Center for American Progress

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Equal Health Care for All

Opportunities to Address Health Care Disparities in Health Care Reform

Dr Lesley Russell, Visiting Fellow December 2009

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Contents

1 Executive summary

3 Introduction

5 The causes of health care disparities

7 The consequences of health care disparities

10 Opportunities to address health care disparities in health care reform

20 Conclusion

21 Appendix 1: The extent of racial and ethnic health care disparities

24 Appendix 2: Trends over time

26 Appendix 3: What works and current efforts in addressing health care disparities

28 Appendix 4: Comparison of current health care reform bills and proposals

30 Endnotes

Executive summary

The current efforts to reform the health care system provide a unique opportunity for Congress to address the disparities in access to services and quality of services that many racial and ethnic minorities in the United States experience—particularly African Americans, American Indians and Alaska Natives, Hispanics, Native Hawaiians, and Pacific Islanders. These disparities are not just a consequence of lower socioeconomic circumstances, less education, and less-than-adequate health insurance coverage. They at some level appear to reflect biases and stereotyping inherent in the health care system and in individuals. And they are a consequence of a lack of culturally competent care.

Health care disparities generate a significant human and economic cost that is borne directly by the individuals involved and indirectly by all Americans. As minorities become an increasing percentage of the American population, their health status will increasingly define the nation's health, and the costs of failing to tackle health care disparities will result in higher total health care spending. Addressing these disparities is also an issue of social justice that can be regarded as a moral imperative.

The health care reform bills currently under consideration in Congress make important contributions toward addressing racial and ethnic health care disparities. Particular initiatives that will help close the gap include:

- Expanding health coverage to as many people as possible, and providing financial assistance to help those with lower incomes purchase coverage.
- Improving access to primary care and "medical homes" to ensure a regular source of care and care coordination.
- Focusing on disease prevention and health promotion.
- Reauthorizing the Indian Health Care Improvement Act.
- Enhancing the quality of health care services.
- Improving the diversity, cultural competence, and distribution of the health care workforce.
- Expanding access to community health centers.
- Collecting data to better measure the effectiveness of these initiatives.

But these measures alone are insufficient for the task at hand. Additional efforts are needed, including:

- More research to better understand the underlying causes of health care disparities.
- Programs and incentives to ensure that all Americans receive the recommended care and treatment, regardless of race or ethnicity.
- Initiatives to tackle bias and stereotyping in the health care system and in the health professional-patient encounter.

These additional efforts, beyond those in the bills currently under consideration, are crucial to ensuring that data are not just collected, but analyzed and used to inform policy and programs, that programs are better targeted, and that we address the cultural issues that may adversely affect the care minorities receive. The goal is a health care system that is focused on ensuring that all Americans have access to quality care when and where they need it, regardless of race and ethnicity.

There are a number of opportunities to address these issues as the health care reform bills proceed. Congress should regard the goal of closing the disparities gap in health care access and quality as an essential and central objective of health care reform.

Introduction

Individuals all experience variations in health care access and quality. But certain population groups—based on race, ethnicity, socioeconomic status, and special health needs—routinely receive less adequate care. The Institute of Medicine defines this disparity as a difference in treatment provided to members of different racial or ethnic groups that is not justified by the underlying health conditions or treatment preferences of patients.[1]

One in three residents of the United States self-identifies as African American, American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, Hispanic/Latino, or multiracial.[2] The proportion of minority groups within the U.S. population is growing rapidly. About half of the U.S. population will be made up of those who are now minorities by 2042,[3] which means that their health status increasingly defines that of the nation.

The 2003 Institute of Medicine report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" remains the seminal evaluation in this area. It highlighted the fact that racial and ethnic minorities tend to receive lower quality health care than nonminorities even when controlled for access-related factors such as insurance status and income. The sources of these disparities are complex; they are rooted in historic inequalities; perpetuated through stereotyping and biases in the health care system, health care professionals, and patients; and aggravated by barriers such as language, geography, and cultural familiarity.

Relatively little progress has been made toward the goal of eliminating racial and ethnic disparities. The mortality rate for African Americans is approximately 1.6 times higher than for white people—a ratio that is identical to the black-white mortality ratio in 1950.[4]

The Agency for Healthcare Research and Quality's 2008 National Health Disparities Report found that some disparities in health care quality and access have been eliminated over time, but many others have persisted unchanged. The magnitude and pattern of disparities are different within subpopulations, and some disparities exist across multiple priority populations.[5]

The current political efforts to implement health care reform provide a unique opportunity to tackle health care disparities. And there are also many mechanisms available under current federal laws to facilitate changes that will make a significant difference in the lives and health of million of Americans.

This report looks at factors that create and perpetuate disparities in health care access and quality, and analyzes the initiatives in current health care reform proposals from the House and the Senate that will address these factors and help close the disparity gap.

The causes of health care disparities

The factors that may lead to differences in health care are various and interrelated. Groups have different underlying rates of illness due to genetic predisposition, environmental factors, or lifestyle choices. They express different types of care-seeking behavior due to cultural beliefs, linguistic barriers, and trust in health care providers. And all these factors are influenced by an individual's ability to pay and the location and management of health care services.

Race and ethnicity are significant factors in determining whether an individual receives care, whether an individual receives quality care, and in determining health outcomes. Even after adjustment for insurance status and income, racial and ethnic minorities tend to have less access to healthcare and receive lower quality care than nonminorities.

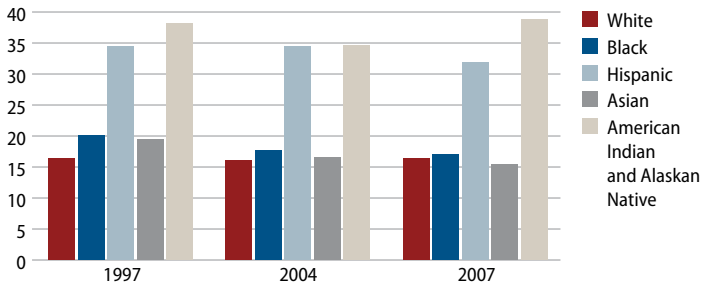
Racial and ethnic disparities in health persist even when comparing groups of similar socioeconomic status. For example, the infant mortality rate for the babies of college-educated black women is higher than that for white women with similar education.[6]

This is not an issue confined to the United States; differences in mortality and morbidity across ethnic groups are a dominant feature of all developed countries, and have been documented in the United States, England, Canada, Latin America, and Australia.

Insurance status

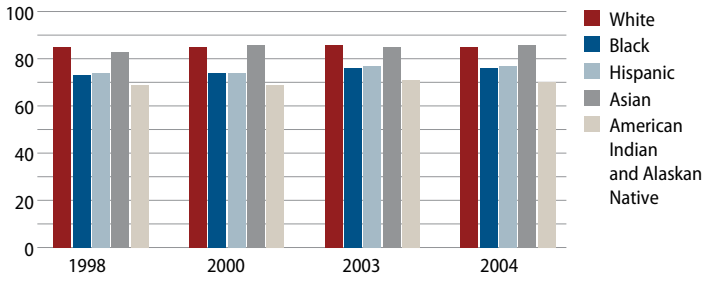
IOM found that insurance status is the primary factor in determining the timeliness and quality of health care, if it is received at all.[7] Among the nonelderly, 31 percent of Hispanics, 32 percent of American Indians/Alaska Natives, 19 percent of African Americans, 18 percent of Asian and Pacific Islanders, and 11 percent of whites are uninsured.[8]

Percentage of population under 65 without insurance by race and ethnicity



The extent of medical care and the location where that care is delivered varies with insurance status. Lack of insurance is associated with less care in all settings except the emergency department.[9] The

Percentage of pregnant women who received prenatal care in first trimester, by race and ethnicity



uninsured receive less preventive care than those with insurance, are less likely to have an early diagnosis of a disease, and receive less care and have higher mortality rates once diagnosed.

Access to primary care and having a medical home

Not having a medical home is related to lower rates of care in all settings.[10] A medical home is defined as a health care setting that provides timely, well-organized care and enhanced access to the range of health providers. When people have a medical home, racial and ethnic disparities in access and quality are reduced or eliminated. Minority patients are just as likely as nonminority patients to receive needed care, obtain preventive screening, and have chronic conditions managed appropriately.[11]

Good primary care experiences are associated with reductions in the adverse effects of income inequality on health.[12]

Access to culturally competent care

Clear communication is essential to healthy patient outcomes, even when there is no language barrier. At least 66 million patient-provider encounters occur across language barriers each year.[13] Without interpreter services, these patients have a more difficult time obtaining medical services, receive lower-quality health care, and have a greater chance of experiencing negative health outcomes. As many as one in five Spanish-speaking Americans report not seeking medical care because of language barriers.[14]

Research suggests that health care providers' diagnostic and treatment decisions, as well as their feelings about patients, are influenced by patients' race or ethnicity.[15] Several studies have shown that racial concordance is substantially and positively related to patient satisfaction, although it is not essential for patient satisfaction.[16]

A 2007 report that looked at cultural and linguistic services in hospitals found that there is much that needs to be done to address cultural and linguistic barriers, particularly in the areas of language access services, informed consent and related patient-education processes, and the collection and use of patient demographic data.[17]

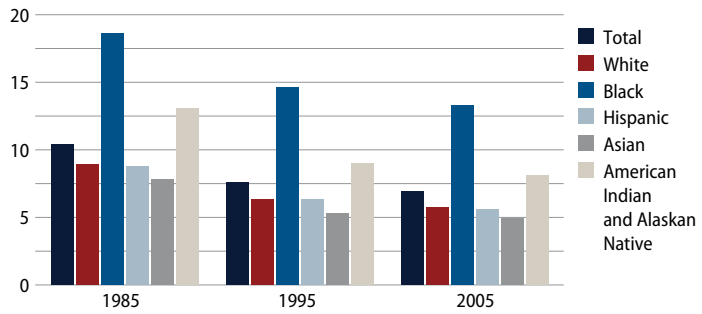
The consequences of health care disparities

Racial and ethnic minorities in the United States experience poorer health relative to national averages from birth to death in the form of higher infant mortality, higher rates of disease and disability, and shortened life expectancy. And all Americans bear the social and economic costs.

Infant mortality

Infant mortality is one of the most important indicators of the health of a nation, as it is associated with a variety of factors such as maternal health, quality of and access to medical care, socioeconomic conditions, and public health practices.

Infant mortality rate: deaths per 1,000 live births, by race and ethnicity

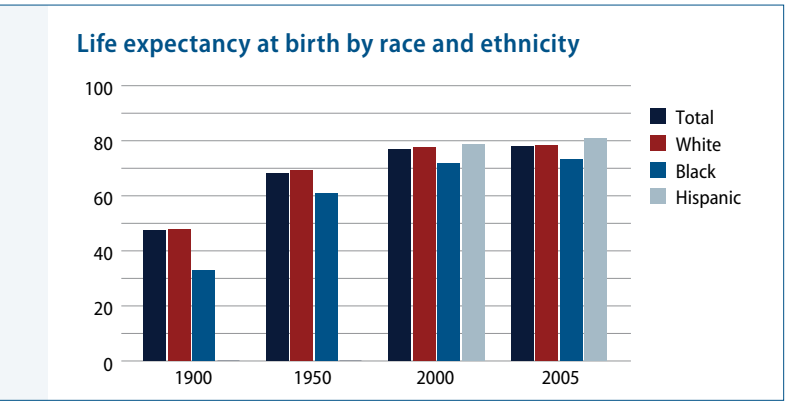


The U.S. infant mortality rate did not decline significantly from 2000 to 2005, which has generated concern among researchers and policy makers. In fact, the U.S. infant mortality rate is higher than those in most other developed countries. The gap between the U.S. infant mortality rate and the rates for the countries with the lowest infant mortality appears to be widening,[18] and there are large disparities in infant mortality rates among racial and ethnic groups in the United States.[19]

Infant mortality rates in 2005 were above the U.S. average (6.86 infant deaths per 1000 live births) for African American (13.63) and American Indian/Native Alaskan (8.06) women. Infant mortality rates for white (5.76), Asian and Pacific Islander (4.89), and most Hispanic (5.53 - 4.42, depending on country of origin) women were below the national average, although the rate for women from Puerto Rico (8.30) was higher.[20]

Life expectancy

Life expectancy is a measure that can be used to gauge the overall health of a population. Life expectancy at birth is strongly influenced by infant and child mortality. Life expectancy later in life reflects issues such as access to health care, advances in medicine, and lifestyles.



Life expectancy at birth in 2005 was 76 years for white males compared with 70 years for African-American males, and 81 years for white females compared with 77 years for African-American females. The gap between men and women is markedly greater in African Americans (6.9 years) than in white Americans (5 years).[21] American Indians and Alaska Natives have a life expectancy at birth that is 2.4 years less than the average life expectancy for all Americans.[22]

The Hispanic population has the lowest levels of access to health care service and lower average incomes and educational levels, yet appears to have higher life expectancies than the more advantaged white American population. The National Center for Health Statistics released a study in 2008 showing that the overall mortality rate for Hispanics in 2006 was 550 deaths per 100,000 people, compared to 778 for white Americans, and 1,001 for African Americans.

Research suggests that factors such as diet, lifestyle choices, and strong social support networks contribute to Hispanics' longer life expectancy.[23] Yet Hispanics' lack of access to quality health care will surely have implications as this population group ages and assimilates. Indeed, this can already be seen in the rapid rise of obesity and Type 2 diabetes in Hispanic children and adolescents.[24]

Burden of disease

Racial and ethnic minorities are burdened with a higher level of chronic illnesses, which diminishes their productivity and quality of life.

A study done in 2005 found that, relative to white Americans, African Americans suffer 67,000 more deaths annually, resulting in 2.2 million years of life lost.[25] This figure drops to 1.1 million years after adjustment for socioeconomic status. Socioeconomic differences between African Americans and white Americans appear to explain the entire health-related quality of life disparity, but only half the mortality disparity. A second analysis using 1991-2000 data concluded that over 880,000 deaths would have been averted if African American mortality rates been equivalent to that of white Americans during this time period.[26]

The heart disease death rate is 20 percent greater and the stroke death rate is 14 percent greater among American Indians and Alaska Natives than the U.S. average for all races. And American Indians and Alaska Natives die from heart diseases at younger ages than other racial and ethnic groups; 36 percent of those who die of heart disease do so before

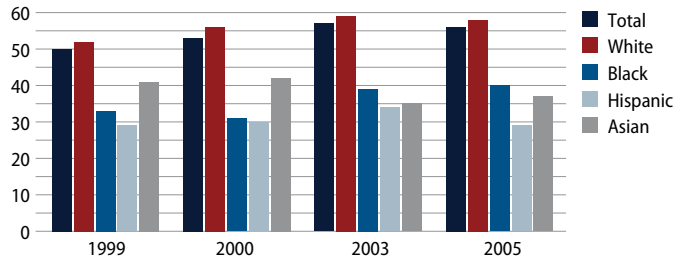
age 65.[27] Diabetes is a major risk factor for heart disease, and the prevalence of diabetes among American Indians and Alaska Natives is more than twice that for all adults in the United States.[28]

Economic and social costs

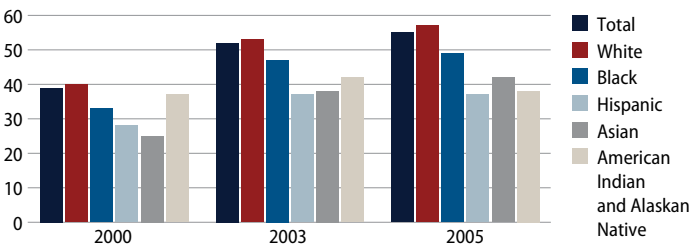
Eliminating current health disparities would decrease the costs associated with the increased disease burden borne by certain population groups. All Americans bear these costs through taxes paid for public health care programs and through cost shifting from the uninsured. A recent report from the Joint Center for Political and Economic Studies shows that the cost to the nation of health disparities is approximately $413 billion annually.[29]

Investments made in focusing prevention and early intervention efforts on people who are at higher risk for disease could produce dollar savings, reduce mortality and morbidity, increase productivity and quality of life for these populations, and lead to better allocation of public resources.

Percentage of noninstitutionalized adults aged 65+ who received pneumococcal vaccination, by race and ethnicity



Percentage who have had a test for colon cancer, by race and ethnicity



This will require collecting of data by population and/or priority group. This will enable the federal government to identify populations with special needs, generate hypotheses about potential causes, develop appropriately targeted programs and interventions, and track and evaluate progress in addressing these disparities.

Opportunities to address health care disparities in health care reform

The advances in health outcomes and health care access over the past century are unquestionably due in substantial part to government initiatives such as Medicare and Medicaid. Yet it still remains that not all Americans have the same opportunities for health, access to care, or quality of care. The level of awareness about health disparities has risen among both policy makers and health care providers, but there is no real consensus on how to address this and little information on which to base policy decisions.

Policy often focuses on reducing health care disparities through interventions at the patient-provider level. This is unquestionably important, but it is also critical to work on systemwide reforms to reduce the numbers of uninsured, improve geographic availability of services, increase workforce diversity, and promote clinical best practices.

An essential part of health care reform is crafting a system that effectively addresses the disparities and measures progress in that regard. There are a variety of issues in the health care reform bills and proposals currently under consideration that will contribute to alleviating health care disparities.

This analysis considers provisions in the health care reform bills—The Affordable Care for America Act, H.R. 3962, as passed by the House of Representatives on November 7, 2009; and the Patient Protection and Affordable Care Act released by Senate Majority Leader Harry Reid on November 18, 2009—that address racial and ethnic health care disparities and that may, with time, reduce the vast gulf in health status across American sub-populations.

The various provisions are presented in a side-by-side table in Appendix 4.

Expanding health coverage

The IOM report found that insurance status is the most critical factor in addressing health disparities.[30] Having health insurance improves access to health care services, the likelihood of receiving appropriate services, and health outcomes. Continuity of coverage increases the quality of care received.[31] And racial and ethnic minorities are disproportionately represented among the uninsured.[32]

Both bills propose significant expansions of health insurance coverage. Given the substantial link between poverty and poor health, the most important provisions for closing the gap in health care disparities are those that provide expanded coverage under Medicaid.

The Congressional Budget Office estimates that the House bill will reduce the number of uninsured people by 36 million in 2019, thus ensuring that 96 percent of legal residents have insurance coverage.[33] The CBO estimates that Medicaid will cover 15 million additional individuals in 2019. Roughly 21 million people would purchase their own coverage through the new insurance exchanges, and 6 million more people would obtain coverage through employers.

The CBO and the Joint Committee on Taxation found that the Senate bill—as released—would reduce the number of uninsured by 31 million by 2019.[34] This means that about 94 percent of legal residents would have health coverage. Roughly 25 million people would purchase their own coverage through the new insurance exchanges, and there would be roughly 15 million more enrollees in Medicaid and CHIP than projected under current law. In contrast to the House bill, the number of people obtaining coverage through their employers is predicted to decline by about 5 million under the Senate bill.

Minority workers face particular problems in obtaining health insurance through employers. But provisions in both bills that require employer-provided coverage and provide assistance to small businesses to help defray costs will help address this particular disparity.

There will always be a vulnerable segment of the population that is at increased risk for health disparities, no matter how benefits and subsidies are allocated under the health reform bills. It is these populations that the health reform bills can effectively target by requiring outreach and enrollment activities using culturally and linguistically suitable materials. The House bill requires such measures on behalf of individuals who are eligible to purchase coverage through the health insurance exchange.

As a cautionary note, the evidence suggests that children's health declines when family members are covered under different plans and some members have coverage while others do not.[35] This situation also adds to the difficulty vulnerable minority families face in navigating different systems for enrolment and utilization in health coverage. A recent study suggests that unless health insurance coverage models are designed to keep entire families covered, the system will not be sustainable and will not achieve the best possible health outcomes for all families.[36]

Improving access to primary care and medical homes

Having a primary care provider and access to regular care substantially improves health outcomes. Many individuals struggle to obtain routine but needed care that can prevent the occurrence of more serious health problems.

Half of Hispanics and more than a quarter of African Americans do not have a regular doctor, compared with only one-fifth of white Americans. Low-income Americans are three times less likely to have a usual source of care compared to those with higher incomes, and almost half of low-income Hispanics lack a usual source of care.[37]

Good primary care, particularly enhanced accessibility and continuity, is associated with better self-reported physical and mental health. It can reduce the adverse association of income inequality with physical health, although not with mental health, and is especially beneficial in areas with highest income inequality.[38]

It is essential to promote primary care through proposed measures such as additional payments to primary care practitioners given the projected need for primary care services in the future and the fact that conventional payment systems tend to undervalue primary care services relative to specialty services. The House and Senate bills both provide such incentive payments for primary care. But only the House bill has such provisions for both Medicaid and Medicare.

Research shows that preventive care, care coordination for the chronically ill, and continuity of care—all hallmarks of primary care medicine—can achieve improved outcomes and cost savings so that a greater investment could be justified.[39]

It is not just a matter of access to primary care, but having regular and coordinated access to the full range of needed health care services. A report from the Commonwealth Fund demonstrates that having a medical home—defined as a health care setting that provides patients with timely, well-organized care, and enhanced access to providers—is associated with a reduction of disparities for adults.[40]

Current bills and proposals all recognize the value of the medical home model, although these are implemented in various ways and for various groups. The House bill has the most expansive initiative, providing support for pilot programs in both Medicare and Medicaid, and allowing for the adoption of these models on a large scale if the pilot programs prove successful. The real need then will be to ensure the timely evaluation of these pilots.

One way to achieve better access to primary care and to provide a medical home to underserved communities is through community health centers. Health centers reduce or even eliminate health disparities among their patients by providing comprehensive, affordable care that is responsive and customized to the low-income, racial and ethnic minority communities they serve.

The House bill provides additional funds to increase community health centers, although the Senate bill does not. An analysis from George Washington University School of Public Health indicates that coupling health insurance reforms with an expansion of community

health centers to reach an additional 20 million patients would result in savings of $212 billion over 10 years, including federal Medicaid savings for $59 billion.[41] These savings were calculated on the basis of the initial investment of $38 billion over 10 years made in HR3200; HR 3962 now spends $15.4 billion over five years on community health centers.

Focusing on disease prevention and health promotion

People who do not have regular access to primary care go without the preventive and routine services that can stop the root causes of disease and detect illness in the early stages when treatment is most effective. African Americans and Latinos are twice as likely as whites to rely upon a hospital outpatient department as their regular source of care, rather than a doctor's office where there are greater opportunities for continuity of care and patient-centered care.[42]

There are debates about the cost savings that can be achieved from the delivery of preventive health care.[43] One of the other major drivers for a prevention agenda in health is the relationship between the health of the community, workforce participation, and national productivity.[44]

Provisions in all the current health care reform proposals that remove cost-sharing from recommended preventative services will benefit those Americans who currently cannot afford them and also contribute to reducing the disparities gap.

Most of the recent analyses of disparities in health show that early life influences are critical to lifetime health status. Addressing needed care and interventions for pregnant women and their babies is an effective way to give young children the best start in life and may help reduce the longer term risks of adult chronic illnesses. Yet the evidence suggests that there are major disparities in maternal and child health services to minorities.[45]

The House and Senate bills both have provisions to support programs for home visits to at-risk families with young children, based on the Nurse-Family Partnership program. This is a nurse home-visiting program that has been shown to improve the health, wellbeing, and self-sufficiency of low-income, first-time mothers and their children.[46]

Improving the number and capacity of providers in under-served areas

The ratio of health providers to patients in underserved areas is especially concerning, as limited access to care affects an individual's health as well as the health of the community at large. One in five Americans lives in a Health Professional Shortage Area—geographic, demographic or institutional areas where there are shortages of primary medical health

care providers—and approximately 25 million individuals reside in dental health professional shortage areas.[47] Members of racial and ethnic minority groups represent a disproportionate number of these individuals. For example, 28 percent of Latinos and 22 percent of African Americans report having little or no choice in where to seek care, while only 15 percent of whites report this difficulty.[48] The shortage of health professionals in rural areas contributes to the racial-ethnic and rural-urban health care disparity gaps.

The situation is worsening with the number of primary care providers declining in recent years. According to a January 2009 statement by Health Resources and Services Administration, a shortage of at least 100,000 doctors and 1 million nurses is imminent.[49]

Primary care accounts for about one-third of the physician workforce, but the number of students entering the field has been steadily declining. Only 247 residency positions were offered in primary care internal medicine in 2009—a substantial decrease from the 328 in 1999.[50] A majority of primary care physicians in areas of workforce shortage have been trained overseas.[51]

Expanding the health care workforce and tackling the difficulties of recruiting and retaining medical professionals in underserved areas are critical components of health care reform. Both the bills currently under consideration address these issues.

The bills offer an array of incentives to encourage a range of needed health professionals to work in primary care settings, in public health services, and in areas of workforce shortage. The bills would reform graduate medical education to train more primary care providers by redistributing residency positions, promoting training in outpatient settings, and supporting the development of primary care training programs.

As previously noted, the House bill would increase Medicare payment rates by 5 percent for primary care services provided by physicians specializing in primary care—family practitioners, internists, etc—and those whose practice is at least 50 percent devoted to primary care. In addition, eligible practitioners in health professional shortage areas would receive an additional 5 percent.

The Senate is somewhat more generous in these incentives. It provides a 10 percent Medicare bonus payment for primary care. General surgeons and primary care physicians practicing in health professional shortage areas would also be eligible for an additional 10 percent Medicare bonus.

Both bills propose an advisory committee to help with planning to meet the nation's health workforce needs. An independent body that can develop, implement, and oversee long-term planning is essential given the long lead time needed to educate and train clinicians. The bills also require studies to look at the adequacy of Medicare payments for rural health care providers.

More efforts will arguably be needed to recruit and retain the health workforce in underserved areas. Issues such as workforce flexibility and role substitution will also need to be considered to ensure that people living in these areas have timely access to care. For instance, greater use of nurse practitioners, physician assistants, nurse-midwives, and dental technicians may be appropriate.

Improving the health care workforce's diversity and cultural sensitivity

Twenty-five percent of the U.S. population is composed of underrepresented groups, yet these minorities represent only 10 percent of the individuals in health professions and are growing very modestly. Hispanics account for 12 percent of the population, but only 2 percent of nurses and 3.5 percent of physicians. Less than one in 20 doctors or dentists are African American, even though one in eight persons in the United States are African American.

The Sullivan Commission on Diversity in the Healthcare Workforce examined disparities and diversity in the health care system in 2004 and noted that "the lack of minority health professionals is compounding the nation's persistent racial and ethnic health disparities."[52]

Increasing the number of underrepresented groups in the health professions can help address health care disparities by both improving access and responding more effectively to minority population needs. Studies have shown that minority health care professionals are more likely to work in underserved areas, and there is also evidence that race concordance—defined as shared racial or ethnic identities between clinicians and patients—is related to patient reports of satisfaction, participatory decision making, timeliness of treatment, and trust in the health system.[53]

The House bill directly addresses this issue. It provides scholarships and loan repayment support for individuals from disadvantaged backgrounds serving in the health professions, and it grants funding for the Health Careers Opportunities Program, which supports schools that recruit and train individuals from disadvantaged backgrounds to work in the health professions. The bill also establishes a grant program at HRSA to promote health care professionals' cultural and linguistic competence.

The House bill has several provisions that look to reduce health disparities through the provision of language services. The Secretary of HHS is required to develop a demonstration program to promote access for Medicare beneficiaries with limited English proficiency by providing reimbursement for culturally and linguistically appropriate services. The program would also conduct a study on the extent to which Medicare providers utilize or make available language services and ways that Medicare should develop payment systems for language services. A second study requires the IOM to examine how the provision of language services affects quality of care, access to care, reduction in medical errors, and related costs or savings.

The Senate bill establishes demonstration grants to create increased opportunities for low-income individuals and other entry-level workers to receive education, training, certification, and professional development for occupations in health care by providing financial aid and supportive services such as child care. These are programs that will assist with increasing workforce diversity.

Reauthorizing the Indian Health Care Improvement Act

Members of more than 560 federally recognized American Indian and Alaska Native Tribes and their descendants are eligible for services provided by the Indian Health Service.[54] The IHS provides health services to approximately 1.8 million of the nation's estimated 3.3 million American Indians and Alaska Natives. The populations served live mainly on or near reservations and in rural communities in 35 states, mostly in the western United States and Alaska.

The Indian Health Care Improvement Act is a core statute for the work of the HIS, but it has not been reauthorized since 1992.

The House bill, which includes a reauthorization of IHCIA, specifically addresses: workforce development, recruitment, and cultural development; facilities construction, maintenance and improvements; access to and financing of health services; a greater focus on health promotion and disease prevention; provision of health services for urban Indians; the provision of behavioral health services; and organizational improvements within the IHS.

These changes will only be effective if sufficient funds are appropriated for their full implementation. According to an actuarial cost model, the funding appropriated to the IHS—approximately $3 billion annually —provides only 55 percent of the necessary federal funding to assure mainstream personal health care services to American Indians and Alaska Natives using the IHS system.[55]

Enhancing the quality of health care services

Health disparities often represent an "inequality in quality." The IOM has identified the provision of care that does not vary in quality because of personal characteristics such as sex, ethnic background, geographic location, and socioeconomic status as one of the attributes we should strive for in a 21st century health care system.[56]

A time-trend analysis of nine clinical performance measures for enrollees in Medicare managed-care plans from 1997 to 2003 shows that improvements in the quality of care are associated with reductions in racial disparities.[57]

This link between quality improvements and disparities is recognized by the Agency for Healthcare Research and Quality, which each year publishes the National Healthcare Quality Report and the National Healthcare Disparities Report.[58] Yet there is little effort to monitor and address disparities in health care through organizational quality improvement. Some of this is a consequence of the way in which data are collected and the failure to analyze and respond to the data that are available.[59]

The House and Senate bills have a number of measures to improve the quality of health care in both community and acute care settings, and these measures recognize that the federal government has a key role to play in addressing disparities. There are also initiatives that will reward health care providers who provide quality care.

The identification of priorities in this area and the development and measurement of quality measures and performance indicators will help improve health care services and patient outcomes for all Americans, but improvements will disproportionately benefit those segments of the population which are least likely to get quality care. Many minority people will benefit, in particular, from the provision in the Senate bill that requires the Secretary of HHS to identify and publish a core set of adult health quality measures for Medicaid-eligible adults—mirroring what is already in place for Medicaid-eligible children—and encourage voluntary state reporting against these measures.

Real change, of course, will not occur if these new initiatives result in nothing more than exercises in setting priorities and subsequent data collection around these priorities. There is already evidence that reports such as the AHRQ's National Healthcare Disparities reports can be subject to political interference,[60] and the fact is that six years of these reports have so far resulted in little progress in addressing the health care disparities gap.

There is evidence that pay-for-performance and public reporting programs can increase the quality of health care for the services being measured. Yet these programs may have the unintended consequence of increasing racial and ethnic disparities if they are not carefully designed.[61] For example, incentive programs have the potential to encourage providers to select patients with more favorable characteristics, and rate increases designed to reduce disparities could inadvertently penalize institutions serving larger minority populations.

Dr. Brian Smedley discussed in a recent congressional testimony the idea of "medical apartheid"—separate and unequal care for low-income and minority patients. Minorities disproportionately receive care in lower-quality hospitals and from physicians who are less likely to possess board certification.[62] There is nothing in any of the bills under consideration that would specifically address these issues.

Improving data collection

Defining and measuring health care disparities is a prerequisite for addressing the problems. But defining and measuring these disparities requires navigating the intersections of health and medicine with poverty, race, and geography. This is a task fraught with difficulty and one that inevitably strays beyond the boundaries of health care.

High-quality data are essential to helping organizations understand and remedy racial and ethnic disparities in health care. A recent report from the IOM finds that the information currently gathered is insufficient to illuminate many disparities in care.[63] For example, there are no statutory requirements to ensure that the sample size of federal surveys is large enough to produce reliable, statistically significant data for various racial and ethnic groups. Statutorily mandated quality reporting programs for Medicare hospitals and doctors do not require the inclusion of data on race, ethnicity, or primary language.

The IOM report recommended that health care providers collect more detailed data on patients' race, ethnicity, and language. The Medicare Improvements for Patients and Providers Act of 2008, PL 110-275, required the Secretary of HHS to evaluate and implement approaches for collecting disparities data on Medicare beneficiaries based on race, ethnicity, and gender.

The Senate bill would require federally funded programs to collect and report data on race, ethnicity, socioeconomic status, health literacy and primary language, and requires that federally-funded population surveys be structured so as to collect statistically reliable data based on race, ethnicity, primary language and disability, to compare health disparities populations. It would also extend the MIPAA provisions regarding collection of Medicare health disparities data to Medicaid and CHIP.

The House bill has a number of provisions related to quality measurements, but none of these specifically address the issues around health disparities. The bill does, however, seek to create a higher profile for minority health issues by placing an Office of Minority Health within the Office of the Secretary of HHS and requiring the Secretary to establish Offices of Minority Health within the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, and the Food and Drug Administration. This increased profile should assist with better addressing the disparities in health care access and quality experienced by racial and ethnic minorities.

It is important to note that it is not sufficient simply to collect data; that data must be examined, analyzed, utilized, and made public. Such data collection and analysis needs to be consistent across both state and federal levels. Only then can we realize the potential to promote greater public accountability, address disparities, investigate potential violations of law, and improve health care quality and access for all Americans.

Funding additional research into health disparities

The NIH Strategic Research Plan and Budget to Reduce and Ultimately Eliminate Health Disparities is intended to provide an overarching structure and coordination for such research being conducted by various NIH institutes and centers.

A March 2006 IOM report, "Examining the Health Disparities Research Plan of the National Institutes of Health: Unfinished Business" assessed how well the plan was providing needed guidance and recommended ways to improve the oversight and coordination of these research efforts.[64] The report found that NIH was conducting and planning valuable health disparities research, but a lack of coordination and limited strategic planning was mitigating the effectiveness of this research. What's more, no funding has ever been allocated for this work.

Neither of the current bills directly addresses this issue, although to the extent that data collection and analysis is improved, this will help formulate, prioritize, and drive research in this area. The push in all the health care reform bills for research in comparative effectiveness will also help with addressing disparities, particularly in the area of clinical services.

The annual budget for the National Center on Minority Health and Health Disparities at NIH has not increased in real terms over the past three years. It stood at $199.4 million in FY2007, $199.6 million in FY2008, and $199.8 million in FY2009.[65]

The largest proportion of the National Center on Minority Health and Health Disparities' FY2007 budget—about 30 percent—was spent on the Centers of Excellence program. The Centers of Excellence were established to develop novel programs across America, Puerto Rico and the U.S. Virgin Islands that would make significant advances and contributions to easing the health burden in underserved populations. The program held a new competition in 2007 and made 37 awards. The major focus of the awards made under this program is on biological factors contributing to health disparities (37 percent of awards), and the effect of socioeconomic factors (29 percent). Other factors being studied by the Centers of Excellence are: the effects of cultural factors (12 percent), political factors (11 percent), and racial/discriminatory factors (11 percent).

Conclusion

The enactment of health care reform legislation will mark the beginning of an iterative and complicated process of program development and implementation. It will require the promulgation of a multitude of regulations, data collection and evaluation, and further legislative initiatives. It is the beginning of the challenges, not the end.

Health care disparities are persistent, stubborn, and difficult to change. An effective strategy to combat these disparities will need to be on a sufficient and sustained scale in order to be effective. It will also need to involve ongoing consultation and partnership with all the relevant stakeholders, across all levels of government, and with community involvement.

What the current health care reform bills do not do is to make addressing health care disparities a policy priority. It is not integrated into health services' planning and performance systems, and there are not measurable goals and targets to be achieved. But that is what must happen if the nation is to finally succeed in closing the gap.

There are currently many examples of successful projects that address health care disparities, and these should be examined to see how applicable they might be to further expansion. It will be crucial to ensure that initiatives to address health care inequalities are not just a collection of small-scale, uncoordinated initiatives, but part of a coherent, long-term approach with secure funding and organization and accountability at the highest levels of government.

Making the changes in the health care system that are outlined in this report will begin the process of closing the gap on health care disparities, and will make a real difference in the lives of many Americans, especially those from racial and ethnic minorities.

Success in tackling the broader issue of health disparities will require efforts beyond health care reforms. The major drivers of health and the distribution of health are social and economic determinants that lie outside the health care system. Issues such as education, housing, employment, and physical and social environments all contribute to the health of the American people.[66] Delivering equitable access to affordable, quality health care is a significant first step toward this larger goal.

Appendix 1: The extent of racial and ethnic health care disparities

The Department of Health and Human Services has identified a number of diseases and conditions that are disproportionately prevalent among racial and ethnic minorities and where there are apparent serious disparities in health access and outcomes:[67]

Diseases and conditions

Cancer screening and management

African Americans' age-adjusted death rate for cancer is approximately 25 percent higher than for white Americans.[68] This is in many cases due to later diagnosis.

African-American women are more than twice as likely to die of cervical cancer as white American women and are more likely to die of breast cancer than women of any other racial or ethnic group. Compared with 72 percent of white women, only 63 to 68 percent of African-American, Hispanic, Asian, and Native American women were frequently screened for breast cancer. African-American, Hispanic, and Asian women were more likely to have never undergone screening. They were therefore more likely to have their first mammogram because of a physical examination finding or breast symptom.

Cardiovascular disease

Heart disease and stroke are the leading causes of death for all racial and ethnic groups in the United States. African Americans experienced 29 percent higher death rates from cardiovascular disease in 2000 that white adults, and 40 percent higher death rates from stroke.

Diabetes

American Indians and Alaska Natives were 2.6 times more likely to have diagnosed diabetes in 2000 than white Americans; African Americans were 2.0 times more likely to be diagnosed, and Hispanics were 1.9 times more likely.

HIV/AIDS

African Americans and Hispanics represented only 26 percent of the U.S. population in 2001, but they accounted for 66 percent of adult AIDS cases and 82 percent of pediatric AIDS cases reported in the first half of that year.

Immunizations

Hispanics and African Americans aged 65 and older were less likely than white Americans to report having received influenza and pneumococcal vaccines. For example, influenza vaccination coverage among adults age 65 and older is 67 percent for whites, 47 percent

for African Americans, and 45 percent for Hispanics. Pneumococeal immunization among adults age 65 and older in 2006 was 62 percent for whites, 36 percent for African-Americans, and 33 percent for Hispanics.

Mental health

Racial and ethnic minorities collectively experience a greater disability burden from mental illness than do whites. This higher level of burden stems from minorities receiving less care and poorer quality of care, rather than from their illnesses being inherently more severe or prevalent in the community.

When compared with other racial and ethnic groups, American Indian/Alaska Native youth have more serious problems with mental health disorders related to suicide, such as anxiety, substance abuse, and depression. American Indian and Alaska Native males in the 15- to 24-year-old age group had the highest suicide rate from 1999 to 2004—27.99 per 100,000, compared to white (17.54 per 100,000), black (12.80 per 100,000), and Asian/Pacific Islander (8.96 per 100,000) males of the same age

Hepatitis

Fifty percent of Americans chronically infected with Hepatitis B in 2002 were Asian Americans and Pacific Islanders, although they represent only 4.5 percent of the population. African-American teenagers and young adults become infected with Hepatitis B three to four times more often than white Americans of the same age.

Sexually transmitted diseases

Surveillance data show higher rates of reported STDs among some minority racial or ethnic groups when compared with rates among whites.

- The rate of infection with syphilis in 2008 was nearly 30 times higher for African Americans than for white Americans.

- All racial and ethnic groups reported increases in chlamydia rates from 2007 to 2008. Chlamydia rates increased by 27.0 percent among blacks from 2004 to 2008, 15.6 percent among American Indian/Alaska Natives, 21.1 percent among Hispanics, 8.7 percent among Asian/Pacific Islanders, and 20.9 percent among whites.

Tuberculosis

Almost 80 percent of all the TB cases reported from 1991-2001 were in racial and ethnic minorities. Asian Americans and Pacific Islanders accounted for 22 percent of those cases, even though they made up less than 4 percent of the U.S. population.

Treatment disparities

A substantial body of evidence demonstrates that racial and ethnic minorities receive a lower quality and intensity of care than other Americans, even when they have the same levels of insurance, similar incomes, and present identical health problems.

Dr. Brian Smedley listed some examples in a recent testimony to Congress:[69]

- Insured African-American patients are less likely than insured white American patients to receive high-tech care such as cardiac catheterization, bypass graft surgery, or kidney transplantation, even when this would be life-saving.

- African-American cancer patients do not get the same combinations of surgical and chemotherapy treatments that white American patients with the same cancer would receive.

- African-American heart patients are less likely to receive diagnostic procedures, revascularization procedures, and thrombolytic therapy than white American patients.

- African-American and Hispanic patients are less likely to receive aspirin upon discharge following a heart attack, to receive recommended care for pneumonia, and to have their pain appropriately managed.

- Minority patients are more likely to receive undesirable treatment such as limb amputation for diabetes complications.

- African Americans are less likely to receive the long-term care they need in nursing homes and assisted living arrangements. Those nursing homes that service predominately African-American residents have fewer nurses and more health-related deficiencies.

- African Americans, Hispanics, and American Indians and Alaska Natives generally have poorer oral health than other segments of the U.S. population. These problems begin earlier and persist or widen with age. Hispanic and African-American preschoolers experience tooth decay at rates 2.5 and 1.5 times higher, respectively, than white American children. American Indian and Alaska Native preschoolers experience tooth decay at six times the rate of white American children.

Appendix 2: Trends over time

The first attempt at a nationwide assessment of mortality in the United States occurred in 1850. The quality was mixed, but the best estimates suggest that life expectancy was around 40 years for white Americans and as low as 23 years for African Americans. The wide gap between whites and African Americans is not surprising, given that slavery was legal in much of the United States at this time. Yet the mortality and life expectancy advantages for white Americans have remained throughout the 20th century, and into the 21st century, despite the enormous improvements in health and life expectancy over the subsequent 160 years.

For example, dramatic declines in the infant mortality rate have occurred in the past four decades, but substantial racial and ethnic differences still exist. Indeed, the racial disparity in infant mortality has not only persisted but increased over time and is not expected to diminish in the near future. The risk of mortality is currently 2.2 times higher for African-American infants than for white American infants.[70]

Data from the NHD Reports show persistent disparities over time in health care quality and access. At least 60 percent of measures of quality of care did not improve or worsened from 2000-2001 to 2005-2006 for African Americans, Asians, Hispanics, and American Indians and Alaska Natives. The majority of core measures of access improved for American Indians and Alaska Natives during the same time period, but declined or worsened for African Americans, Asians, and Hispanics.[71]

Some of the findings from these National Health Disparities reports—particularly the earlier ones—should be read with caution. The Minority Report from the House of Representatives Committee on Government Reform compared the final version of the NHD Report 2003 with the draft written by DHHS scientists and revealed evidence of significant alterations. Changes to the scientists' draft minimized the importance and extent of racial and ethnic disparities in health care. In particular, the final version of the report eliminated the conclusion that health care disparities are "national problems" and dropped findings on the social costs of disparities.[72]

A study published earlier this year used three approaches to measuring health disparities and found that in all cases disparities between Hispanics and white Americans for two broad indicators of health care use—total medical spending and any doctor visit in the past 12 months—have grown over the period 1996-1997 to 2004-2005. African-American disparities remained roughly constant during that period.[73]

The study attributes these disparities for Hispanics to high levels of uninsurance and underinsurance and continuing problems with access to care due to language and cultural barriers. Increasing levels of immigration by Hispanic populations may also contribute to increasing disparities. Foreign-born Hispanic Americans are more likely to live in poverty and more likely to be uninsured.

American Indians and Alaska Natives are a heterogeneous population with approximately 560 federally recognized tribes residing in the rural and urban areas of 35 states. Average life expectancy among American Indians and Alaska Natives increased 39 percent between 1940 and 1995, from 51 years in 1940 to 71 years in 1995, but American Indians and Alaska Natives experienced an increase in mortality rates for chronic diseases, including cancer, over this time period.

American Indians and Alaska Natives have increasingly relocated from rural and reservation communities to urban centers over the past three decades.[74] Census data show that 61 percent of American Indians and Alaska Natives resided in these areas in 2000, up from 38 percent in 1970.

The departure of American Indians and Alaska Natives from reservations has typically resulted in a loss of access to health care, which was historically provided by the Indian Health Service. This, combined with high rates of poverty, has contributed to their persistent health disparities.

Appendix 3: What works and current efforts in addressing health care disparities

What works

The General Accounting Office looked in 2003 at identifying promising approaches to addressing racial and ethnic disparities in health care. They found this task to be challenging, especially because evaluations and data were limited, and information on the nonfinancial causes of health care disparities was incomplete.

The experts consulted by the GAO identified the following promising approaches that the federal government could pursue to address disparities:

- Developing new demonstration projects in federal programs using the best available evidence to target areas of disparities and plan promising interventions.
- Expanding current efforts in programs and demonstration projects such as CDC's Racial and Ethnic Approaches to Community Health across the United States, also knows as REACH US, 2010 community-based coalitions.
- Strengthening federal leadership on disparities, including prompt dissemination of information on successful interventions to reduce or eliminate health care disparities.
- Collecting complete and accurate racial and ethnic health care data in national surveys to better understand and target efforts to reduce health care disparities through steps such as ensuring the inclusion of adequate numbers of minority participants.[75]

Current efforts

The Department of Health and Human Services has an Office of Minority Health and Health Disparities located within the Centers for Disease Control and Prevention.[76] The OMHD aims to eliminate health disparities for vulnerable populations as defined by race/ethnicity, socioeconomic status, geography, gender, age, disability status, risk status related to sex and gender, and other categories.

The OMHD coordinates White House Executive Orders and DHHS Departmental Initiatives, supports cooperative agreements for research and professional development, reports on the health status of vulnerable populations in the United States, and initiates strategic partnerships with government, national, and regional organizations.

The OMHD's work is guided by *Healthy People 2010*, a statement of national objectives for promoting health and preventing disease.[77] One of the two goals of *Healthy People 2010* is

to eliminate health disparities among different segments of the population. Consultations are currently underway for the development of *Healthy People 2020*.

The REACH program is the cornerstone of the DHHS efforts to reduce and eliminate the health disparity gap. The federal government funded 40 REACH 2010 communities in priority areas from 1999 to 2007. These programs have now been replaced by REACH Across the U.S.[78]

The Agency for Health Research and Quality provides an annual national overview of disparities in health care among racial, ethnic, and socioeconomic groups in the general U.S. population and within specific priority populations. It also tracks the progress of activities to reduce disparities in health care quality and access.[79]

The Minority Health and Health Disparities Research and Education Act of 2000 (PL106-525) established the National Center on Minority Health and Health Disparities at the National Institutes of Health to administer special grant programs, coordinate minority health disparities research across the NIH, and lead the development of an NIH-wide strategic plan on health disparities. A primary goal is to ensure that NIH health disparities research is conducted as an integrated and inclusive field of study, rather than as an aggregate of independent research activities occurring in separate research domains.

The Obama administration's 2010 fiscal year budget proposal for the DHHS includes $354 million to combat health disparities and improve the health of racial and ethnic minorities and disadvantaged populations.[80]

The American Recovery and Reinvestment Act of 2009 designated $10.4 billion for the NIH to use over fiscal years 2009 and 2010. The NCMHD received approximately $52 million of this. These funds will be used to jumpstart initiatives and expand innovative approaches in areas such as prison health, rural health, biological and nonbiological determinants of health, tele-health, training of the health workforce, and training of community health workers.[81]

Appendix 4: Comparison of current health care reform bills and proposals

House bill H.R. 3962 as passed by the House, November 7, 2009	Senate bill as released November 18, 2009
Expanding health coverage	
• Requires all individuals to have health insurance • Creates a health insurance exchange through which individuals and smaller employers can purchase health coverage, with premium and cost-sharing credits available to individuals and families with incomes up to 400 percent of the federal poverty level • Requires employers to provide coverage to employees or pay into a health insurance exchange trust fund, with exceptions for certain small employers, and provide certain small employers a credit to offset the costs of providing coverage • Imposes new regulations on plans participating in the exchange and in the small group insurance market • Expands Medicaid to all individuals with incomes up to 150 percent of the federal poverty level • Phases out CHIP after 2013 or as the health insurance exchange has the capacity to support CHIP enrollees	• Requires all individuals to have health insurance • Creates state-based exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals and families with income between 100 percent and 400 percent of the federal poverty level • Creates separate exchanges through which small businesses can purchase coverage • Assesses a fee on certain employers that do not offer coverage for each employee who receives a tax credit for health insurance through an exchange, with exceptions for small employers • Imposes new regulations on health plans in the exchange and in the individual and small group markets • Expands Medicaid to all individuals—children, pregnant women, parents, and adults without dependent children—with incomes up to 133 percent of the federal poverty level; all newly eligible adults will be guaranteed a benchmark benefit package that at least meets the minimum creditable coverage standards • Maintains CHIP through 2019 with increase in federal medical assistance percentages in years 2014-2019 • Removes income disregards as of January 1, 2014 and instead measures income based on modified gross income
Public health insurance option	
Yes	Yes, but state legislatures may vote to opt out
Improving the number and capacity of providers in underserved areas	
• Reforms Graduate Medical Education to increase training of primary care providers by redistributing residency positions, promtoting training in outpatient settings, and supporting the development of primary care training programs • Supports training of health professionals, including advanced education nurses, who will practice in underserved areas • Supports the development of interdisciplinary mental and behavioral health training programs • Establishes a training program for oral health professionals • Expands funding for the National Health Service Corps • Establishes a Public Health Workforce Corps. • Establishes an Advisory Committee on Health Workforce Evaluation and Assessment to ensure that health workforce is meeting the nation's needs • Commissions an IOM study on Medicare geographic adjustment factors that will report to CMS; CMS is required to respond to the report's recommendations and may spend up to $4 billion a year over two years to effect needed payment increases	• Reforms Graduate Medical Education by redistributing currently unused training positions, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios; promoting training in outpatient settings; and ensuring the availability of residency programs in rural and underserved areas • Supports training of health professionals in direct care, primary care, and dentistry; provides health education and training grants for professionals in geriatric care and mental and behavioral health; and provides prevention, public health, and cultural competence training for health care professionals • Increases loans for nursing students and establishes loan repayment programs for public health workers and pediatric specialists • Expands funding for the National Health Service Corps • Establishes a reserve corps to the Public Health Commissioned Corps • Establishes a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy for recruiting, training, and retaining a health care workforce that meets current and projected health care needs • Requires MedPAC to review and make recommendations on Medicare payment adequacy for rural health care providers, and report these to Congress

House bill H.R. 3962 as passed by the House, November 7, 2009	Senate bill as released November 18, 2009
Primary care and medical homes	
• Increases Medicaid payments for primary care providers, and provides Medicare bonus payments to primary care practitioners with larger bonuses paid to primary care practitioners serving in health professional shortage areas • Conducts pilot programs in Medicare and Medicaid to assess the feasibility of reimbursing qualified patient-centered medical homes; medical home models would be adopted on a large scale if pilot programs prove successful at reducing costs • Establishes the Center for Medicare and Medicaid Payment Innovation Center to test payment models that address populations experiencing poor clinical outcomes or avoidable expenditures, and evaluates all models and expands those models that improve quality without increasing spending, or reduce spending without reducing quality, or both • Provides an additional funding of $15.4 billion for five years to community health centers	• Provides 10 percent Medicare bonus payments for one year to primary care physicians and a further 10 percent Medicare bonus for one year to general surgeons and primary care physicians practicing in health professional shortage areas • Creates a new Medicaid state plan option under which Medicaid beneficiaries with chronic conditions could designate a provider as their medical home • Provides grants for improving health system efficiency, including grants to establish community health teams to support a medical home model • Establishes the Center for Medicare and Medicaid Innovation to develop innovative payment and service delivery models
Increasing the diversity and cultural sensitivity of health care workforce	
Promotes training of a diverse workforce and provides cultural and linguistics competence training for health care professionals	No provision
Reauthorization of the Indian Health Care Improvement Act	
Yes	No
Quality improvements	
• Establishes the Center for Quality Improvement to identify, develop, evaluate, disseminate, and implement best practices in the delivery of health care services • Develops national priorities for performance improvement and quality measures for the delivery of health care services	• Requires the development of a National Strategy to Improve Health Care to improve the delivery of health care services, patient health outcomes, and population health that includes publishing an annual national health care quality report card • Creates processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs • Establishes the Medicaid Quality Measurement Program to establish priorities for the development and advancement of quality measures for adults in Medicaid
Improving the data base	
• Reduces racial and ethnic disparities by conducting a study on the feasibility of developing Medicare payment systems for language services, providing Medicare demonstration grants to reimburse culturally and linguistically appropriate services, and developing standards for the collection of data on race, ethnicity, and primary language • Establishes an Office of Minority Health within the Office of the Secretary of HHS and with offices in all major health agencies	• Requires enhanced collection and reporting of data on race, ethnicity, and primary language. Also requires collection of access and treatment data for people with disabilities
More research on disparities	
No provision	No provision
Beyond health	
Conducts a study of the feasibility of adjusting the federal poverty level to reflect variations in the cost of living across different areas	No provision

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