
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1. INTRODUCTION

Question: What do health insurance costs, tobacco billboards, golden arches, unsafe neighborhoods, grocery store locations, and low numbers of minority doctors have in common?

Answer: All these factors contribute to the disturbing health disparities that prevail in the United States along racial, ethnic, and socioeconomic lines.

One might assume that health disparities are basically the result of lack of access to health care. But actually, a great number of systemic, cultural, local, and individual components—referred to collectively as social determinants of health—contribute to the problem. For example:

- If a neighborhood has lots of fast-food restaurants and no full-service grocery stores, its residents will have low rates of fruit and vegetable consumption and high rates of obesity.
- Lower-income communities' proximity to environmental problems such as industrial pollution is often correlated with higher prevalence of asthma.
- The presence of drugs, gang violence, and other criminal activity not only reduces the life expectancy of those involved but harms a whole neighborhood's health by discouraging residents from jogging or walking through the streets to stay fit.
- Cultural divides between minority communities and predominantly White health professionals can lead minorities to make less use of the medical services available to them. Black distrust of the medical profession—fostered by the infamous Tuskegee syphilis study in which nearly 400 Black men were intentionally left untreated for research purposes—further discourages the use of health care.

Health disparities are a big problem in America and play a large part in explaining why the United States ranks first in per capita health care expenditures but far down the charts in health outcomes. But many people have been working to solve the problem, in both the public and private sectors and at national, state, and local levels, and many of their efforts have achieved significant success. This Institute of Politics *Status Report* focuses both on the vexing and complex nature of the problem and on some of the many signs of progress in understanding and eradicating health inequities in America.

This is the second Institute of Politics report on the topic. Six years ago, as the "health equity" movement began to take shape, the Institute published a briefer policy summary, *Eliminating Health Disparities: Addressing Minority and Rural Community Issues* (Faccenda 2002, available online at the Institute's Web site, www.iop.pitt.edu). The considerable expansion of health disparities research and interventions since then, along with the continuing growth of minority populations in America, justifies a fresh look at the issue today.

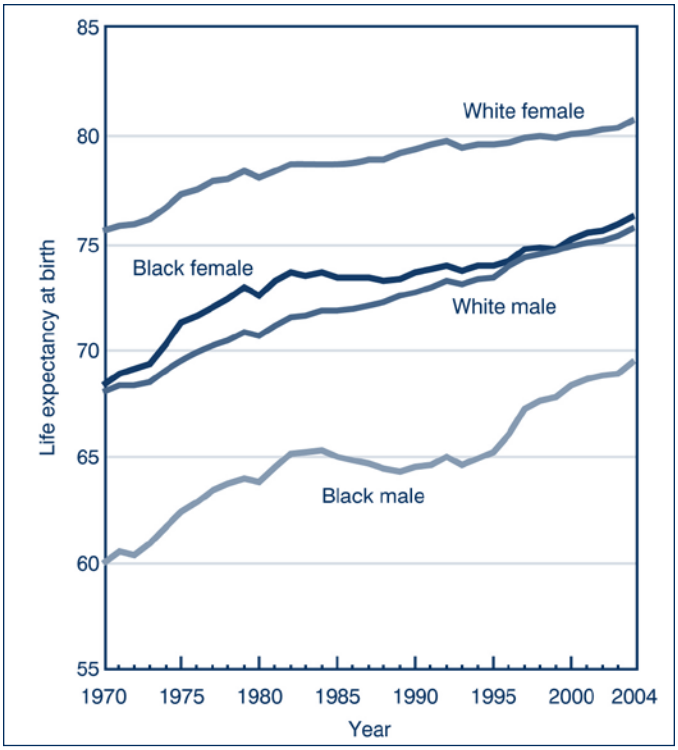
2. THE PROBLEM

Few dispute that the United States provides the world's best health care—to some of its citizens. But not to all. While the United States spends more money per capita on health care than any other country—a whopping total of $2 trillion in 2005—about 40 million Americans each year do not obtain needed health services (National Center for Health Statistics [NCHS] 2007, page 5).

Poverty, lack of health insurance, and geography are among the explanations for the disparities in health care. Rural Americans frequently have less convenient access to health providers than do urban residents. Uninsured people are less likely to seek preventive care and more likely to end up in emergency rooms with maladies that could have been more easily treated if detected at an earlier stage.

In the literature on health disparities, however, race and ethnicity represent the most commonly studied dividing line. Because of the correlation between race and socioeconomic status in American society, lack of health insurance is the largest factor explaining racial disparities with regard to access to health care (Lillie-Blanton and Hoffman 2005). As of 2005, more than half of the 42 million Americans without health insurance were non-White or Hispanic (NCHS 2007, page 77).

Lesser access to health care is a major cause of the racial disparities in U.S. health outcomes, such as the White-Black life expectancy gap of six years (NCHS 2007, page 55) or the fact that the African American infant mortality rate is more than double that among Whites (NCHS 2007, page 159). African



Black Americans' life expectancy has consistently lagged five to eight years behind that of Whites. Source: Centers for Disease Control

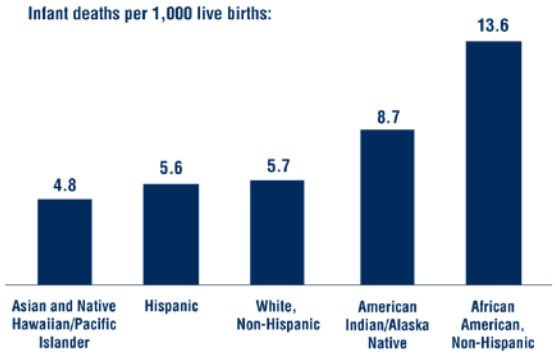
Americans are more than twice as likely as Whites to suffer from diabetes and also have much higher rates of high blood pressure, heart disease, and stroke (Office of Minority Health [OMH] 2006).

Expectation of life by age, race, and sex: United States, 2004

Age	All races			White			Black		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
0	77.8	75.2	80.4	78.3	75.7	80.8	73.1	69.5	76.3
1	77.4	74.7	79.9	77.7	75.2	80.2	73.1	69.6	76.3
5	73.5	70.8	76.0	73.8	71.3	76.3	69.2	65.7	72.4
10	68.5	65.9	71.0	68.9	66.3	71.3	64.3	60.8	67.5
15	63.6	61.0	66.1	63.9	61.4	66.4	59.4	55.9	62.5
20	58.8	56.2	61.2	59.1	56.6	61.5	54.6	51.2	57.7
25	54.0	51.6	56.3	54.4	52.0	56.6	50.0	46.7	52.8
30	49.3	46.9	51.5	49.6	47.3	51.8	45.4	42.3	48.1
35	44.5	42.2	46.6	44.8	42.6	46.9	40.8	37.8	43.4
40	39.9	37.6	41.9	40.1	37.9	42.1	36.3	33.4	38.8
45	35.3	33.1	37.2	35.5	33.4	37.4	31.9	29.1	34.3
50	30.9	28.8	32.7	31.1	29.1	32.9	27.8	25.1	30.1
55	26.6	24.7	28.3	26.7	24.9	28.4	24.0	21.5	26.0
60	22.5	20.8	24.0	22.6	20.9	24.1	20.4	18.2	22.2
65	18.7	17.1	20.0	18.7	17.2	20.0	17.1	15.2	18.6
70	15.1	13.7	16.2	15.1	13.7	16.2	14.1	12.4	15.3
75	11.9	10.7	12.8	11.9	10.7	12.8	11.4	9.9	12.2
80	9.1	8.2	9.8	9.1	8.1	9.7	9.1	8.0	9.6
85	6.8	6.1	7.2	6.7	6.0	7.1	7.1	6.3	7.5
90	5.0	4.4	5.2	4.9	4.3	5.1	5.5	4.9	5.7
95	3.6	3.2	3.7	3.5	3.1	3.6	4.2	3.8	4.3
100	2.6	2.3	2.6	2.5	2.2	2.5	3.2	2.9	3.2

Source: Centers for Disease Control

Infant Mortality Rate by Race/Ethnicity, 2003

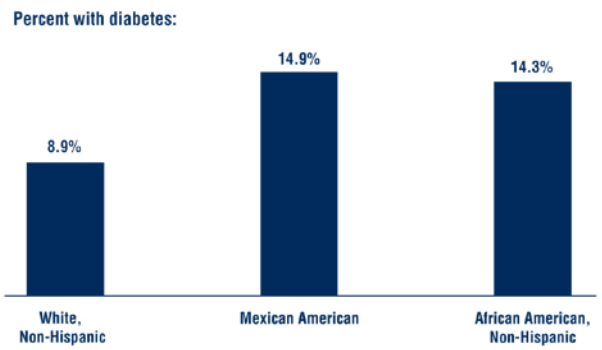


NOTE: Births are categorized according to race/ethnicity of mother.

DATA: National Center for Health Statistics, National Vital Statistics System, Linked Birth/Infant Death Data Set.

SOURCE: *Health, United States, 2006*, Table 19.

Diabetes Prevalence Among Adults Age 20 and Over by Race/Ethnicity, 2001–2004



NOTE: Diabetes prevalence includes physician-diagnosed (self-reported) and undiagnosed diabetes (fasting blood glucose of at least 126 mg/dL).

DATA: National Center for Health Statistics, National Health and Nutrition Examination Survey.

SOURCE: *Health, United States, 2006*, Table 55.

*"**Key Facts: Race, Ethnicity and Medical Care, 2007 Update**" (#6069-02), The Henry J. Kaiser Family Foundation, February 2007*

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But even when access to *health care* appears to be equitable, disparities in *health status* often persist. Explanations of this persisting health gap include the relative safety of neighborhoods; cultural differences in diet and nutrition; differing levels of trust in medical professionals, often exacerbated by the dearth of minority physicians and other health professionals; and access to healthy foods. As the American health system invests much more heavily in care than in prevention, some contributing factors, such as the higher obesity rate among African Americans (Kaiser Family Foundation 2007, page 12), can go overlooked.

Sometimes the racial disparities defy easy explanation. The authors of a 2002 Institute of Medicine study amassed compelling evidence that—even when severity of disease, insurance status, and socioeconomic factors were comparable—minorities were still less likely to receive diagnosis and treatment. It has been suggested that subconscious racial bias may lead some medical providers to make different treatment recommendations for minorities than for White patients (Smedley et al. 2002; Freeman and Payne 2000).

When minorities receive subpar care, all of us feel the pain in terms of lost productivity and social impact. As the United States is expected to become a "majority minority" nation (with minorities outnumbering Whites) by 2050, the importance of minority health will only grow.

3. NATIONAL EFFORTS ON HEALTH DISPARITIES

Is the loss of a Black baby more tolerable than the loss of a White baby? That was the unintended implication of a goal established by *Healthy People 2000*, the U.S. government's plan for improving Americans' health. Released in 1990, this document established targets of reducing infant mortality by the year 2000 to no more than seven of every 1,000 live births overall and to no more than 11 of every 1,000 live births to Black mothers (Thomas and Quinn 2008).

The practice of setting separate objectives for different racial or ethnic groups may have reflected realistic goal setting, but it also suggested that racial disparities were unavoidable. That practice was discontinued in *Healthy People 2010*, which instead set forth elimination of health disparities as one of its two overarching goals.

While the U.S. government's approach to racial disparities has varied in recent years, the issue has had a federal home for more than two decades. In 1985, U.S. Secretary of Health and Human Services (HHS) Margaret Heckler released the report of a task force that documented health inequities by race. One year later, her department established an Office of Minority Health (OMH) to implement the task force's recommendations.

Full Circle: From Minority Emphasis to "Integration" and Back

The contemporary health equity movement dates to the release of the Heckler report in 1985, but it is actually the second major effort in American history to address minority health issues. Thomas et al. (2006) explain:

"Booker T. Washington, founder and president of Tuskegee Institute [now Tuskegee University] in Alabama, … made a direct link between the economic progress of Blacks and the negative impact being caused by premature death from disease. … [M]inority health [initiatives] started outside of the federal government with leadership from Booker T. Washington when he launched the Negro Health Improvement Week in 1915. This comprehensive public health education campaign evolved into the National Negro Health Movement and focused on dissemination of modern public health hygiene to Blacks living in poverty in the rural South. The program grew into a year-round campaign across the nation and became so successful that around 1932 it was adopted by the U.S. Public Health Services as part of the new federal Office of Negro Health Works. In 1951, however, the Office of Negro Health Works was decommissioned in the name of integration and thus brought to an end the longest sustained minority health campaign in U.S. history."

OMH has initiated various campaigns designed to promote minority health, including the annual Take a Loved One for a Checkup Day in September. It has developed a Toolkit for Health and Resilience in Vulnerable Environments (THRIVE) to help minority communities identify and address health challenges at the local level (OMH 2004). OMH also provides technical assistance to states and community organizations, including minority health consultants in each of its 10 regional offices.

The federal Institute of Medicine conclusively documented the extent of health disparities in its 2002 publication *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* However, another newly established federal publication, the HHS *National Healthcare Disparities Report*, generated political controversy in 2003 after the media disclosure that HHS political appointees had rewritten sections so as to soften references to the pervasiveness and cost of health disparities. Under pressure from congressional Democrats, HHS Secretary Tommy Thompson released the original version of the report.

In contrast, the 2007 edition of this annual report (Agency for Healthcare Research and Quality 2007) shows no signs of sugarcoating. It cites three primary themes:

- Overall, disparities in health care quality and access are not getting smaller.
- Progress is being made, but many of the biggest gaps in quality and access have not been reduced.
- The problem of persistent lack of insurance is a major barrier to reducing disparities.

OMH's approach to addressing health disparities is presented in the office's 2006 "Strategic Framework for Improving Racial/Ethnic Minority Health and Eliminating Racial/Ethnic Health Disparities" (OMH 2006). This document recognizes the interplay of three major categories of factors that contribute to the problem:

- **Individual factors**, such as knowledge of ways to stay healthy, attitudes toward doctors, or genetic risks. Efforts to address these factors include public outreach, education, and health screenings.
- **Environmental and community factors**, such as crime, housing conditions, poverty, and access to health care. Efforts in this category include programs to deliver health care to lower-income Americans, along with a broad range of programs attacking social problems that impact health.
- **Systems-level factors**, or how health care providers and public health agencies apply their resources to address problems. Strategies in this area include steps to reduce cultural barriers, initiatives to enhance the diversity of the health care workforce, and research on health disparities.

Calvin Johnson, who served as Pennsylvania's secretary of health through September 2008, credited OMH with making possible the creation of Pennsylvania's Office of Health Equity. "OMH is doing a tremendous job of keeping health disparities on the table in a federal environment where competing priorities could easily knock it off the table," Johnson said. "Many state offices across the country were established through OMH funding or have received significant OMH support to move their agendas forward."

Another federal center

In 2000, the U.S. Congress created the National Center on Minority Health and Health Disparities (NCMHD) within the National Institutes of Health to advance research on the scientific, cultural, and socioeconomic factors that contribute to health inequities. Directed by John Ruffin since its inception, the center had a budget of more than $199 million for fiscal year 2008.

NCMHD sponsors 37 Centers of Excellence, including one based at the University of Pittsburgh. Along with scientific and social scientific research, the agency supports development of academic courses on health disparities, loan repayment for researchers who focus on that topic, and recruitment of minority faculty and students. NCMHD also encourages research collaborations with community-based organizations and increased representation of minority subjects in clinical trials. The NCMHD centers have involved universities and community organizations in novel partnerships that have significantly expanded the nation's research capacity around issues of health disparity.

Pittsburgh hosts VA research

Some of the most important federal research on health disparities is occurring through the U.S. Department of Veterans Affairs (VA) Center for Health Equity Research and Promotion (CHERP), whose 35 investigators are based in Pittsburgh and Philadelphia. Along with medical researchers, the center also employs social scientists who investigate the impact of such factors as community attitudes and doctor-patient communications.

The VA provides a unique laboratory for studying health disparities. Because all veterans have guaranteed access to VA health care, the problems of access and affordability virtually disappear, and any significant disparities that remain must be due to other causes.

"This is something the VA feels very passionately about," explained CHERP Director Michael Fine. "Within our level playing field [of access to care], we have large databases and access to electronic medical records that enable us to investigate whether health disparities exist and, if so, why."

One VA center study, originally published in 2007, compared White and African American patients hospitalized with a variety of diagnoses. The authors found that African Americans had better mortality rates than Whites at 30 days after discharge but less favorable mortality rates two years later (Volpp and Polsky 2008). These results suggest that, even when different groups have access to the same health care, community-based factors may still affect long-term health outcomes.

Said Ibrahim, associate professor of medicine at the University of Pittsburgh and a member of the VA center's research team, has examined disparities with regard to joint replacement for patients with osteoarthritis. He has found that disparities may be a little smaller within the VA system, but that they still exist.

"African Americans are significantly less likely to consider joint replacement," Ibrahim stated, "because they are more concerned about negative outcomes or complications. Actual differences in patient outcomes are minimal, but African American candidates for joint replacement know less about the treatment and have suspicions that are not consistent with the data. So we are trying to educate and build trust, believing that if African Americans know the chances are just as good as for anyone else, they will be more likely to pursue treatment."

Stephen Thomas, director of the University of Pittsburgh Center for Minority Health, delivers his keynote address at the Academy for Health Equity's first national conference in June 2008, while academy executive committee cochair Thomas LaVeist listens.

Building capacity beyond the government

Thomas LaVeist, professor of health policy and director of the Hopkins Center for Health Disparities Solutions at Johns Hopkins Bloomberg School of Public Health, believes that government action alone cannot effectively combat these discrepancies in health care or health status. "On cancer," LaVeist stated, "you have two legs working in tandem, inside and outside government: the National Cancer Institute and the American Cancer Society. We haven't had that on health disparities."

To fill this gap, Stephen Thomas, director of the University of Pittsburgh Center for Minority Health, and LaVeist have cofounded the Academy for Health Equity, a national organization that hopes to coordinate efforts in the research, policy, and community advocacy sectors.

The Academy for Health Equity held its inaugural conference in Denver on June 26–27, 2008. A multidisciplinary group of 250 people from 30 states heard presentations on issues related to health disparities and endorsed the academy's mission of creating "a social movement designed to ensure equal opportunity for health."

While the field of health disparities has not had a national nonprofit standard-bearer until now, two giants in health care funding, the Robert Wood Johnson Foundation and the W.K. Kellogg Foundation, have made significant long-term investments in this area. The Robert Wood Johnson Foundation has sponsored an issue of the medical journal *Health Affairs* (March/April 2008) devoted fully to the topic of health disparities. The foundation also has launched the Commission to Build a Healthier America (www.commissiononhealth.org), a two-year effort to focus on the social factors that negatively affect Americans' health and determine policy recommendations.

The Kellogg Foundation has invested more than $20 million to train 150 scholars with an interest in health inequities. These scholars "are moving into universities all over the country to teach about the social determinants of health and about ways to reduce health inequalities in the United States," explained Barbara Krimgold, director of the Kellogg Health Disparities Scholars Program. "These scholars are largely from underrepresented minority groups whose voices have often been absent from the discussion." The University of Pittsburgh Center for Minority Health has been a Kellogg training site since 2006.

At a more popular level, the Public Broadcasting Service (PBS) sought to raise public awareness through a four-hour television series called *Unnatural Causes*. The programs, which aired in spring 2008, featured a diverse group of American communities to show how health status is inextricably tied to social and economic conditions. One episode probed why Mexican immigrants, despite their lower socioeconomic status, are

actually healthier than the average American when they arrive in this country but lose their advantage over time; long work hours and social stresses appear to erode family cohesion, while fast food and lack of health insurance also help to make America more toxic from a public health standpoint. Another segment highlighted what a lower-income Seattle neighborhood has done to combat negative health impacts—rebuilding a public housing community to include a health clinic, library, gardens for growing produce, and ventilation improvements to reduce the high prevalence of asthma.

A Web site (www.unnaturalcauses.org) contains transcripts from the PBS programs and seeks to continue the impact of the television series through resource links, case studies, and an action toolkit. Locally, the Center for Minority Health hosted a town hall meeting, broadcast on WQED-TV, to view *Unnatural Causes* and discuss regional solutions.

4. STATE-LEVEL EFFORTS

The 1985 federal report on health disparities spawned responses at the state level as well. Ohio was the first state to respond institutionally, forming its own task force on minority health in 1986. In the following year, that state's legislature created the Ohio Commission on Minority Health, an independent agency specifically tasked to address the problem of health disparities.

In this recent wave of interest in minority health, Cheryl Boyce, executive of the Ohio commission, is one of the old-timers. "I was committed to improving the health status of disadvantaged populations before anyone assigned this work a name," said Boyce, who began her career at a community health center in impoverished East St. Louis, Ill., in 1971 and entered the field of health policy after deciding that there were too many "people doing administration and policy who had never done direct service."

As the founding director of the commission, Boyce began by identifying leaders throughout the state, funding innovative programs, and institutionalizing the successful ones. Early capacity-building grants helped to build lasting organizations like Adelante, a nonprofit that promotes healthy living in Toledo's Latino community, and enabled fledgling volunteer medical outreach programs to become established as federally funded community health centers. In 1989, the commission began celebrating April as Minority Health Month, a designation that has since spread nationally.

During the last 20 years, virtually every state has followed Ohio's lead and created an office specifically dedicated to minority health or health equity, but without much national coordination. In 2007, these offices came together to form the National Association of State Offices of Minority Health (NASOMH). Boyce chairs the association; its first director, Joy Smith, formerly worked in Missouri's state office.

"When you've seen one office of minority health—well, you've seen only one, because there is little standardization as to what they do," Smith noted. NASOMH hopes to establish more consistent standards as to what state offices can do. She emphasized that, to work effectively, offices of minority health need policymaking authority within state government, access to health data, and strong connections with local minority communities.

Smith pointed to North Carolina's Office of Minority Health and Health Disparities (OMHHD), created in 1992, as an example of a mature, effective agency. OMHHD's agenda encompasses five areas: research, cultural competency training, policy development, collaboration with other involved stakeholders, and advocacy. The office's most striking publication is a "report card" describing North Carolina minority groups' statistical performance on several dozen health measures relative to the statistics for Whites. A ratio of 2.0 or greater (e.g., infant mortality twice the White rate) gets a grade of D, and a ratio of 3.0 or more gets an F. The report card, last updated in 2006, highlights the most glaring gaps and helps policymakers and other stakeholders to set action priorities.

Pennsylvania is a relative latecomer to the movement. Governor Edward G. Rendell created the Office of Health Equity within the state health department's Bureau of Health Planning in 2006. In 2007, he signed an executive order making it a stand-alone office that reports directly to a deputy secretary. That move "gave the office increased visibility and the ability to achieve goals," said Jamahal Boyd, who became its director in February 2008.

The Office of Health Equity has conducted a Workforce Diversity Initiative, awarding grants to entities that plan to promote health careers among minorities and/or to enhance the cultural competence of those treating minority patients. "I don't think you have to be an African American doctor to understand or communicate with an African American patient," Boyd explained, "but being part of the same culture eliminates the learning curve." Another priority of his office is to expand the pool of trained medical interpreters available to assist patients with limited English skills—not a frequent concern yet in Southwestern Pennsylvania, but a pressing problem in Lancaster, Allentown, and Philadelphia.

While Pennsylvania's efforts to end health disparities did not have a bureaucratic home until 2006, they have been visible since 2001 in another health department activity: the allocation of funds received through the state's settlement with tobacco companies. Solicitations for competitive health research grant projects funded through this source have asked applicants to indicate how their work will reduce or eliminate health

Phil Hallen (left), president emeritus of the Falk Foundation, and Donald Burke (right), dean of the University of Pittsburgh Graduate School of Public Health, greet volunteers staffing barbershop outreach on Take a Health Professional to the People Day.

disparities. In addition, since fiscal year 2005–06, applicants have been required to include collaboration with a "minority-serving academic institution." This requirement has resulted in a large number of partnership opportunities for Cheyney and Lincoln, the state's two historically Black universities.

According to Patricia Potrzebowski, director of the health department's Bureau of Health Statistics and Research, the academic partnership provision has incorporated Cheyney and Lincoln students into numerous research projects based at other institutions, and some of these students have continued on into graduate programs in health research. In order to make this opportunity available to more organizations, the requirement has been broadened to permit grant applicants to collaborate with a minority-serving community organization as well as with Cheyney or Lincoln.

5. LOCAL-LEVEL INITIATIVES WITH NATIONAL IMPLICATIONS

There is ample evidence of the need for systemic "upstream" interventions to address the plethora of social factors that contribute to health disparities—housing, crime, air quality, education, work conditions, grocery access, health insurance, and more. But those who care about improving lives today can't wait for all the systemic inequities to disappear. In Pittsburgh, visionary leaders have achieved impressive changes by working at the community level, showing that the ties between socioeconomic status and health status can be severed.

Community engagement and research: The Healthy Black Family Project

"Run to your neighborhoods … the poorest, most depressed neighborhoods," Stephen Thomas, director of the University of Pittsburgh Center for Minority Health (CMH), told a congressional hearing in December 2007, "and start organizing, because that is where the action is" ("Reducing" 2007). Thomas knows what he is talking about, for his organization has pioneered innovative, enormously successful outreach programs aimed at improving minorities' health status.

In 2001, the U.S. Department of Health and Human Services launched the annual Take a Loved One to the Doctor Day as a means of focusing attention on minority health issues. Starting in 2002, Thomas and CMH have gone one better—rather than waiting for people to come to doctors, CMH brings doctors to them by holding Take a Health Professional to the People Day twice a year. On those dates, medical professionals come to participating barbershops and hair salons in African American neighborhoods to provide health screenings and distribute health information.

For one day, Big Tom's Barbershop is among the locations in Pittsburgh's Hill District that become sites for prostate screenings and other medical checkups.

CMH staff carefully lay the groundwork for these interactions in advance. They educate barbers on medical issues, and the barbers introduce participating White physicians and nurses to the cultural norms and behaviors they will encounter at the barbershop. The project has succeeded in getting African American men to discuss openly health concerns that they might not have taken to a doctor, such as getting tested for prostate cancer. As Thomas puts it, in many minority communities "a barber may have more credibility than a doctor."

In 2004, CMH initiated the Healthy Black Family Project, an ambitious grassroots effort to reach African Americans in Pittsburgh's East End and the adjacent borough of Wilkinsburg. The project established operations at two existing community organizations: the Kingsley Association in Pittsburgh's East Liberty neighborhood and Hosanna House in Wilkinsburg. At each site it offers individualized health risk assessments; fitness coaching; exercise groups; and classes in stress management, nutrition, and smoking cessation. The project installed exercise equipment at both locations, providing fitness opportunities to people for whom commercial health clubs are geographically and financially out of reach. Individuals may register free by simply filling out an enrollment card. CMH also has recruited through churches and community organizations.

Hundreds of people have participated in Healthy Black Family Project screenings and provided their health histories for genetic counseling; overall, an amazing 6,000 people have signed up for the project and about 4,000 have participated actively in some way. The project has now expanded its programming to additional neighborhoods of inner-city Pittsburgh.

Bringing Health Professionals—and Trust—to the People

On September 18, 2008, the University of Pittsburgh Center for Minority Health conducted its seventh annual fall Take a Health Professional to the People Day. On that day, at nine barbershops and hair salons in minority neighborhoods of Pittsburgh, blood pressure tests outnumbered haircuts and stylings.

Approximately 200 health professionals spent at least part of the day staffing health outreach at these nine locations. They conducted more than 700 blood pressure screenings; 150 depression screenings; and dozens of lung function tests, echocardiograms, and prostate tests. The following anecdotes, told by participating health professionals, reflect the depth of the day's impact.

"We met several people who are already in treatment for serious mental health issues. In one case, a female admitted feeling so depressed that she felt life was not worth living on three of the past seven days. We spent time providing psychoeducation about contacting her psychiatrist when things get that bad, and we educated her about the use of any emergency room if she becomes suicidal. Although this participant is in her 40s and has long been involved with mental health treatment, this information seemed novel to her. She was under the impression that she just needed to wait (and suffer) until her next appointment with the psychiatrist in three months."

"I met a gentleman in his 60s who had lost his wife, his mother, his job, and his home all within a few months. Seven years later, he's still suffering and struggling. When I explained that the Healthy Black Family Project had a program to address stress in older adults, he replied, 'I never would have thought that there was something like this. I thought it was normal to feel this way.' He was honestly surprised to learn that help is available."

"This project is changing people's lives in a very real way," Kingsley Association Executive Director Malik Bankston said in a 2007 WQED-TV television interview. "The people who come to this program aren't gym rats; they are ordinary folks who have all kinds of infirmities, disabilities, aches and pains, but [they're] also people who have taken an active interest in and responsibility for figuring out what they can do to improve their quality of life. This project offers an opportunity. It doesn't require you to be an Olympic athlete, but it does get you up and running."

Hosanna House Executive Director Leon Haynes believes that the partnership has been ideal for his agency, which opened an on-site family health center in 1994 and has conducted various community health initiatives since then. "The Healthy Black Family Project has brought out people who would not normally come for an exercise program or to get health and wellness information," Haynes said. About 75 percent of the project participants at Hosanna House are females age 45 or older.

"The Center for Minority Health has built a research infrastructure from which meaningful programs can be launched, measured, and evaluated," said former Pennsylvania Secretary of Health Calvin Johnson. "It is giving us a clear programmatic model of how to make a difference in eliminating disparities."

Thomas deflects the credit for the Healthy Black Family Project's astounding results to the community organizations and participants. "The community owns this project," he stated. "Our job is to stay out of their way and watch it grow and to learn as much as we can so that Black people around the country can benefit from what we are learning in Pittsburgh."

Centers for Healthy Hearts and Souls

Bruce Block and Mattie Woods have spent the last 10 years seeking to reduce inner-city health disparities by building trust. They are the medical director and executive director, respectively, at the Centers for Healthy Hearts and Souls (www.healthyheartsandsouls.com), a faith-based effort to promote wellness in Pittsburgh's minority communities.

As director of the family health center at Shadyside Hospital (now UPMC Shadyside), Block tried to make the care he offered to inner-city patients "better than what anyone else could get" but realized that, no matter what he did at the clinic, "health happens between visits." As a result, he envisioned a wellness program that would reach beyond the health center's walls and into the community.

At their inception, the Centers for Healthy Hearts and Souls (CHHS) hired Woods, formerly with Allegheny County's Healthy Start infant mortality program, to be their community liaison. Woods drew on her existing relationships with inner-city churches, which Block considered "the most viable institutions available in these communities," to build trust and generate interest in health promotion. The original funders (Highmark and Shadyside Hospital Foundation) asked Woods to establish partnerships with at least three churches; she exceeded expectations by bringing 50 congregations into a network of health ministries. In response to the priorities indicated on community surveys, the center created culturally sensitive programs on smoking cessation, exercise programs, and diabetes support groups.

The community outreach has been enormously successful. "No longer can the health care institutions say these people don't care about their health," Woods said. "I can show you pictures of 400 people trying to get to a table to complete a health survey." Woods believes that when diabetes patients trained in the support group "go to the doctor with forms and say they need their hemoglobin A1C count, the physician looks at them differently."

To address further the cultural divide between patients and physicians, CHHS created dramatizations illustrating problematic doctor-patient contacts. In one of them, a physician assumes that a man wearing gold jewelry must be a drug dealer and is reluctant to treat him; in another case, the doctor dispatches a nurse to announce a cancer diagnosis to a patient rather than telling the patient himself.

Meanwhile, Block worked to make his own primary care site more inviting. He added evening hours, gave free bus passes to people at risk, offered free immunizations, and initiated regular follow-up calls to patients with hypertension and diabetes. The results have been impressive: The no-show rate at Block's clinic has been cut in half, and CHHS participants have shown improvement on both physiological and attitudinal measurements.

CHHS receives financial support from the Center for Minority Health (CMH) and benefits from CMH's public awareness activities. Block hopes his organization's advocacy also can help to break down the traditional "colonial relationships" that have muted needy communities' influence over how the programs that serve their neighborhoods operate.

Philanthropy matters

Like Barbara Krimgold at the Kellogg Health Scholars Program, the local foundation community has recognized the multifaceted nature of the health equity problem. "We understood that, to make a measurable difference in health disparities, we would have to address the problem from several related perspectives," said Kevin Jenkins, the Pittsburgh Foundation's senior program officer for health and special needs.

Pittsburgh Foundation grantmaking in this sector has encompassed community-based, scientific, and academic initiatives. In addition to funding the Healthy Black Family Project,

the foundation has helped Pittsburgh Theological Seminary to establish a Healthy Church Network, supported the Health Disparities Scholars Program at Pitt's Graduate School of Public Health, helped to make primary care available to people seeking to become involved in disease prevention programs who do not have a doctor, and funded the hiring of an epidemiologist within the Allegheny County Health Department to track progress in addressing health disparities. The Pittsburgh Foundation has convened a board of nationally prominent evaluators to assist in evaluating its investments and to inform the Center for Minority Health's work.

"Opportunities to improve health can be accomplished by every organization or entity that touches people's lives," Jenkins said. "There are health implications in all sorts of activities that are not necessarily identified as health related. Health promotion and disease prevention strategies, such as making better foods available, can be woven into myriad services that organizations traditionally offer."

The DSF Charitable Foundation also has made a major investment in the Healthy Black Family Project. "We made this a high priority because we recognized the severity and urgency of the disparities problem and because we found the proposed approach compelling," explained foundation Executive Director Nick Beldecos. "Particularly important was the intent of the project to take a culturally tailored approach, drawing on inherent strengths and resources of the communities targeted."

Beldecos sees in the project a "pathbreaking social movement in health promotion. Research published in the *New England Journal of Medicine* [Christakis and Fowler 2007] found that obesity appears to spread through social ties; if your friends are overweight, you are likely to be as well. The Healthy Black Family Project appears to have demonstrated the inverse of this relationship: If your friends reduce their weight by engaging in health-promoting behaviors, you are likely to do the same."

Disparities awareness in Louisville

Louisville, Ky., has become familiar to many Allegheny County civic leaders as a possible model for city-county consolidation. One interesting initiative that emerged after Louisville's consolidation was an innovative countywide analysis of health disparities.

The Louisville Metro Department of Health and Wellness conducted a survey on health risk factors and analyzed it geographically, grouping contiguous council districts into five regions of the county. The graphic illustration of health outcomes had a powerful impact, explained health department Planning Director Sheila Andersen—especially, but not only, in lower-income districts.

"One council member," said Andersen, "was shocked to find his district in the darkest color on the maps of mortality rates and spent his discretionary money to hold a health fair. We found more areas with high infant mortality than we had realized and expanded Healthy Start to cover these areas. We also found high levels of hypertension and heart disease in upper-income areas where people drive everywhere and are not physically active. And nobody's where they should be on eating fruits and vegetables."

Andersen recommended that urban health departments publicize subregional breakdowns of data, as well as make health status comparisons with other cities, to inform health improvement priorities.

Changing the local food environment

Obesity and diabetes, two major health risks that disproportionately affect lower-income and minority communities, particularly flourish in neighborhoods that have limited access to healthy foods (California Center for Public Health Advocacy 2008). Amparo Castillo of the University of Illinois at Chicago has described an effective grassroots effort to transform southeastern Chicago from a "food desert" into a community better positioned to promote healthy eating and disease prevention ("Reducing" 2007).

As Castillo explained, an initial study of the neighborhood found 28 stores selling tobacco and alcohol but only three that offered any fruits or vegetables. With strong support from the local chamber of commerce president, community business meetings began providing fruit and water rather than coffee and doughnuts. Stores and restaurants received financial incentives to try marketing healthier foods. These efforts on the supply side, combined with public education encouraging residents to change their eating habits, have resulted in greater availability of healthy foods.

6. ACADEMIC INITIATIVES

Research on health disparities suggests that cultural gaps between medical professionals and minority communities contribute to the problem. Training institutions can bridge this gap by recruiting more minorities into health science fields or by increasing the cultural competence of health professionals who work with minorities.

Richard Steinman of the University of Pittsburgh School of Medicine has been opening doors for promising African American students since 2001, when he received a grant from a National Cancer Institute program to foster relationships between cancer research centers and historically Black colleges and universities. Steinman set up a laboratory at Hampton

University in Virginia, seeking to involve biology students in cancer research, and began teaching some Hampton students through a combination of on-site visits and videoconferences. "Before that, the Hampton biology department was strictly focused on teaching," Steinman recalled. "Even some of the faculty started using our lab for research."

Approximately 60 Hampton students have completed Steinman's research-based curriculum, and 18 of them have come to Pittsburgh for summer research projects. Most of these students, Steinman said, have gone on to research careers or medical school. In addition, Hampton faculty have collaborated in Pitt research studies on epidemiological oncology—that is, the factors contributing to the prevalence of cancer. According to Steinman, the education has been "bidirectional," in that Pitt researchers and physicians also have become more attuned to racial disparities in cancer outcomes.

The low number of minority students entering medical school leads to a comparable underrepresentation of minorities among health care researchers. Said Ibrahim of the Pitt medical school knows the problem of getting more minorities into medical school is beyond his scope, so he has zeroed in on a different bottleneck: equipping physicians to become researchers.

"We have decided to recruit young minority health professionals who are early in their careers," Ibrahim explained, "and give them nine months of focused training and mentoring that will allow them to write competitive grants to the National Institutes of Health or other funding sources. This step will increase diversity in health care research, which I believe is necessary to make our health care system more responsive to all people." Ibrahim's program graduated its first three students in 2008.

At Pitt's School of Nursing, two faculty members each year attend the University's program on cultural competence, with the specific goal of revising their course curricula to address cultural gaps and health disparities. "I think it is our obligation, as educators in the health professions, to educate students in the factors that contribute to health disparities in our country and in the world," said School of Nursing Dean Jacqueline Dunbar-Jacob.

Stephen Thomas has observed that the Healthy Black Family Project has not only encouraged African Americans to pursue better health but also has served as a practical education experience for White physicians. When he began holding health screenings at barbershops and beauty salons, Thomas recounted at last December's Congressional Hispanic Caucus hearing, "All of a sudden we have these health professionals, 99 percent of whom are White and have never been in a Black barbershop, engaging people in settings that they trust" ("Reducing" 2007).

The renowned Mayo Clinic in Rochester, Minn., sends physician and scientist scholars to Pittsburgh for a week of immersion in Take a Health Professional to the People Day and other Center for Minority Health activities. The aim is to help these scholars, enrolled in the Mayo Graduate School master's program in clinical research, increase their understanding of existing health disparities, enhance their cultural competence and confidence, and improve their ability to engage communities in research collaboratively and productively (see Coles 2008).

7. POLICY RECOMMENDATIONS

Health disparities are a multifaceted problem, with potential solutions ranging from federal policy change to grassroots outreach. There is some debate as to where to start; for example, a recent article coauthored by former U.S. Surgeon General David Satcher, emphasizing community-based approaches, provoked a vigorous reply from a Tufts University professor who faulted the authors for overlooking socioeconomic causal factors (Satcher and Higginbotham 2008; Schlaff 2008). But others feel that all the factors—whether related to individual behavior, community culture, or the broader social and policy environment—can be attacked in complementary fashion.

Barbara Krimgold of the Kellogg Health Scholars Program believes that the U.S. emphasis on funding medical treatment over prevention has created a barrier to the elimination of health disparities. "In Washington, D.C., policy has primarily followed the money, so health policy has been focused largely on the organization and financing of medical care, and public health has been relatively neglected," Krimgold said. "But I think this is changing, both because of the deterioration of our health care system and also because of the growing awareness that the United States is not getting much bang for the buck. We are spending more of our gross domestic product than other industrialized countries without getting better health outcomes."

Nick Beldecos of the DSF Charitable Foundation seconded Krimgold's diagnosis, stating, "Our health-related expenditures are skewed far in the direction of acute care. We clearly need to move further in the direction of prevention and health promotion." Beldecos recommended expanding reimbursement eligibility for "demonstrably effective health promotion and disease prevention activities."

Bruce Block also bemoaned that the bias toward funding medical care and research rather than prevention or community intervention continues despite wide recognition of the behavioral and community-based factors that affect health. "The confusion between medical care and health remains," he said.

From a policy perspective, Block would support a taxpayer-funded community-based health system empowered to make regional decisions about health care resource allocation. But because he doesn't expect that policy reform to occur soon—

"there isn't a high enough level of suffering among the children of legislators," he noted—he recommended a smaller-scale emphasis on community empowerment. "Agencies think that if they put together a program, it's the same as if it were run by a community organization," Block said. "Few of them understand that when people run their own programs, something different happens. If you expect communities to take responsibility for their own lives, you have to give them the opportunity to fail."

Thomas LaVeist agreed with Block on the futility of waiting for national policy to change. "We can't even figure out how to insure 45 million people," LaVeist said, "so an approach that focuses only on the national level is certain to fail. But, in the meantime, we have 50 states with the ability to structure their own health systems in somewhat different ways, adopting different policy approaches and learning what works or doesn't work. So let's take advantage of the situation—letting local initiatives evolve and bringing successful ones up to the national level, while at the same time we pursue political mechanisms to produce systemic change."

LaVeist offered several other proposals to address health disparities at various levels:

- A national program that would let people access primary health care when they need it rather than at the emergency room
- Requiring training in cultural competency for health care providers as a condition of their licensure
- Continued funding of research and of the *National Healthcare Disparities Report*
- Mandating that health care providers report outcome data by race and ethnicity

Cheryl Boyce said that there have been many noteworthy successes at the community level but that community-based organizations can go only so far without policy support. "Is our goal to have services funded episodically [e.g., by grant programs] and then get people jaundiced because the services come and go, or is there a strategic effort?" she asked rhetorically. "We set national goals but without changing policy and providing resources; as a result, there is no national system to support efforts to eradicate health disparities."

Pennsylvania Office of Health Equity Director Jamahal Boyd echoed Boyce's perspective: "Programs are great, but programs are not sustainable; policy drives change. If you do a health fair today, no one will remember it 10 years from now; if you put a policy in place that mandates steps to address health equity, programs will be born out of that policy and will be more sustainable because we have all agreed that this is what should be done."

At the community level, Dave Brewton of the East Liberty Family Health Care Center, which has provided faith-based primary care services in Pittsburgh's East End since 1982, emphasized the need to bridge the trust gap between doctors and minority communities through long-term commitment. "Black doctors are hard to find," Brewton observed. "We have just one part-timer. But in the absence of minority physicians, you can get over the racial wall if you have doctors who are here out of a sense of call. If you look at our physician retention rate, you see their long-term commitment; they stay here and build unconditional relationships with their patients. As a result, the patients develop trust and comply with their physicians' recommendations."

Richard Steinman stressed another often-overlooked contributing factor to health disparities: communication and worldview gaps between the medical and popular communities. "Many of the highest-profile recommendations in the medical community do not make sense within the context of how high-risk individuals interpret the causation of disease," Steinman stated. "Some people think that cancer is a punishment from God, or that a positive outlook will cure it, or that if you have a lump but it doesn't hurt it can't be cancer. Some think that being around other people with cancer can cause you to get the disease, so they don't want to sit in a waiting room for mammography. In one study of men with stage one lung cancer (which can be cured surgically), 15 percent of African Americans—compared to just 6 percent of Whites—refused surgery on the basis that they thought surgery would cause the cancer to spread."

These misconceptions, Steinman continued, often lead lower-income people and minorities to wait longer before seeking treatment. As a result, their treatment outcomes are poorer and their communities' distrust of medical interventions is reinforced: "They may have presented themselves for treatment too late, but the perception is that they went into the hospital and something bad happened to them." Steinman's efforts to improve community health literacy have included the development of educational video for the general public and a board game for middle school students.

Whatever their preferred solutions, the experts agree that health disparities cannot be ignored; on the contrary, as U.S. minority populations continue to increase, these inequities become a growing threat to drag the nation's health system down. As Boyce stated it, "Disparities are not a low-income or a racial/ethnic problem, they are an 'all of us' problem. If we don't get a handle on this problem soon, it will become the face of public health in our country."

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