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## Issue Brief

# Addressing Unequal Treatment: Disparities in Health Care

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### Introduction

Health care services<sup>1</sup> in the U.S. have been improving for decades, but in many instances, racial and ethnic minorities<sup>2</sup> receive fewer health care services, lower quality services,<sup>3</sup> and services later in the progression of illness.<sup>4</sup> Some disparities in health care services can be explained by differences in income, insurance status, and medical need. However, there is increasing evidence that racial and ethnic disparities in care persist even after accounting for these factors.<sup>5</sup>

Disparities in health care services not only raise ethical questions, they also play a role in the differences in health status among racial and ethnic groups, and they may limit economic development in minority communities. Disparities in health care services also may affect the health and economic well being of the nation because the health of one portion of the population is ultimately linked to the health of the whole country.<sup>6</sup> These concerns will become more pressing as the percentage of the population belonging to a racial or ethnic minority increases.

Key strategies to address disparities in health care services include overall quality improvement and targeted strategies for health care services; improving access to services in minority communities; and increasing the number of minorities in health professions.<sup>7</sup> However, there is limited understanding of the drivers of racial and ethnic disparities and limited ability to monitor the progress of the problem or its solutions. Without this information, it is difficult to determine which strategies are most effective and which have the greatest impact on health outcomes. Health care data collection that includes racial or ethnic information<sup>8</sup> as well as improved survey research<sup>9</sup> will help promote effective strategies (see Table 1).

### Disparities in Health Care Services

There are significant differences across racial and ethnic groups in the amount, quality, and timing of health care services received. In many cases, minorities fare worse than whites.<sup>10</sup> The severity of this problem varies by region, institution, and population.<sup>11</sup> Differences in care are documented most often between African Americans and whites, and evidence is very strong in cardiac care,<sup>12</sup> but examples can be found in many critical areas of health care services and among all racial and ethnic groups. In addition, African Americans,<sup>13</sup> Asians,<sup>14</sup> and Hispanics<sup>15</sup> are more

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Table 1  
**Examples of Racial and Ethnic Disparities in Health Care**

**Cancer Screening:** In 1998, 49 percent of Asian women received Pap tests (a screening test for cervical cancer), as compared to the national average of 64 percent.<sup>1</sup>

**Diabetes Management:** African American diabetics are 30 percent less likely than their white counterparts to have an eye care visit, which is an important part of diabetes management.<sup>2</sup>

**Heart Disease Care:** African Americans are much less likely to receive critical cardiac care, including diagnostic procedures, revascularization procedures, and thrombolytic therapy.<sup>3</sup>

**HIV Infection/AIDS Treatment:** In 1998, 20 percent of African Americans did not receive the standard care for human immunodeficiency virus (HIV) infection, as opposed to 12 percent of whites.<sup>4</sup>

**Immunizations:** Sixty-nine percent of older whites received influenza vaccinations, compared with only 50 percent and 48 percent of older African Americans and Hispanics, respectively.<sup>5</sup>

**Prenatal Care:** In 1996, only 67 percent of American Indian women received prenatal care in their first trimester of pregnancy, while 84 percent of white women and 81 percent of Asian women received such care.<sup>6</sup>

<sup>1</sup> Collins, K.S. et al. 1999. *U.S. Minority Health: A Chart Book*. The Commonwealth Fund. Chart 4-10.

<sup>2</sup> Cowie, C. and M. Harris. 1997. Ambulatory Medical Care for Non-Hispanic Whites, African-Americans, and Mexican-Americans with NIDDM in the US. *Diabetes Care* (20): 142-47.

<sup>3</sup> The Henry J. Kaiser Family Foundation and the American College of Cardiology Foundation. October 2002. *Racial/Ethnic Differences in Cardiac Care: The Weight of the Evidence. Highlights*.

<sup>4</sup> Lillie-Blanton, M. et al. June 2003. Key Facts: Race, Ethnicity & Medical Care. The Henry J. Kaiser Family Foundation. Figure 32.

<sup>5</sup> United States General Accounting Office. Briefing for Congressional Staff of Senator Bill Frist. *Health Care: Approaches to Address Racial and Ethnic Disparities*. GAO-03-862R.

<sup>6</sup> Collins, K.S. et al. 1999. *U.S. Minority Health: A Chart Book*. The Commonwealth Fund. Chart 4-12.

likely to report lower satisfaction with those services they do receive.

Disparities exist across health care settings, from clinics to hospitals to nursing homes. Disparities are experienced by patients who are insured through private companies, patients who are beneficiaries of public funding, and patients who have to pay out of pocket. Even within public programs, where the population is insured and has equal access to services, disparities persist. For example, African Americans under Medicare receive lower levels of care, including fewer office visits, mammograms, and colonoscopies than whites.<sup>16</sup> Within Medicare managed care, African Americans are less likely to receive beta-blockers after a myocardial infarction (heart attack) or have eye examinations if diabetic.<sup>17</sup>

There is very limited awareness of disparities in health care on the part of the public or providers. Most

people believe that African Americans and whites generally receive equal quality health care.<sup>18</sup> Physicians believe that disparities in health care are very rarely, if ever, due to race or ethnicity.<sup>19</sup>

## Reasons for Disparities in Health Care

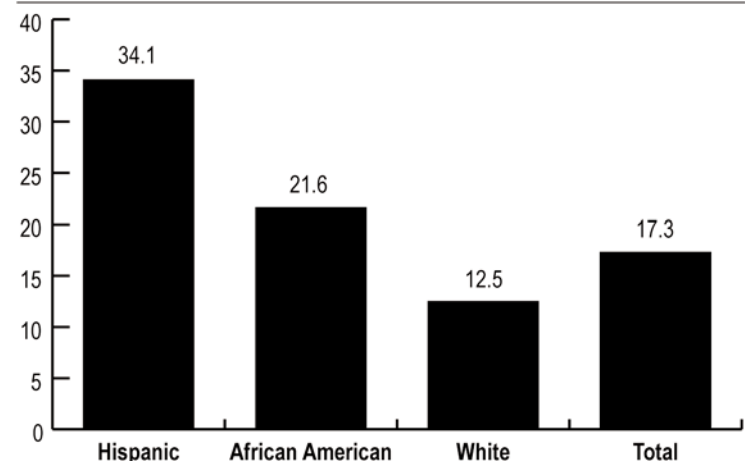
### 1. Socioeconomic Differences: Income

Persons who are poor are more likely to receive fewer and lower quality health care services.<sup>20</sup> Because persons who are in a racial or ethnic minority group are more likely to be poor, they are more likely to receive fewer or lower quality services. Differences in care among minority and white populations are significantly reduced and even disappear in some cases when one accounts for income.<sup>21</sup>

### 2. Barriers to Access

Racial and ethnic minorities have lower rates of health insurance. For example, nearly one half of Hispanics under 65 report a time when they were uninsured in the past year, as opposed to one fifth of whites.<sup>22</sup> Racial and ethnic groups also tend to live in areas with fewer health care providers<sup>23</sup> and limited transportation. Many minorities live in rural areas where there are fewer hospitals and health care centers. Even in urban areas, it may require taking multiple buses, for example, to get to a hospital, or the nearby facilities may be insufficiently staffed or supplied. Minorities generally face more “personal factors” in accessing health care, such as challenges in getting time off work to visit a doctor.<sup>24</sup> The result is that individuals forgo medical evaluation, preventive care, and even treatment. People also may seek less cost-effective but more accessible alternatives to regular care, including emergency rooms even for routine needs.<sup>25</sup>

Figure 1  
**Percent Uninsured Hispanics, African Americans, and Whites Under 65, U.S., 2002**



Source: P. Fronstin, *Sources of Insurance and Characteristics of the Uninsured, Analysis of the March 2003 Current Population Survey*. Employee Benefits Research Institute. Issue Brief No. 264. December 2003.

### 3. Medical Need

Patients in different racial and ethnic groups may receive different services and treatment because they have different medical needs. For example, African Americans have higher rates of dialysis because they have higher rates of end-stage renal (kidney) disease than whites, which stem from higher rates of diabetes and hypertension.<sup>26</sup> That said, higher rates of disease may come from lower rates of preventive care. Differences in medical need do not explain differences in preventive care because all groups have equal need for preventive services. Preventive care includes services like basic physical examinations and immunizations.

### 4. Differences in Health Care Delivery

Even after accounting for differences in income, barriers to access, and medical need, racial and ethnic disparities in health care services persist.<sup>27</sup> Such disparities are especially well documented in cardiac care,<sup>28</sup> but are seen among most illnesses. While precise reasons for these disparities are not well understood, it is believed that multiple, interacting factors in health care delivery are responsible, including the following:<sup>29</sup>

- *Language and Cultural Barriers*

Very often patients who do not speak English have limited or no access to translation services, making it difficult to communicate with providers. Even if they speak English, cultural barriers may make the health care system especially difficult to navigate.<sup>30</sup>

- *Provider-Patient Interactions*

Tight time and financial constraints may limit care providers' abilities to listen to patients effectively, and prompt them to rely more heavily on information they can observe about patients (including race and ethnicity) and on stereotypes.<sup>31</sup> Even individuals who believe they do not use stereotypes may do so without realizing it.<sup>32</sup> If patients mistrust the system, they may withhold information and prompt care providers to fall back on stereotypes.<sup>33</sup> This negative cycle may be more likely to occur under managed care or other financial structures where cost-containment pressures are particularly high.<sup>34</sup>

- *Patient Preferences and Biological Influences*

Although it is unlikely that patient preferences play a large role in explaining racial and ethnic differences in health care, some researchers have noted that patients within some groups may prefer, refuse, or overuse certain treatments.<sup>35</sup> In a few cases, researchers have postulated that differences in biological reactions to drugs may account for some of the difference, but studies show the effect is minimal.<sup>36</sup>

## Implications

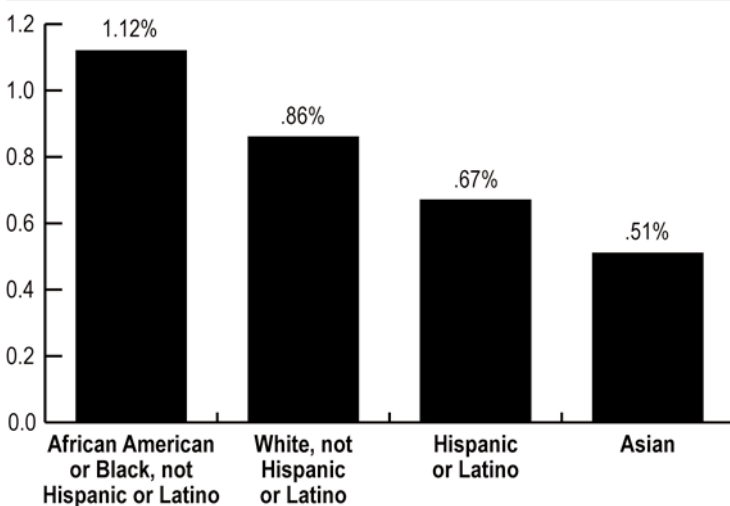
Racial and ethnic disparities in health care services are a critical problem for the United States. They raise moral and ethical concerns about distributive justice, as well as concerns about health and economic impacts on minority communities and the nation as a whole. The issue of disparities in health care is likely to take on greater urgency as the percentage of minority Americans grows. By the year 2050, nearly half of the U.S. population will belong to a racial or ethnic minority.<sup>37</sup>

### *Impact on Health*

Disparities in health care play a role in exacerbating or creating differences in health status among racial and ethnic groups.<sup>38,39</sup> In some cases, it has been shown that differences in health care create differences in health outcomes. One study reported that African Americans with coronary disease received poorer quality care and had lower survival rates than whites.<sup>40</sup> Another study showed that African Americans were less likely to receive surgical treatment for early-stage lung cancer, and more likely to die sooner.<sup>41</sup> However, the link between health care services and health status is not always clear-cut. For example, although Hispanic women receive fewer prenatal care services than whites, some Hispanic groups experience lower infant mortality rates.<sup>42,43</sup> There is limited data that capture the relationships between health care and health status among racial and ethnic groups, so it is difficult to know which health care differences contribute most to differences in health status. In addition, other factors, such as income, education and culture, play a large role in differences in health status.<sup>44</sup> These factors affect health status by shaping people's daily lives (including their family structure,<sup>45</sup> work environment,<sup>46</sup> or behaviors, such as smoking<sup>47</sup>) as well as by influencing their access to health care services.

The link between racial/ethnic disparities in health care and racial/ethnic disparities in health status is made more complicated by the relationship between health status and race or ethnicity. In many instances, minorities have poorer health status than whites.<sup>48</sup> For example, the African American death rate between 1999 and 2001 was 1.12 percent, whereas the white death rate was .86 percent. But minorities do not always fare worse. In the same time period, Hispanics and Asians faced death rates of .67 percent and .51 percent respectively.<sup>49</sup> Death rates from individual diseases show similar patterns. For example, African Americans and Hispanics are more likely than whites to die from diabetes,<sup>50</sup> but Asians are less likely to die from diabetes.<sup>51</sup> More information is needed to explain the reasons for these differences in health status and the role that differences in health care may play (see Figure 2).

Figure 2  
Average Annual Age-Adjusted Death Rates, U.S., 1999–2001



Source: *Health, United States, 2003*. National Center for Health Statistics. Table 28.

The health of the country as a whole is related to the health of individual populations, including racial and ethnic groups.<sup>52</sup> At a biological level, infectious disease can spread from underserved groups to the broader public. Alternatively, resources required to care for a particularly unhealthy portion of the population may limit resources available for the health care infrastructure that supports the entire population.<sup>53</sup> Poor quality of care for one part of the population may also raise questions about the overall quality of care in the U.S.

#### *Impact on Economic Well-Being*

Insofar as disparities in health care cause poor health, they may limit professional and economic advancement within minority communities.<sup>54</sup> In turn, this limits the potential of U.S. economic development as a whole. Racial and ethnic disparities also threaten the financial stability of the health care industry and federal government by raising costs for individuals, providers, private insurance, and public programs, like Medicare and Medicaid.<sup>55</sup> Inadequate care today frequently costs more in the future because missed or incorrect diagnoses or ineffective treatment for chronic illness can lead to otherwise unnecessary care. This problem is cyclical because disparities in health care can undermine the public's faith in medical and public health institutions. People then become reluctant to seek care until a problem reaches a critical stage, and costs are higher.<sup>56</sup>

#### **Strategies to Address Disparities**

The most promising current strategies to address disparities in health care include enhancing services, improving access, and increasing the number of minorities in health professions. Most of these efforts are in their early stages,

and it has not been possible to evaluate their effectiveness fully.<sup>57</sup> Because the mechanisms that cause disparities in health care have not yet been clearly delineated, there may be additional strategies that would work well.<sup>58</sup> For these reasons, experts agree it is important to improve health services data collection and survey research. Program and research-based solutions are often viewed as part of quality improvement efforts in which the goal is to improve services for all people, including different racial and ethnic groups, by equalizing care across the board.<sup>59</sup>

#### *1. Enhancing Health Care Services Programs*

Health care institutions and providers have developed programs that try to equalize care across populations by addressing specific needs of various racial and ethnic groups.

- *Outreach and Education:* Traditional programs are becoming more culturally sensitive. The use of community workers, for example, helps providers reach people who might not otherwise seek care.<sup>60</sup> Language-translation services help patients who have difficulty with English. “Cultural competence” education teaches care providers how to better address patients’ cultural beliefs and behaviors.<sup>61</sup>
- *Clinical Guidelines and Decision-Making:* By requiring providers to base decisions on clinical guidelines (published standards of care), health systems can try to ensure that patients receive treatments based on medical need, not on race or ethnicity differences.<sup>62</sup>

#### *2. Improving Access*

Creating new programs in minority neighborhoods and increasing transportation to existing services elsewhere are important means of improving access. Increasing the availability of insurance coverage helps increase access as well.<sup>63</sup> To reduce barriers within health plans, experts recommend policies to strengthen the stability of patient-provider relationships over time, so patients can continue to visit care providers they are comfortable with.<sup>64</sup> Experts also recommend financial policies that allow providers to have sufficient time with each patient.<sup>65</sup>

#### *3. More Minorities in Health Professions*

Experts believe that having a greater percentage of racial and ethnic minorities in the ranks of health care professionals will help reduce culture and language barriers within the system, and help ensure more providers are available in ethnic and minority communities.<sup>66</sup>

#### *4. Racial and Ethnic Health Care Data Collection*

In order to better understand the causes and solutions of this problem, many experts believe that data collection about access and utilization of health care services is essential.<sup>67</sup> Data can be used to support:

- *Racial and Ethnic-Specific Quality Measures.* Quality measures can allow health plans and providers to identify problem areas and develop appropriate responses.
- *Report Cards.* If report cards are available, private and public purchasers may be more likely to consider the issue of disparities in health care in their purchasing decisions, which can motivate health plans and providers to address disparities.
- *Research and Policy Planning.* Data that helps researchers evaluate the causes of the problem may allow policy makers to plan initiatives that improve the quality of care.

One way to ensure better data collection is to include racial and ethnic identification in data that hospitals and health plans provide to accrediting organizations and purchasers.<sup>68,69</sup> Supporters advocate that reporting requirements be established by federal and state programs, as well as accrediting bodies such as the National Center for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

While most health plans do not collect racial and ethnic data, a growing number do.<sup>70</sup> For example, Aetna U.S. Healthcare has implemented a program, “The Minority Health Initiatives,” which includes voluntary collection of data on race/ethnicity and language preference.<sup>71</sup> Few health organizations are likely to adopt similar practices unless there is a more compelling business reason to collect data (such as purchasers’ consideration of racial and ethnic disparities) or a legislative mandate.

Both supporters and opponents recognize there are challenges and concerns in collecting and reporting health care data by racial and ethnic categories. In addition to practical concerns about costs and ensuring data accuracy, there are legal, ethical and practical concerns about protecting patient confidentiality and privacy and preventing health plans and others from using the information discriminatorily. Currently no federal statutes prohibit the collection of racial, ethnic or primary language data. Although an increasing number of policies emphasize the need for such data collection, these policies are not uniform,<sup>72</sup> and states can create laws that prohibit health plans from collecting this information.<sup>73</sup>

### 5. Survey Research

Given the complexity of the issues at hand, researchers and governmental agencies call for more research to understand the causal mechanisms at work.<sup>74,75</sup> New survey research about the health status, health opinions, and health services experiences of racial and ethnic minorities as compared to whites may be a critical part of such efforts. Existing surveys such as MEPS,<sup>76</sup> NHANES,<sup>77</sup> and NHIS<sup>78</sup> can include related questions to support these efforts.<sup>79</sup>

### Federal Efforts to Date

The federal government plays a significant role in the health care of minority Americans. For example, it finances 45 percent of African Americans with insurance through Medicare, Medicaid, and military health care, including the Department of Veterans Affairs and the Department of Defense’s TRICARE program.<sup>80</sup> It also provides health care services, particularly preventive care, to minority groups through public health programs.

In Healthy People 2010, the nation’s health care agenda for this decade, the Surgeon General explicitly includes the elimination of racial and ethnic disparities in health as a primary goal. Following this recommendation, there have been a greater number of efforts within federal agencies to document, understand, and address this issue. Many agencies have developed central offices to direct minority-specific efforts internally. However, there is no interagency plan or coordinated budget to address racial and ethnic disparities in health care. Further, many efforts focused on addressing health care disparities are intertwined with those designed to address disparities in health status, and there is less focus on disparities in health care per se.

#### *Documentation & Monitoring*

To better document both the extent of the problem and progress in overcoming it, Congress enacted the “Healthcare Research and Quality Act of 1999” and requested that the Agency for Healthcare Research and Quality (AHRQ) produce two complementary annual reports. The first of these, the National Healthcare Quality Report, addresses quality of care issues generally, noting that equality across populations is a necessary component. It focuses on a set of performance measures that serve as a baseline for evaluation. The second, the National Healthcare Disparities Report, focuses on health care disparities explicitly, and looks at these same quality performance measures in “priority populations,” including racial and ethnic minority groups, as well as women, children, the elderly, low income groups, residents of rural areas, and individuals with special health care needs.<sup>81</sup> The first set of these reports was released in late December 2003.<sup>82</sup> Among their primary conclusions, the reports note that Americans have high quality care in general, but the National Healthcare Disparities Report also notes that racial and ethnic disparities exist. In some cases, ethnic and racial minorities do worse than the general population, and in some cases they do better. Often the areas in which racial and ethnic groups do well coincide with efforts to improve disparities. The reports also suggest that there is much to learn and greater improvement in this area is possible. Particular areas to note include preventive care and management of chronic disease.

### *Program Research*

There are a limited number of research efforts to develop and evaluate new strategies to address disparities within the health care system. Several of these programs have been supported by the Agency for Healthcare Research and Quality (AHRQ). For example, AHRQ developed a program entitled Excellence Centers to Eliminate Ethnic/Racial Disparities (EXCEED), which has awarded grants “to analyze underlying causes and contributing factors for racial and ethnic disparities in health care and to identify and implement strategies for reducing and eliminating them.” Efforts are centered around evaluating projects linked by a central theme, like cultural competence.<sup>83</sup>

### *Program Development*

While multiple government efforts address minority health status, relatively few programs address racial and ethnic disparities in health care. One example of a health care-specific program is “Take a Loved One to the Doctor Day.” This event is part of the Department of Health and Human Services’ “Closing the Health Gap,” a larger effort intended to reduce disparities in health status by bringing awareness and education messages to minority communities through radio programming. “Take a Loved One to the Doctor Day” is designed to encourage “individuals to take charge of their health by visiting a health professional, making an appointment for a visit, attending a health event in the community, or helping a friend, neighbor or family member do the same.”<sup>84</sup>

There have been efforts to develop guidelines or quality measures for health care programs, such as:

- *Measuring Cultural Competence in Health Care Delivery.* The Health Resources and Services Administration (HRSA) is developing a cultural competence measurement profile for health care delivery settings.<sup>85</sup>
- *Disparities Quality Report Card.* HRSA is developing a report card “to assess quality at the health plan level for members of various racial/ethnic minority groups.”<sup>86</sup>

### *Regulations*

Federal agencies are beginning to implement policies and regulations that encourage relevant bodies to address racial and ethnic disparities. As part of the regulations surrounding implementation of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, health plans that participate in Medicare+Choice will be required to participate in a special project on either disparities in health care or cultural and linguistically appropriate services.<sup>87</sup>

### *Training and Recruiting of Minority Health Professionals*

Several agencies include provisions to train, recruit and retain minority health care researchers and providers. The Indian Health Services (IHS) provides loans and scholarships to American Indians and Alaska Native individuals interested in the health profession.<sup>88</sup> The National Institutes of Health, while focused on biomedical and bio-behavioral research rather than health care research, funds training and professional development programs for minority students and faculty through its Office of Minority Health and Research (OMHR).<sup>89</sup> To document the extent of disparities in the number of providers, the Bureau of Primary Health Care at HRSA is conducting a series of minority health research and evaluation studies to assess the ratio of minority health care providers to patients in the centers it funds.<sup>90</sup>

### **Current Legislation**

The 108th Congress is considering a range of approaches to address issues raised by racial and ethnic disparities in health care. Two major proposals embody these approaches. The “Healthcare Equality and Accountability Act” (S. 1883/H.R.3489), introduced on November 6, 2003, represents the approach of Senate and House Democratic leadership. The Senate Republican leadership approach is under development and will be introduced later in this Congress.

Major provisions of S.1883/H.R. 3459 would:

- Expand coverage by giving states the option to broaden eligibility and streamline enrollment in Medicaid and the State Children’s Health Insurance Program.
- Reduce language and cultural barriers by codifying existing standards for culturally and linguistically appropriate health care, assisting care professionals to provide cultural and language services, and increasing federal reimbursement for these services.
- Improve workforce diversity by expanding existing programs and creating new ones to address the shortage of minority health care providers.
- Increase funding for programs to reduce health disparities, including providing grants for community initiatives and funding programs to help patients navigate the health care system.
- Improve data collection on race, ethnicity, and primary language to identify the sources of health disparities, implement effective solutions, and monitor improvement.
- Promote accountability by expanding the Office of Civil Rights and the Office of Minority Health at the Department of Health and Human Services; by

creating minority health offices at the Food and Drug Administration and the Centers for Medicare and Medicaid Services; and by establishing compliance offices in federal health agencies.

- Strengthen health institutions that serve minority populations by establishing loan and grant programs as well as quality improvement initiatives.

The Senate Republican leadership is developing legislation to deal with the problem of disparities in health status among racial and ethnic minorities. Tentatively titled “Closing the Health Care Gap Act of 2003,”<sup>91</sup> this draft legislation would:<sup>92</sup>

- Provide grants to promote broad local health awareness and prevention programs.
- Expand health coverage available to the uninsured using tax credits among other resources.
- Expand the mission of the Office of Minority Health at the Department of Health and Human Services.
- Increase federal funding for programs that increase the pool of minority health care professionals.
- Increase the level of federal support for historically black colleges and universities.
- Steer more money into researching health disparities and developing strategies to combat the problem.

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- <sup>3</sup> The Institute of Medicine defines the term quality of care as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” See Smedley, B. 2002. *Unequal Treatment*.
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- <sup>6</sup> Ibid.
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- <sup>49</sup> National Center for Health Statistics. *Health, United States, 2003*. Table 28. Retrieved from: <http://www.cdc.gov/nchs/data/hs/tables/2003/03hus028.pdf>. Please note that the NCHS states that these data slightly overestimate the death rate for African Americans and whites and slightly underestimate the death rates for Hispanics and Asians or Pacific Islanders. Data for American Indians have more error, and for this reason, have not been included. Error is due in large part to misclassification of race and ethnicity during standardized data collection processes.
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- <sup>52</sup> U.S. Department of Health and Human Services. *Healthy People 2010*. Retrieved from: [http://www.healthypeople.gov/document/html/uih/uih\\_1.htm](http://www.healthypeople.gov/document/html/uih/uih_1.htm).
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- <sup>55</sup> Ibid.
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- <sup>73</sup> Proposed legislation to restrict racial and ethnic group data collection as part of Proposition 54 was turned down in California by public vote on October 7, 2003.
- <sup>74</sup> Smedley, B. 2002. *Unequal Treatment*.
- <sup>75</sup> U.S. GAO. 2003. *Health Care: Approaches to Address*.
- <sup>76</sup> Medical Expenditure Panel Survey, sponsored by the Agency for Healthcare Research and Quality (AHRQ) and the National Center for Health Statistics (NCHS).
- <sup>77</sup> National Health and Nutrition Examination Surveys, conducted by the National Center for Health Statistics
- <sup>78</sup> National Health Interview Study, conducted by the National Center for Health Statistics
- <sup>79</sup> U.S. GAO. 2003. *Health Care: Approaches to Address*.
- <sup>80</sup> Ibid.

<sup>81</sup> The report defines individuals with special health care needs as: “children with special needs, the disabled, people in need of long-term care, and people requiring end-of-life care.”

<sup>82</sup> The reports are available online at: <http://www.qualitytools.ahrq.gov>.

<sup>83</sup> Information available at: <http://www.ahcpr.gov/research/exceed.htm>.

<sup>84</sup> Information available at: <http://www.healthgap.omhrc.gov/index.htm>.

<sup>85</sup> Information available at: <http://www.hrsa.gov/OMH>.

<sup>86</sup> Nerenz, D. 2002. [Eliminating Racial/Ethnic Disparities](#).

<sup>87</sup> Ibid.

<sup>88</sup> Information available at: <http://www.ihs.gov>.

<sup>89</sup> Information available at: [http://ncmhd.nih.gov/about\\_ncmhd/what.asp](http://ncmhd.nih.gov/about_ncmhd/what.asp).

<sup>90</sup> Information available at: [http://bphc.hrsa.gov/OMWH/minority\\_health.htm](http://bphc.hrsa.gov/OMWH/minority_health.htm).

<sup>91</sup> Summary available at: [http://caregivers-usa.org/news/frist\\_minority.html](http://caregivers-usa.org/news/frist_minority.html).

<sup>92</sup> Personal communication with staff of Senator Frist. November 4, 2003.

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