

Call to Action on Health

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Dear Health Advocate:

In 2004 in the wealthiest nation in the world, large numbers of people do not have access to quality healthcare services. Recent studies show us that despite improvements in health and healthcare across the board, African Americans continue to suffer significantly worse health outcomes than their white counterparts in many disease areas. This state of affairs is unacceptable to the NAACP and our members; and more importantly, it is a state of affairs that can be changed for the better.

The NAACP issues this *Call to Action on Health* to our members and to leaders and policymakers in communities, healthcare facilities, and government entities across the nation. We ask that you work with our national, state, and local Health Committees as we develop and implement a *Five-Year Healthcare Equity Partnership Plan* for reducing the racial disparities in healthcare by at least 25% over the next five years.

This is an ambitious goal, one that will require the participation and commitment of all stakeholders in our healthcare systems: patients and their families, healthcare professionals and providers, advocacy and membership organizations, private healthcare and medical companies, and government policymakers. None of us can address this critical problem alone; but working together, we can translate our knowledge about the problem into solutions. We look forward to working with you on these critical issues.

With best wishes and hope for the future, I am,

Sincerely,

Kweisi Mfume
NAACP President and CEO

Dear Health Advocate:

While we are seeing healthcare and technology result in wonderful outcomes in many aspects of health – cancer survival, infant mortality, longevity and the like – there are incomprehensible numbers reminding us that these wonders do not exist for all Americans, particularly racial and ethnic minorities. African Americans have overall worse outcomes, up to and including higher rates of death, in the treatment of cancer, cardiovascular disease, HIV/AIDS, diabetes, and mental illness, than white Americans. Some of the disparity is attributable to problems such as lower incomes, lower educational levels, less access to care, and less insurance coverage; but even taking these problems into account, the disparities persist .

This clearly creates a need for all Americans, and particularly our NAACP family, to create an outcry insisting on change in the current healthcare system. The status quo is literally killing us, and cannot continue to go unaddressed. This document, the NAACP's *Call to Action on Health*, explains what the issues are, and what we can do to address them. If each of our state, local, and college NAACP Health Committees takes up this charge, working with our community partners in both the private and public sectors, we will quickly see changes in our communities. It is time for us – and for government officials and healthcare administrators – to actually go to work to end the health disparities, and not simply give lip service to the problem.

We wish to thank Pfizer, Inc., a research-based pharmaceutical company devoted to healthcare, for their partnership in this important project. They have provided critical resources to the research and preparation of the *Call to Action on Health*, and are committed to working with us and with our members across the nation to close the healthcare gap in this country. This is an example of the type of ongoing partnership that is essential to our success in achieving equitable access to quality healthcare for all.

The NAACP and its Health Advocacy Division have long noted that quality healthcare is a human right of all Americans. We also recognize that to fight for all of our rights and freedoms, we need freedom fighters – and they must be healthy in order to fight and win the battle! This *Call to Action on Health* is the NAACP's directive to all, to see that health disparities are ended now.

Sincerely,

Willarda V. Edwards, MD, MBA
NAACP National Health Advocacy Director

Health Disparities in the African American Community

The National Institutes of Health (NIH) define “health disparities” as “the differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.” As the American Medical Association notes, “Health disparities are the result of biologic, genetic, social, cultural, and environmental factors, as well as specific health behaviors. Health disparity is also the outcome of racial and ethnic differences in rates of access, utilization, and prescription of health care services.”¹

A number of recent reports suggest that racial and ethnic minorities receive different kinds and quality of healthcare than non-minorities, resulting in poorer health outcomes. According to the 2002 Institute of Medicine (IOM) report on racial and ethnic disparities in healthcare in the United States, African Americans have the highest mortality rates of any U.S. racial and ethnic group, 1.6 times higher than that of whites.² This ratio is the same as the black/white mortality ratio in 1950.³ In a number of areas – from specific diseases such as diabetes, cancer, and HIV/AIDS, to broader factors such as environmental toxicity and lack of health insurance – African Americans across the United States suffer from the results of hampered access to a full range of healthcare services.

For decades, the NAACP has been working to improve the health status of African Americans and to ensure access to quality healthcare services. Most recently, in its strategic planning process during 2003, the NAACP recognized once again the serious impact that problems and disparities in the healthcare system have on the lives of African American men, women, and children. These disparities are unacceptable; but more importantly, they are correctable. By raising awareness about this problem and empowering our members with the information needed to take action, we can end the healthcare gap in the United States.

Since the publication of the IOM report and the development of the NAACP strategic plan for health advocacy, the NAACP National Health Committee and the NAACP Health staff have been highlighting the need for each NAACP state and local branch to establish Health Committees, involving representatives from all the branches within the state. These state and local Health Committees will play a critical role in the implementation of the NAACP’s strategic plan for health advocacy. The health committees will provide information and guidance to the NAACP’s national and regional work and programming in this area. Just as importantly, the local Health Committees will be able to work within their own communities, evaluating the status of healthcare services and meeting the health needs of their constituents. Working together, we can affect the healthcare services available and decrease health disparities at the local, state, regional, and national levels.

The information and recommendations in this Call to Action on Health are tools for the use of our local branches and state Health Committees as they work on these issues, as well as for the regional and national offices. The Call to Action incorporates the findings and recommendations of the IOM report, information and ideas from other reports, and resources available from the NAACP and other medical and healthcare organizations. What you do, and what pieces make

sense for your community, are for you to decide. The National Health Advocacy Division staff looks forward to providing any assistance needed by the committees as they undertake this work.

The NAACP is submitting this document as a Call to Action, and requests that each NAACP Health Committee take the following steps:

- In consultation with the community, develop and submit to the NAACP National Health Division a *Five-Year Healthcare Equity Partnership Plan* for reducing the racial disparities in healthcare by at least 25% over the next five years.
- The requested Five-Year Plan should include an agreed upon method for measuring achievement. That method should include measures along the dimensions mentioned in this Call to Action.
- The requested Five-Year Plan should include specific forms of corrective action that the locality, state, or district will undertake in order to move toward the elimination of racial disparities in healthcare.
- The requested Five-Year plan should identify the resources that your state and local branches plan to dedicate to the initiative, and outline the community support and resources that would assist you in implementing your plan.

The NAACP recognizes that putting an end to egregious racial disparities will require a concerted and coordinated effort among health policymakers, administrators, patients, community groups, and healthcare and pharmaceutical companies. We strongly urge you to take action now and collaborate with the NAACP as we engage healthcare policymakers and providers across the United States in a local, state, and national campaign to eliminate these racial disparities and close the health disparities gap. Again, please submit all plans and steps to the NAACP by December 31st. Thank you in advance for your cooperation.

NAACP 2002 Resolution on Equity in Health Care & Safety

WHEREAS, the study made public by the Institute of Medicine on March 21, 2002 is the first comprehensive look at racial disparities in healthcare among people who have insurance; and

WHEREAS, the study found that racial and ethnic minorities receive lower quality healthcare than non-minorities, even when access factors such as patient's insurance status and income are controlled; and

WHEREAS, the study found that the source of the disparities are rooted in historic and contemporary inequities and involve many participants at several levels, including health systems, their administrative and bureaucratic processes, utilization managers, healthcare professionals, and patients; and

WHEREAS, the study found that minorities are less likely to be given appropriate medications for heart disease or to undergo bypass surgery, are less likely to receive kidney dialysis or transplants than whites and are also less likely to receive the most sophisticated treatments for HIV infection, which could delay the onset of AIDS; and

WHEREAS, the study found that in major medical centers in New York State, African-Americans were 37% less likely to undergo angioplasty and other heart procedures, including bypass surgery, than whites and in ninety (90%) percent of the cases in which patients did not get the surgery, the doctor had not recommended it; and

WHEREAS, minorities are more likely to receive certain less desirable procedures; for example, African-Americans are 3.6 times as likely as whites to have lower limbs amputated as a result of diabetes; and

WHEREAS, in interviews with doctors, researchers found "classic negative racial stereotypes," such as assumptions that African-American patients would be less likely to participate in follow-up care;

THEREFORE, BE IT RESOLVED THAT, the NAACP support the Institute of Medicine's recommendation to improve the quality of care for racial and ethnic minorities by promoting the increase of the proportion of under-represented U.S. racial and ethnic minorities among healthcare professions; and

BE IT FURTHER RESOLVED THAT, the NAACP promote culturally appropriate education programs to improve minority knowledge of how to access care and how to improve the ability to participate in clinical decision-making; and

BE IT FURTHER RESOLVED THAT, the NAACP promote cross-cultural curricula to be integrated into the training of future healthcare providers and practical, care-based, rigorously evaluated training to persist through practitioner continuing education programs; and

BE IT FINALLY RESOLVED THAT, the NAACP urges health plans, federal, and state payers to collect, report and monitor patient care data as a means to assess progress in eliminating disparities, to evaluate intervention efforts, and to assess potential civil rights violations. **(2002)**

NAACP 2003 Resolution Expressing Concern for the Disparate Health Care Treatment Afforded to African Americans

WHEREAS, the United States Congress authorized the study of disparities in the health care treatment system; and

WHEREAS, a study was undertaken by the National Institute of Medicine that found that minorities were receiving substandard health care in comparison [to] the comparable white citizens; and

WHEREAS, these disparities existed regardless of income or insurance coverage; and

WHEREAS, the overwhelming evidence suggested by the study demonstrated that African-Americans received substandard health care; and

WHEREAS, this substandard health care has led to higher death rates for African Americans in the categories of HIV/AIDS, cancer and heart disease; and

WHEREAS, the study concluded that bias and stereotyping contributed to racial and ethnic disparities in the health care system; and

WHEREAS, minorities are more likely to receive less desirable surgical procedures, such as amputations at a rate up to 3.6 times greater than their white Medicare peers; and

WHEREAS, patient education and more racial and ethnic minority health care professionals will serve to ameliorate systematic disparities in the health care industry.

THEREFORE, BE IT RESOLVED THAT all local NAACP units collaborate with local medical care centers and treatment facilities to develop patient education programs and to promote enhanced recruitment and retention of African American health care providers; and

BE IT FINALLY RESOLVED THAT the NAACP re-affirms its 2002 resolution “Equity in Health Care & Safety” at its 2003 Convention in Miami, Florida. **(2003)**

Disparities in the Prevalence and Management of Diseases

The healthcare services and healthcare needs of minority populations in the United States are impacted by a variety of social, political, cultural, and economic factors. As found by the Institute of Medicine, “Racial and ethnic disparities in healthcare exist and, because they are associated with worse outcomes in many cases, are unacceptable.”⁴

The NAACP has recognized the critical importance of effective advocacy in this field for many years. In our 1995-1996 Health Summits, we stated the following: “The NAACP’s Health Summit participants concluded that strong advocacy efforts were needed to ensure that the health needs of African-Americans and other minorities are adequately addressed in the current debates surrounding the health care delivery system. In addition, it is imperative that branches of the NAACP receive adequate information and training on the issues regarding the status of minority health, strategies for advocacy efforts and particularly education in the area of managed care in the minority communities, i.e. resources that are needed from this particular health delivery system.”

This report and recommendations supply us with our next steps in this important work for the health and well-being of ourselves, our families, our communities, and the community at large.

The History of Healthcare Services in the United States

As documented by the Institute of Medicine, “Racial and ethnic disparities in healthcare occur in the context of broader historical and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life.”⁵ Historically, the United States has long had racially segregated healthcare systems, whether explicitly or *de facto*. During slavery, slaves routinely received healthcare in separate hospitals set up either on plantations by plantation owners, or by white physicians who organized hospitals for slaves and contracted with plantation owners to provide healthcare.⁶ After the end of the Civil War, the federal Freedmen’s Bureau established nearly 100 hospitals for freed slaves; however, by 1868, only the one at Howard University Medical Center remained in operation.⁷ Over the following decades, healthcare services provided for “the poor” were theoretically provided by state and local governments; however, they were almost uniformly inadequately funded and culturally insensitive.⁸

During the early to mid-twentieth century, Jim Crow laws legally separated facilities for black and white communities. Scientific theories such as Darwinism and eugenics were used to predict and explain perceived inferiority in certain groups, including African Americans. And as hospitals became more and more important as centers of medical training and provision of care, minority patients and healthcare providers were increasingly excluded. Minority physicians responded by establishing their own facilities; however, it remained difficult to provide adequate services, especially as patients’ ability to pay – as opposed to public funding – became an increasingly significant factor in determining who received medical services.⁹

In recent decades, the passage of civil rights legislation and the establishment of Medicare and Medicaid in the 1960s changed the structure of healthcare dramatically. Mandated integration resulted in 70 black hospitals either closing or merging with white hospitals between 1961 and 1988. According to studies reviewed by the IOM, these closings were not mere shifts in service sites; instead, they were often devastating for minority communities, resulting in “a loss of geographic convenience and accessibility to care, a sense of safety with known institutions, and a loss of a major source of employment in the community.”¹⁰ Followed as they were by a dramatic rise in managed care plans during the 1980s and 1990s, large urban hospitals continued to downsize or close, reducing care sites accessible to many African Americans even further.¹¹

Racial Disparities in the Broader Culture of the United States

Racial disparities and biases in the provision of healthcare services for African Americans cannot be viewed outside of the broader cultural and societal context of the United States. Over the past fifty years, racial attitudes and race relations in this country have undergone many changes. Some are positive and some are negative, resulting in a seemingly contradictory picture. For example, recent research by sociologist Lawrence Bobo found that Americans’ attitudes toward integration and equality have steadily improved in recent decades.¹² At the same time, public support has not grown for policies or other efforts to improve educational, employment, housing, and other opportunities for racial and ethnic minorities in the United States; and white Americans continue to believe negative stereotypes regarding African Americans’ intelligence, industriousness, propensity towards violence, and preference for living on public assistance.¹³

Evidence of discrimination based on race exists not only in the world of healthcare, but in a variety of societal spheres in the United States. Examples include housing, mortgage lending, education, employment, and the criminal justice system. Each of these areas impacts on availability of and access to healthcare services, emphasizing once again that health and healthcare disparities cannot be viewed within a vacuum.

Sources of Racial Disparities in the Healthcare System

“Many sources – including health systems, healthcare providers, patients, and utilization managers – may contribute to racial and ethnic disparities in healthcare.”¹⁴ In order to address the problem of healthcare disparities effectively, each of these sources must be examined and considered. Only by improving our understanding of each one’s contributions to this problem can we move towards a system of equality in healthcare.

Many patient and system-level factors contribute to differences in healthcare experiences, which in turn may contribute to disparities. Patient-level variables include an array of issues: preferences for particular types of treatment;¹⁵ mistrust of medical providers, which is higher among minority patients;¹⁶ treatment refusal (African American patients are slightly more likely to refuse certain types of care, particularly invasive procedures; however, this does not account for much if any of the overall disparities in outcomes);¹⁷ biological differences that may justify differences in receipt of care;¹⁸ and overuse of clinical services by white patients.¹⁹

At the health-system level, differences in decisions and outcomes can occur at many points both prior to and during interaction with healthcare providers. As the Institute of Medicine described in its recent report, the variables that result in disparities seem endless. For example, African American patients may experience lower rates of availability of services, and access to services may be less convenient or obvious.²⁰ Differences in referral patterns, the logistics of maneuvering through clinical bureaucracies, and the fragmentation of healthcare systems, particularly when specialty care is necessary, may result in different rates in the receipt of services for racial and ethnic minorities even when formal “equality” of access exists.²¹ Finally, managed care, market forces, and legal and regulatory policies may drive decision-making within the healthcare structure, and may not successfully protect African Americans from healthcare system failures.²²

In addition to systemic and structural contributors to disparities, “[b]ias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare.”²³ Medical decision-making always takes place within the time pressure of clinical encounters, and almost always with limited information on the part of providers. As a result, the opportunity for biases, stereotyping, and prejudices – including those related to race and ethnicity of the patient and/or the provider – to contribute to decision-making arises.²⁴ Whether consciously or unconsciously, providers may rely on negative stereotypes about African American patients (for example, that they comply with treatment less frequently), resulting in differences in medical treatment decisions; and different medical treatment, in turn, can have a negative impact on African Americans’ willingness to access the healthcare system, or to trust its advice and guidance.²⁵

Disease-specific Disparities

African Americans and other racial and ethnic minorities experience worse health outcomes for many particular diseases and conditions than their white counterparts, as described below. Some of the gap is attributable to higher prevalence rates; that is, a particular disease may actually occur more often among African Americans and other racial and ethnic minorities than among whites. Some of the gap, however, arises from another problem, known as the prevalence-to-diagnosis gap: African Americans may experience lower diagnosis rates or diagnosis later in the course of the disease; lower rates of treatment or lesser quality of treatment; or lower rates of treatment compliance. When considering health disparities and ways to reduce them, it is critical to address this prevalence-to-diagnosis gap.

Adequate health awareness and literacy and access to quality prevention and treatment services leads to earlier diagnosis and better management of disease. Doctors and patients can manage disease by encouraging wellness both before and after disease contraction (through diet and exercise, and through appropriate disease management), providing access to quality care and treatment options, and ensuring that patients know and understand about their own disease and its treatment options. In many cases, the direst outcomes of disease can be avoided, making it possible to manage and control chronic diseases; and overall health can be improved.

Cardiovascular Diseases

The prevalence of this disease among African-Americans remains higher than among whites: nearly one in three African-Americans has high blood pressure, compared to one in four whites.²⁶ Although rates are declining across the board, age-adjusted heart disease death rates are 29% higher among African Americans.²⁷ Between 1992 and 2000, rates of myocardial infarction (i.e., heart attacks) declined by 28% among whites, but by only 19% among African Americans.²⁸

Heart disease is related to a number of other health concerns, including hypertension, high cholesterol, diabetes, congestive heart failure, and stroke. In almost all of these areas, African-Americans have multiple risk factors for heart disease, including high blood pressure, high cholesterol, diabetes, an inactive lifestyle, being overweight or obese, and smoking. Over thirty million Americans have both high blood pressure and high cholesterol, two of the major, controllable risk factors for heart disease. When the two conditions co-exist, they compound the risk for heart disease.²⁹ Furthermore, African Americans are less likely than whites with similar health situations to receive certain cardiovascular procedures, including coronary artery bypass graft (CABG),³⁰ percutaneous transluminal coronary angioplasty (PTCA),³¹ and cardiac catheterization.³²

High Blood Pressure (Hypertension)

Rates of hypertension are on the rise among both African Americans and whites in the United States. As of 2000, however, the prevalence of this disease among African Americans remains significantly higher than among whites: 36% versus 30% overall.³³ When considered by gender and age, similar disparities between African Americans and whites are apparent.³⁴ Differences were most significant among people between the ages of 40 and 59: 50% of African Americans in this age group tested positive for hypertension, compared with only 30% of whites.³⁵

Diabetes

Diabetes, a chronic disease that can result in serious illness and death, affects over 2.7 million African Americans in the United States.³⁶ The prevalence of diabetes among African Americans is 11%, compared with only 8% among whites.³⁷ Most people with diabetes don't know that they are at increased risk for heart disease, even though 2 out of 3 people with diabetes die of heart attack or stroke. Diabetes is an independent risk factor for heart disease, heart attack and stroke.

Approximately 25% of black women over 55 have diabetes, as do 25% of all African Americans between the ages of 65 and 74.³⁸ Rates of diabetes among African American children are also on the rise.³⁹ African Americans experience a significantly higher rate of illness and mortality related to diabetes than white Americans, and yet diabetes is managed more poorly in minority patients.⁴⁰ For every white American diagnosed with diabetes, 1.6 African Americans are diagnosed; and they are more likely to develop complications and disabilities related to those complications,⁴¹ including higher rates of kidney failure and higher rates of lower extremity amputation.⁴²

Diabetes is a disease that can be effectively controlled, and standards of care for its treatment are published regularly.⁴³ Recommended care includes ongoing controlling of blood sugar (glycemia), lipids, and blood pressure and screening for diabetic eye disease (retinopathy), kidney disease (nephropathy), and foot disease; however, the recommended standard of care is often not achieved.⁴⁴

Stroke

Strokes are a significant source of death and disability among African Americans in the United States. Although African Americans have a slightly higher rate of stroke than whites across the board,⁴⁵ the disparities between African American women and white women are particularly striking: stroke mortality rates among African Americans are 40% higher than among white Americans, and are highest among African American women.⁴⁶

High Cholesterol

High cholesterol has an impact on the risk of developing heart disease. Among African-Americans, 45% of men and 46% of women have total blood cholesterol levels over 200 mg/dl.⁴⁷ Eleven percent of African-American men and 18 percent of African-American women have total blood cholesterol levels of over 240 mg/dL.⁴⁸ African-Americans are less likely than whites to report having their cholesterol levels checked, or take cholesterol-lowering medications.⁴⁹

HIV/AIDS

The incidence rates of HIV infection and death vary significantly by race. In 2001, African Americans – comprising only 12% of the population – accounted for 50% of the new HIV cases reported in the United States.⁵⁰ The rate of new AIDS cases is also much higher among African Americans: a rate of 75 per 100,000, as compared with 7 per 100,000 among whites.⁵¹ AIDS is the leading cause of death among African American women ages 25 to 34, and among African American men ages 35 to 44.⁵²

As early as 1992, the NAACP recognized that “HIV/AIDS is a public health crisis in the African-American community.”⁵³ Despite over a decade of work urging African American leaders and organizations, government officials, and individual members of the African American community to improve prevention and treatment for this epidemic, the problem has not decreased.

According to the Institute of Medicine, “HIV infection continues to spread more rapidly among African-American and Hispanic populations than any other racial/ethnic group in the United States.”⁵⁴ Despite the expansion of federal government programs to increase the availability of antiretroviral therapies, minorities face greater barriers to appropriate care than whites.⁵⁵ As a result, African Americans who are HIV positive “are less likely to receive antiretroviral therapy, less likely to receive prophylaxis for pneumocystis pneumonia, and less likely to receive protease inhibitors than non-minorities with HIV.”⁵⁶

The fight against the HIV epidemic also must address its physical, mental and social aspects within the African American and broader community and culture. Often the stigma attached to HIV and AIDS creates an additional barrier for those in need of services to treat and manage their disease. Prevention and treatment services, as well as research efforts, must take these realities into account.

In its Health Resolutions in 1998-99, the NAACP recognized that the rate and severity of HIV/AIDS among the African American community continued to increase, and that existing policies were failing to respond effectively to the community's prevention and treatment needs. Noting that "the [African American] population has been left vulnerable as prevention and health care options have been neglected," the organization specifically called on the government to increase substantially the funds available "to help minorities with AIDS prevention and treatment," and called on African American communities and civil rights leaders to "help increase AIDS awareness."⁵⁷

Cancer

According to the recently released National Healthcare Disparities Report, racial minorities and people of lower socioeconomic status are less likely to receive cancer screening services, are more likely to have late-stage cancer at the time of diagnosis, and have higher death rates from cancer.⁵⁸ Blacks have a 10% higher cancer incidence rate and a 30% higher cancer death rate compared with whites.⁵⁹ While cancer death rates among African Americans are declining more quickly than among whites, cancer survival remains lower among African Americans for almost all cancers regardless of site or stage.⁶⁰

Additionally, African Americans tend to receive certain cancer treatments less often than whites with similar health situations. For example, "African American women were less likely than white women to receive progesterone receptor assays (a prognostic test), were less likely to receive radiation therapy in combination with radical/modified mastectomy, and were less likely to receive rehabilitation support services following mastectomy."⁶¹ Similar results were found in other studies reviewing breast cancer, prostate cancer, colon cancer, and others: African American patients received particular treatments less often, and experienced higher rates of death, than similarly situated white patients.⁶²

Sickle Cell Diseases

The sickle cell diseases primarily strike persons of African American heritage. As of 1998, approximately 38 million persons in the United States carried the trait for sickle cell disease. During the late 1990s, the National Institute of Health reduced the already disproportionately small percentage of its budget available for the support of sickle cell research and care throughout the United States between 1998 and 2003.

Recognizing the seriousness of this funding decision for African American communities, the NAACP called on the NIH to increase the funding levels for sickle cell research and care, and undertook an educational campaign to inform its members and constituents about this problem.⁶³

The NAACP has continued its support of increased availability of funding and treatment services for sickle cell disease patients, most recently by its support for the “Sickle Cell Treatment Act of 2003” (S. 874/H.R. 1736).⁶⁴

Lupus

Lupus is a chronic disease where the immune system attacks the body’s own cells. It affects any and all systems in the body, including the muscles, bones, joints, kidneys, heart, brain, liver, gallbladder, pancreas and skin. Currently, lupus has no cure, and affects more people than HIV/AIDS, Sickle Cell Anemia, Multiple Sclerosis, Cystic Fibrosis and Cerebral Palsy combined.⁶⁵ It is estimated that between 1.4 and 2 million people have lupus. One out of every 250 African-American women has lupus, and 60% of all lupus patients are African-American. People of color develop lupus at an earlier age than whites, and more often die from this disease. According to the NAACP 2001 Health Resolutions, it has been speculated that research funding for this disease has been limited because its victims are primarily women and people of color.⁶⁶

Chronic Kidney Disease and End Stage Renal Disease

Chronic kidney disease is defined as “structural or functional damage to the kidney with or without impairment of the kidney’s ability to filter water and waste from the body.” Chronic kidney disease is a degenerative disease, ultimately leading to end stage renal disease (ESRD). Research has demonstrated that disparities in care for chronic kidney disease exist.⁶⁷ There are significant differences among racial and ethnic groups in the rates of referral to renal transplant centers, in the placement on waiting lists for transplants, in the timing of placement on a transplant waiting list, and in the actual receipt of kidney transplants: African Americans receive these services at a lower rate than their white counterparts.^{68, 69}

Asthma

Approximately 15 million Americans are affected by asthma, numbers which have been on the rise since the 1980s.⁷⁰ African Americans are significantly more likely than white Americans to be hospitalized for asthma-related attacks:⁷¹ according to data in the 1990s, among children and young adults, “African Americans were three to four times more likely than whites to be hospitalized for asthma, and were four to six times more likely to die from asthma.”⁷² A variety of factors may contribute to the risk of having severe asthma attacks, from broad issues such as poverty, lack of education, inadequate healthcare access, and failure to take appropriate medications, to specific problems such as exposure to increased levels of certain indoor allergens due to substandard housing.⁷³

Escalated rates of asthma have serious consequences beyond the immediate health impacts. For example, asthma is the number one cause of school absences due to chronic illness, with asthmatic children missing an extra 10 million school days each year.⁷⁴

Mental Health Issues

Mental health issues encompass a broad range of illnesses and problems, from the relatively minor to the extremely serious, and are experienced by 7% of the adult population.⁷⁵ As noted by the National Healthcare Disparities Report, “the personal and social costs associated with inadequate mental health care are staggering” with direct costs totaling over \$69 billion in 1996, and lost productivity and premature death costing an additional \$75 billion.⁷⁶

According to a recent report by the U.S. Surgeon General, “Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender.”⁷⁷ The disparities in mental health services experienced by racial and ethnic minorities are due not only to barriers such as cost and fragmentation of services; but also to barriers that are particularly significant to minorities in mental health treatment, including mistrust, fear, and discrimination.⁷⁸

In the area of mental illness, disparities in services for African Americans play out in both over- and under-diagnosis and treatment.⁷⁹ For example, studies demonstrate that African Americans tend to receive higher quantities of antipsychotic medications in emergency room settings, both in frequency and in dosage.⁸⁰ At the same time, African Americans tend to receive less medication when presenting with depression: 44% of white patients received antidepressants within 30 days of the first indicator of depression, while only 27.8% of African American patients did.⁸¹

The NAACP’s 2001 Health Resolutions noted an array of problems with mental health services provided to African Americans, including the following:

- “Although Blacks seek out care as frequently as whites, the researchers explain, ‘Blacks are much less likely to receive care that conforms with [standard] recommendations.’”
- “[M]ental illness is often misdiagnosed in Blacks; not only are African-Americans over diagnosed with schizophrenia, their treatment is frequently of briefer duration than whites.”
- “[S]even percent of all police contacts, both investigations and complaints, involve persons believed to be mentally ill.”⁸²

Behavioral Risk Factors

Smoking

Smoking rates are on the decline across the board among African Americans and whites, men and women, and all age groups.⁸³ Nevertheless, smoking continues to have severe health consequences for African American youth and adults, with 45,000 African Americans dying from smoking-related diseases each year.⁸⁴ The American Lung Association reports that in 2001, an estimated 5.1 million African American adults (or 22% of the African American

population) smoked cigarettes.⁸⁵ Overall smoking rates among African Americans and whites are similar;⁸⁶ however, research indicates that smoking is more common among African American males than white males (27.7% vs. 25.4%).⁸⁷ The most alarming trend is that African Americans on average choose cigarette brands with higher nicotine and tar levels such as mentholated cigarettes. Studies suggest that menthol enhances the absorption of carcinogens already present in cigarette smoke.⁸⁸ Ultimately, African Americans have higher lung cancer incidence and mortality rates than whites.⁸⁹

Fortunately, smoking trends among African American youth have an increasingly positive outlook. Since the 1970s, there has been a significant decrease in smoking rates in African American youth.⁹⁰ The data published in the 2000 National Youth Tobacco Survey by the Centers for Disease Control and Prevention reveals that African American middle school and high school students are less likely to have a regular smoking habit than whites and other minorities.⁹¹

Alcohol

As with all races and ethnicities, alcohol consumption has varying medical and social consequences on African American health.⁹² Moderate alcohol use has been proven to be beneficial for the reduction of heart disease;⁹³ however, excessive alcohol use and alcohol dependency is extremely dangerous to the health of the drinker and can lead to fatal diseases such as cirrhosis of the liver.⁹⁴ Although rates of alcohol use among African Americans are lower than those among whites and Hispanics; however, African Americans have much higher diagnosis rates of alcohol-related health problems, as well as higher rates of alcohol cirrhosis and fetal alcohol syndrome.⁹⁵ “Nationwide, death rates attributed to alcohol dependence syndrome also were highest for blacks, although a higher percentage of blacks than whites abstain from using alcohol.”⁹⁶ Alcohol use and alcohol dependency can also be dangerous to those around the drinker due to social affects such as drinking and driving, violence, or suicide. Because of the many complicated factors involved, prevention and treatment efforts require an understanding of drinking behaviors and their development in order to be effective.⁹⁷

Other drug use

Illegal drug use and drug dependence continues to be a serious health problem in the African American community, and can lead to drug-related health problems.⁹⁸ A 2002 National Survey on Drug Abuse and Health revealed that 9.7% of African Americans use illicit drugs.⁹⁹ Although these rates are not disproportionate when compared with other races and ethnicities, the consequences are often different for African Americans: African Americans are much more likely than whites to be arrested on drug-related charges (both possession and distribution), and serve much longer sentences on average.¹⁰⁰ Additionally, health consequences are increasingly serious for African Americans who use drugs. HIV/AIDS can be transmitted through sharing of syringes, and people who share drug paraphernalia are at an increased risk of transmitting or obtaining this disease.¹⁰¹ Approximately one-third of new AIDS cases among African-American women were due to injection drug use or sex with an injection drug user.¹⁰²

Obesity and Low Exercise

Obesity is a major health problem in the African American community, and is a leading contributing factor to heart disease, diabetes, hypertension, and stroke.¹⁰³ A 2000 study in “Weighing in on Obesity: America’s Growing Health Epidemic” by Grantmakers in Health found that obesity affects almost 30% of African Americans.¹⁰⁴ The American Obesity Association reports that African American women suffer from the highest rates of obesity;¹⁰⁵ and obesity in children and adolescents is also alarmingly high and on the rise.¹⁰⁶ The National Health and Nutrition Survey by the CDC reveals that African American girls in particular tend to be more overweight than their white and Hispanic counterparts.¹⁰⁷

Cultural factors, including sedentary behavior and poor food choices,¹⁰⁸ have led to the obesity epidemic in the African American community. Studies show that African Americans get less exercise compared to other groups.¹⁰⁹ According to the Surgeon General, “physical inactivity contributes to 400,000 preventable deaths (17% of total deaths) a year in the United States. More than 40% of deaths in the United States are caused by behavior patterns that could be modified. A sedentary lifestyle is a major risk factor across the spectrum of preventable diseases that lower the quality of life and kill Americans.”¹¹⁰ The economic and health consequences of obesity are tremendous.

Community Public Health Issues

Environmental Toxicity

Environmental dangers plague many African-American communities. Largely due to economic factors, minorities disproportionately live in areas where environmental hazards abound. A majority of all African-Americans live in communities containing one or more hazardous waste disposal sites. Furthermore, the resources of the Superfund are not being equitably used to identify and ameliorate hazardous conditions in minority and poor areas. Environmental hazards in the home, at work and at play pose increasingly significant risks to the health of African-Americans.¹¹¹ For example, lead poisoning continues to disproportionately affect African-American children and youth; and there is a correlation between exposure to environmental contaminants and the high rate of cancer, respiratory disease and birth defects among African-American children and youth.

Violence

The environment of violence experienced within many predominantly African American communities results in significant increased risk of health and mental health problems. Violence may be intentional, as in assaults, homicides, and domestic/family violence; self-inflicted, as in suicides and drug-related overdoses; or accidental, as in drownings, fires, and motor vehicle accidents. In any of these cases, however, violence contributes to increased levels of risk of injury and harm for African Americans.

Unintentional violence impact thousands of African American families in the United States. As recently as 2001, unintentional injuries were the fourth leading cause of death among all African Americans, and the third leading cause of death for African American men.¹¹² Intentional violence also has far reaching consequences: in 2001, homicide was the fifth leading cause of death among African American men;¹¹³ suicide rates among African American men doubled between 1980 and 1995;¹¹⁴ and rates of non-lethal intimate partner violence were higher among African American women than their white counterparts.¹¹⁵ Additionally, violence experienced or witnessed by children, whether in the home or in their neighborhoods, is experienced as trauma, with immediate health effects; contributes to increased mental health problems; and results in greater likelihood of future involvement in violence, either as perpetrator or victim.

Healthcare Provision

Availability and sources of care

Regular and convenient access to comprehensive healthcare services results in better health outcomes. To be most beneficial, this should include access to information about maintaining health and general well-being, to prevention services and screenings, to quality treatment, and to needed medications is critical to reducing both the prevalence and the severity of diseases suffered by African Americans. Overall health outcomes are better when patients are not only treated for diseases that they already have; but are also identified early as at risk for contracting a particular disease, and provided with information about ways of reducing that risk through diet, exercise, and other lifestyle changes or through preventive medications and treatments.

Access to healthcare services within the community also makes regular and consistent care more feasible. In many predominantly African-American communities, there are insufficient primary care providers and routine care clinics nearby. Many people have to travel to other areas of the city or region for care, requiring significant extra time, access to private or public transportation, and resources to meet other obligations such as childcare and time off from work or school. If healthcare is needed for a child or elderly family member, the logistics become even more complicated.

According to the Institute of Medicine, consistency and stability within a doctor/patients relationship “is an important determinant of patient satisfaction and access to care.”¹¹⁶ Consumers with an identifiable “usual source of care” are less likely to report having difficulty obtaining care or going without needed services.¹¹⁷ Yet in 2001, 17% of African American men and 8% of African American women reported that they have “no usual source of care.”¹¹⁸ This is an improvement from earlier reports (in 1997, 21% of African American men and 10% of African American women reported no usual source of care); however, African Americans continue to lack a usual source of care at higher rates than whites.¹¹⁹ Similarly, African Americans are more likely than whites to report that their usual source of care is a “clinic, hospital emergency room, or hospital outpatient facility, rather than a doctor’s office.”¹²⁰

An ongoing relationship with a primary care provider increases the likelihood that an individual will access preventive healthcare services, such as blood pressure and cholesterol monitoring, flu

shots, and prostate exams or Pap smears; reduces minority patient mistrust of the healthcare delivery system; and increases appropriate access to clinical resources within the community.¹²¹ In addition to better health outcomes, having a primary care provider as one's usual source of care leads to lower long-term health care costs.¹²²

Health insurance

According to the National Healthcare Disparities Report, research suggests that people who are uninsured undergo the following negative experiences, as compared with the insured:

- Receive less preventive care, are diagnosed at more advanced disease stages and, once diagnosed, tend to receive less therapeutic care (drugs and surgical interventions)¹²³
- Are more likely both to be sicker upon hospital admission and to die while hospitalized¹²⁴
- Are more likely to have poor health status^{125,126}
- Are more likely to receive their care in a hospital outpatient clinic or emergency room
- Are more likely to report needing (but not receiving) medical care, primarily for economic reasons
- Have higher out-of-pocket medical expenses, despite generally being poorer.¹²⁷

In the face of these negative consequences, racial and ethnic minorities in the United States are significantly less likely to have health insurance than whites.¹²⁸ African Americans lack health insurance almost twice as often as whites.¹²⁹ According to the Institute of Medicine, "Insurance status, perhaps more than any other demographic or economic factor, determines the timeliness and quality of healthcare, if it is received at all."¹³⁰

Not only are African Americans considerably less likely to have insurance at all, those who are insured are more likely than white Americans to be covered through Medicaid or other publicly funded insurance.¹³¹ Because of this, Medicaid's coverage restrictions for certain services, medications, and treatment options affect both the quality and the individualized nature of healthcare services provided to African Americans.

Finally, the prevalence of managed care systems has raised concerns for African Americans and other groups that are at higher risk of many diseases and health problems. Even among those covered by private health insurance, African Americans are significantly more likely than whites to be enrolled in health maintenance organizations: 54% versus 36% respectively.¹³² The goal of managed care programs is to provide appropriate healthcare at a reduced cost by creating a financial incentive to keep people healthy and to reduce unnecessary procedures. Critics argue that managed care systems do not in fact result in healthcare savings; however, the greater concern is that they shift costs to other insurers.

African Americans in Health Professions

African Americans enter health professions at much lower rates than their percentage of the population. Furthermore, when they do enter the healthcare field, they are more likely to do so at lower levels (for example, to become trained as nurses instead of physicians, or to become trained as LPNs instead of RNs); and are less likely to become teachers and administrators at

medical professional schools. This is a concern not only because of its implications for African American healthcare providers themselves, suggesting as it does a failure to prepare, recruit, and retain minorities for careers in healthcare. It is also troubling because cultural competence among all healthcare providers results in better compliance and better health outcomes for African American and other racial and ethnic minority patients, and diversity among healthcare professionals is an important part of creating a culturally sensitive healthcare system overall.

Call to Action to End Health Disparities

The Institute of Medicine recommends that advocates and educators work to “[i]ncrease awareness of racial and ethnic disparities in healthcare among the general public and key stakeholders.”¹³³ The discussions and recommendations below provide guidance and ideas for achieving that increased awareness, ensuring access to healthcare services, and improving the delivery of care.

Each recommendation requires action – be it direct education, monitoring and oversight, or advocacy – on the part of all NAACP Health Committees. In many cases, the recommendations cannot be accomplished without the involvement and commitment of other stakeholders: coalition partners, including patient groups, provider groups, and other advocacy organizations; public and private education and healthcare entities; the healthcare and pharmaceutical industries; and federal, state, and local government officials and policymakers. By serving as the initiating and coordinating body for all of this work, the NAACP can achieve our goal of decreasing the health disparities that continue to plague African American families and communities across the United States.

Increase Individual and Community Awareness

A. Raise awareness of key diseases affecting minorities.

As the statistics in this report demonstrate, the prevalence and poor health outcomes for many diseases and conditions are higher among African Americans than other racial and ethnic groups. A need for improvement exists across the board; and many changes would impact the entire system of care, resulting in a positive impact on the prevalence rates and outcomes in almost all diseases.

Additionally, some specific diseases are of particular concern to the NAACP and its members because they affect African Americans and other minorities at unusually high rates and/or in large numbers. Successfully reducing the disparate and high rates of these diseases will require not only the general improvement of care and access needed more generally; but also specific strategies for improving awareness of the particular problem, for pursuing effective prevention, and for providing sufficient and appropriate quality treatment services.

Cardiovascular disease, for example, is the leading cause of death in the United States today, including among African Americans;¹³⁴ yet many people do not realize its significant impact, or the steps that can be taken to reduce the likelihood of serious health consequences and heart-related mortality. Similarly, HIV and AIDS have had a devastating impact on the African American community, and rates of infection continue to grow. Raising awareness about these diseases generally, and the ways in which they affect African Americans specifically, requires a significant level of resources and a culturally appropriate focus. Other pathologies, such as sickle cell diseases and lupus, affect African Americans at a dramatically higher rate than other racial and ethnic groups. Although information and awareness-raising within the African American community is needed with these diseases as well, there is a need for constant advocacy

and monitoring to ensure that research and medical services for these diseases are prioritized and sufficiently supported.

Mental health issues are surrounded by a great deal of stigma, fear, and lack of understanding, both in United States society at large and within the African American community. Many people who suffer from mental illness do not seek assistance and treatment, either because they do not recognize that they have a medical problem; or because they feel a sense of shame, personal weakness or failure. Additionally, medical providers may not identify mental health issues when they come into contact with patients because they do not ask the questions that would lead to their diagnosis. Because of all this, it is critical that public awareness and educational campaigns focus on demystifying mental health issues, informing the public (1) what they are and how they can be identified; (2) that they are medical problems (not personal failings) and are common among all demographic groups (male and female, all races, all socioeconomic classes); and (3) that in most cases, they can be managed with appropriate ongoing care and treatment. Appropriate intervention and treatment services are especially important because unidentified and/or untreated mental health issues often relate to other social problems that have a disproportionate impact on the African American community, such as homelessness, criminal justice involvement, and unemployment.

Finally, we are interested in building the capabilities of families to serve as a center of health and wellness for African American men, women, and children. Families are an important avenue for dissemination of information about healthcare services and treatment options, and family members can provide support for each other in prevention efforts and in seeking treatment services when needed.

Recommendations for all NAACP Health Committees

Community Education and Oversight

1. NAACP Health Committees, in partnership with others, should monitor healthcare prevention and treatment resources for fairness in distribution, effectiveness, and sufficiency of funds.
2. NAACP Health Committees, in partnership with others, should work together to develop health education programs that raise awareness of the disparities that exist and the increased risk level African Americans face in serious, but treatable conditions.

Policy Change and Advocacy

3. Federal, state, and local government resources should be committed specifically for healthcare prevention and treatment services among African American consumers. Records of the amounts of funding and the ways in which they are used should be compiled on a regular basis, and programs receiving funds should be evaluated with regard to quality and availability of services, patient satisfaction, and health outcomes.

4. Federal, state, and local government resources should be committed specifically for health education campaigns targeted to African American consumers, taking into account that African Americans are approximately 12% of the population and have historically experienced less access to health education and services. Records of the amounts of funding and the ways in which they are used should be compiled on a regular basis, and programs receiving funds should be evaluated for effectiveness in reaching their target audience and impacting behaviors.

Disease-Specific Recommendations

1. Sickle Cell Diseases and Lupus:^{*}

Community Education and Oversight

- NAACP chapters and branches should collaborate with state and community-level sickle cell and lupus foundation chapters to develop and implement educational programs about sickle cell and lupus within the African American community, and to coordinate fundraising programs for research and outreach programs.
- Media and public education strategies should be developed to educate African Americans about the need for an increase in funds available for sickle cell and lupus research and care.
- NAACP Health Committees should work with federal, state and local healthcare agencies, both public and private, to devise, support and implement educational and outreach programs directed towards African Americans and other sub-groups afflicted by sickle cell disease and lupus, in order to improve accessing of treatment services and to reduce the possibilities of the spread of the diseases by urging individuals to seek testing for the trait prior to having children.

Policy Change and Advocacy

- The National Institutes of Health (NIH) funding for sickle cell disease research should reflect its prevalence among African Americans, who comprise over 12% of the U.S. population.
- The National Institutes of Health (NIH) funding for lupus research should reflect its disproportionate prevalence and fatality rates among African Americans, who comprise over 12% of the U.S. population.
- The NAACP should continue its support for the “Sickle Cell Treatment Act of 2003” (S. 874/H.R. 1736), federal legislation to treat sickle cell disease patients and increase the

^{*} Many of the recommendations in this section reflect goals of the NAACP’s 1998-99 Health Resolution on Restoration of Budget Cuts by NIH for Research and Care for Sickle Cell Disease, and 2001 Health Resolution on Equitable Funding and Awareness for Lupus Research.

number of services available to them, and similar bills; and should actively advocate for their passage.

2. Cardiovascular Diseases:

Community Education and Oversight

- NAACP Health Committees should work with federal, state, and local governments and with private healthcare companies to develop and implement ongoing educational programs about cardiovascular disease that specifically target African American community members. Program materials and programs should be culturally appropriate, and should include information about the prevalence and seriousness of heart disease among African Americans; strategies for preventing cardiovascular disease, beginning in childhood and continuing throughout life; information about screening and treatment services for cardiovascular problems and risk factors (such as high cholesterol levels and hypertension); and opportunities for consultation with healthcare professionals.
- NAACP Health Committees in partnership with others should work with federal, state, and local government agencies to raise awareness about cardiovascular diseases to members and constituents.

Policy Change and Advocacy

- NAACP Health Committees in partnership with others should work with federal, state, and local government agencies to ensure that funding for the prevention and treatment of cardiovascular disease and related risk factors are available and conveniently accessible to the African American community.

3. HIV/AIDS:[†]

Community Education and Oversight

- NAACP Health Committees and state and local government agencies should work together to develop strategies and programs to address HIV/AIDS. Prevention and community education messages should be presented repeatedly in various forms and during appropriate times to reach the intended audiences.
- NAACP Health Committees in partnership with others should work to eliminate the myths and stereotypes about HIV/AIDS, focusing specifically on the ways that those myths and stereotypes exist within and impact on the African American community.

[†] Many of the recommendations in this section reflect goals of the NAACP's 1992 and 1998-99 Health Resolutions on HIV/AIDS.

Direct Service Provision

- Most common modes of HIV transmission should be identified within particular geographic areas, and comprehensive prevention programs for reducing new infection rates should be implemented accordingly. Factual, science-based information about transmission through sexual contact and injection drug use should be provided to all audiences within the African American community; and materials necessary to prevent transmission should be easily and confidentially available, including condoms and sterile syringes.
- Federal, state, and local governments should establish a longitudinal, comprehensive HIV prevention, detection and treatment program for each person under the jurisdiction of the criminal justice system. Because risks and rates of HIV are higher among people who are incarcerated, the criminal justice system provides an opportunity for prevention, education, and treatment services. Such services should be made available to people from the time of arrest to final release, whether institutionalized or not, and should include probationers and parolees.

Policy Change and Advocacy

- Funding and resource allocations for HIV/AIDS prevention services should be increased to reflect the fact that new infection rates and levels of HIV/AIDS-related illnesses remain significantly higher among African Americans than other racial and ethnic groups than among white Americans.

4. Mental Health Issues

Community Education and Oversight

- NAACP Health Committees should work to educate their members and their community about mental illness. Educational efforts should include information about what mental illness is, how it can be recognized, and how it can be managed.
- NAACP Health Committees in partnership with others should seek to eliminate the stigma surrounding mental health problems. Educational efforts should focus specifically on the ways that such stigma impacts African Americans and their willingness to seek assistance and treatment, and should emphasize that mental health problems are common and treatable.

Direct Service Provision

- Intervention and treatment services should be available for those suffering from any form of mental illness or problem, from minor to major. Services should be available in an accessible and confidential manner, and should include a range of treatment options and follow-up.

Policy Change and Advocacy

- Public funding for mental health intervention and treatment services should be increased so that they are available to all who need them; and federal, state, and local governments should ensure that such services are available in each local community.

5. Family Health:[‡]

Community Education and Oversight

- Federal, state, and local governments should develop and implement comprehensive programs on education for parenthood and family life. These programs should be located in schools and community-based organizations. Programs should work with both parents and/or other primary caretakers; and should provide information on all modalities of family planning and human sexuality. Programs should make participants aware of the entire family life cycle and family functions, and should build skills in approaching them satisfactorily.
- Federal, state, and local governments should develop and implement programs to promote comprehensive health for all family members. Programs should include information about the importance of prevention and treatment services; the healthcare needs of children, women, and men; and healthcare services available within the community.

Direct Service Provision

- Federal, state, and local governments should work together and with community members to ensure better coordination of programs serving families, including programs such as HEADSTART; Women, Infants, and Children's Nutritional Program (WIC); Healthy Start (infant mortality reduction); the Prevention Block Grant, the Maternal and Child Health Block Grant; the Health Promotion/Disease Prevention Act of 1992; and Obesity Prevention Programs. Outreach and information about the programs should be tailored to reach potential African American participants. Services should be provided in ways that are culturally sensitive, and that effectively meet the needs of African American participants.

Policy Change and Advocacy

- Federal, state, and local governments should ensure that programs serving families are adequately funded to meet the needs of all who need them; and that African American families have the information and access necessary for them to participate.

[‡] Many of the recommendations in this section reflect goals of the NAACP's 1992 Health Resolution on the Care of Women and Children.

B. Raise awareness about the impact of community environmental factors on minority health.

Environmental factors have a significant impact on the health and well-being of African American individuals, families, and communities. As discussed above, African Americans are more likely to live in geographic areas disproportionately plagued by negative environmental factors such as violence, both intentional and unintentional, and high levels of dangerous toxins and pollutants.

The disparities in healthcare and health outcomes for African Americans cannot be fully eliminated by increases in community awareness and availability of appropriate medical services. Unless environmental dangers are reduced, elevated levels of injury and pollution-related disease will simply continue to endanger the health and lives of African Americans at a greater rate than those of their white counterparts, making it impossible to do away with the disparities completely.

Recommendations for all NAACP Health Committees[§]

Community Education and Oversight

1. NAACP Health Committees, in partnership with others, should work with state and local environmental groups to develop educational campaigns about environmental issues targeted to the local African American community. Educational campaigns should include information and data on the dangers of exposures to lead, mercury, pesticides, radon, and other environmental health hazards; as well as the levels of exposure to these materials in their own communities.
2. NAACP Health Committees, in partnership with others, should support health and environmental advocacy communities in collecting and making available information on the environmental hazards present in the community and in monitoring the work of responsible regulatory agencies.
3. Federal, state, and local governments should work with the NAACP and with community-based organizations to establish violence prevention task forces, paying particular attention to violence within predominantly African American communities.
4. Federal and state agencies regulating media outlets should require that commercial electronic broadcast media air prime-time violence prevention messages, such as public service announcements.

[§] Many of the recommendations in this section reflect goals of the NAACP's 1992 Health Resolution on the Prevention of Injury and Violence, the 1998-99 Health Resolution on Tobacco in the African-American community, and the 1993 and 1998-99 Health Resolutions on Environmental Health.

Direct Service Provision

5. Federal, state, and local environmental agencies and organizations should train and hire a proportionate number of culturally competent environment and public health workers, and support them in programs to research and continually monitor the environmental quality in and around African-American communities.
6. NAACP Health Committees in partnership with others should work with community organizations and government agencies to reduce unintentional violence through comprehensive educational and prevention programs, including but not limited to the following topics:
 - Driver and automobile safety.
 - Use of seatbelts, infant car seats, and helmets.
 - Water safety education (to prevent accidental drowning).
 - Fire prevention and safety.
7. NAACP Health Committees in partnership with others should work with community organizations and government agencies to reduce community and self-inflicted violence through comprehensive educational programs, including but not limited to the following topics:
 - Alcohol and drug abuse prevention.
 - Domestic and family violence prevention.
 - Non-violent approaches to conflict.
 - Gun violence prevention.
 - Weapons safety and storage.
 - Suicide prevention and mental health services.
8. NAACP Health Committees should undertake a comprehensive campaign to decrease the use of assault weapons and cheap handguns. Such a campaign should include education, legislation, regulation, and the increased use of neighborhood-oriented policing, neighborhood based policing, and neighborhood-based violence prevention programs.

Policy Change and Advocacy

9. The NAACP Health Division should coordinate with other divisions within the organization and with regional, state, and local units to build internal capacity for a multi-pronged advocacy program to clean up environmental contamination in African American and other minority communities, bringing them into compliance with basic environmental standards.¹³⁵
10. NAACP Health Committees in partnership with others should call upon elected officials to enforce equitably existing legislation and regulations to carry out the Clean Air and Water Acts, and to identify and clean up environmentally hazardous conditions.

11. The federal government should routinely collect and analyze environmental and health data by ethnicity, race and income, in order to ensure the equitable application, implementation, and enforcement of environmental laws.
12. Federal, state, and local governments should conduct environmental impact evaluations on all existing and proposed permutable facilities sited in or near African American communities, and should approve building and expansion permits only if environmental impacts fall within safe and acceptable ranges.
13. Racial and ethnic based data on the effects of multi-media pollution should be gathered state by state on an ongoing basis, and rates of pollution or of effects should be monitored for any changes.
14. State, local, and federal enforcement agencies should reduce and ultimately eliminate workplace exposure to unsafe levels of toxic materials through improvements in the enforcement of workplace safety rules.
15. Federal, state, and local government agencies should assure that minorities receive their fair share of smoking prevention and cessation funds, including tobacco settlement funds, in proportion to their prevalence in the smoking population.
16. NAACP Health Committees in partnership with others should work to reduce gun violence in African American communities through legislative and regulatory advocacy and litigation (including lawsuits against the gun industry) where appropriate.
17. The NAACP should actively support legislative and regulatory efforts to decrease the availability and use of assault weapons and handguns.
18. Federal, state, and local government agencies should regulate advertising for alcohol and tobacco products such that they are not disproportionately directed towards African American consumers; and should ensure that the alcohol and tobacco industry are proportionately involved in counter-advertising, prevention, cessation and research.
19. Federal, state, and local governments should support international tobacco control initiatives; and should provide adequate support for communities impacted by tobacco legislation and regulation, including farmers, farm workers, and tobacco employees.

C. Increase levels of health awareness and health literacy in minority communities.

Increased health awareness among individual healthcare consumers makes it possible for them to protect their own health and to seek quality healthcare services. To do this effectively, they must have information about medical conditions and potential treatments; know what services are available to them in their own communities; and know what steps and strategies they can use to advocate for themselves, their families, and healthcare consumers in general. An awareness and understanding of the racial and ethnic disparities in healthcare in the United States further increases the effectiveness of this advocacy for improved health outcomes.

In order for information about health services and their own health situation to be useful, patients need to have a functioning level of health literacy. “Health literacy” has been defined as “a patient’s ability to understand common health care communications, such as prescription instructions, test results and insurance forms.” Patients who are informed about their own health and their healthcare options in a way that they can understand are better able to seek advice and assistance when needed, to follow directions related to their health, and to advocate for their own preventive care and treatment. As a result, they experience better health outcomes at a lower cost than those who have low levels of health literacy.¹³⁶

Competency in health literacy is important at every stage of health and healthcare provision: undertaking personal care and prevention, accessing appropriate services and treatment, and ensuring complete follow-up and ongoing monitoring. In order to be fully health literate, people must be informed both about their individual health needs and resources, and about their community’s health needs and resources. An individual patient’s involvement in his or her own healthcare is critical to accessing care when necessary, and to receiving appropriate preventive and treatment services.

Low levels of health literacy have dramatic economic implications and cost the healthcare system as much as \$58 billion a year. People with low health literacy are often less likely to comply with prescribed treatments and self-care regimens, make more medication or treatment errors, and fail to seek preventive care.¹³⁷ People with low health literacy skills are also at a higher risk for hospitalization than people with adequate literacy skills.¹³⁸ Their low health literacy results in an average of 6% more hospital visits, and in hospital stays nearly two days longer than people with higher literacy skills.¹³⁹ In total, people with low health literacy have annual health care costs that were four times higher than those people with higher health literacy.¹⁴⁰

Studies show that educational efforts specifically targeted at improving rates of health literacy are successful at producing more efficient and appropriate use of healthcare resources.¹⁴¹

In its 2003 Health Resolutions, the NAACP resolved that as an organization, the NAACP would “promote culturally appropriate education programs to improve minority knowledge of how to access care and how to improve the ability to participate in clinical decision-making.” Specific strategies for accomplishing this resolution are discussed below.

Recommendations for all NAACP Health Committees

Community Education and Oversight

1. Educational campaigns to raise awareness about racial and ethnic disparities in healthcare should be developed and targeted towards broad audiences, including African American consumers in particular.¹⁴²
2. Culturally competent educational materials about the importance of participatory healthcare should be developed for use in public health awareness campaigns, and disseminated in such a way that members of the African American community are reached effectively.
3. Healthcare consumers should receive information and training about ways to participate actively during office visits and other encounters with healthcare providers, including asking questions about their medical conditions and their treatment regimens.¹⁴³
4. Regional and state NAACP units should continue to hold informational conferences and Health Advocacy workshops, providing information to African American healthcare consumers about health issues of particular concern and ways to self-advocate for better health outcomes.¹⁴⁴

Direct Service Provision

5. Local and state-level healthcare agencies and Health Departments should ensure that health fairs and other health educational events in the community are developed with African American and other racial and ethnic minority communities in mind. This awareness will impact the topics covered at such events, focusing on issues and services particularly useful to the relevant community; the materials developed for dissemination, both in topic and in style; the places and times at which such events are held, making them convenient and comfortable for members of the African American community; and the publicity and recruiting of participants, specifically targeting African American families and individuals.
6. Many local and state health departments develop educational campaigns on particular preventive healthcare topics, such as the importance of nutrition and exercise, prenatal care, or immunizations. These should also be relevant and appealing to an African American audience.
7. Elementary and secondary schools provide an excellent point of entry for health education and health literacy programs. Schools create an opportunity not only to educate children and young people about their own health and opportunities for managing it, but also to disseminate information relevant to parents and other family members. State and local school systems should ensure that the healthcare and health education services provided meet the needs of African American students and their families, focus on increasing health literacy, and are culturally sensitive and appropriate.

8. In addition to community level educational efforts, healthcare visits (whether in a primary care provider's office or in an emergency room) provide an excellent opportunity for individualized education to increase and encourage health literacy. Healthcare providers should be aware of the importance of health literacy for all their patients, including African Americans and other racial and ethnic minorities, and should be prepared to present information and refer patients to other educational information in a culturally sensitive way. Medical organizations, as well as health care and patient groups such as Pfizer's Partnership for Clear Health Communication, have developed "health literacy educational kits" targeted to physicians and other healthcare providers, which they can use to improve their understanding and communication around these important issues.¹⁴⁵

Policy Change and Advocacy

9. State level healthcare and public health resources should be deployed in a manner that recognizes the historical and current lack of access to certain services for African American healthcare consumers. Resources going towards health education and direct services in the African American, other racial and ethnic minority, and low-income communities should be at least proportionate to those going towards white and/or middle-income communities; and should be increased as needed to accomplish this.

D. Work with private and public organizations, voluntary health organizations, medical associations, and specialists to increase health awareness and health literacy and to improve education, prevention, and treatment efforts in specific disease areas.

In our organizational work to build and improve the healthcare access and experiences of individual patients, a broad range of potential partners exist. Medical associations, healthcare professional associations, disease-specific voluntary organizations, local and state agencies, and private healthcare-related companies all have a responsibility to improve and broaden the availability of healthcare services in the African American community.

Healthcare organizations and associations are well-situated to reach particular audiences. Additionally, many organizations and agencies have a primary mission related to prevention, research, or treatment of specific diseases; or have programs or committees that focus on particular diseases or groups of diseases. From national nonprofit organizations such as the American Cancer Association, to the American Medical Association and National Medical Association, to committees of state medical professional associations, they provide a broad array of partners in working to eliminate health disparities among African Americans and other racial and ethnic minorities. Often they have extensive information about their area of focus, including what services are available and where they can be accessed. By developing partnerships with these types of organizations, the NAACP can coordinate their own educational work with existing efforts and can ensure that those efforts reach African American healthcare consumers.¹⁴⁶

Private healthcare, research, and pharmaceutical companies are another important partner that can offer information and resources to improve health awareness and literacy. These companies have extensive and growing expertise about particular diseases and their treatments, on the cutting edge of new ideas and medications. They also are committed to working within communities, both to learn more about the health needs and priorities of particular communities and to provide information about the medications and other services provided by the company. Often they are directly involved in research and development of treatments, and can play a key role in increasing research specifically focused on improving treatments for African American patients. Finally, these companies may also be able to provide technical assistance in important areas such as public education campaign strategies, media relations, and legislative lobbying.

Working in coordination with organizations and agencies such as the ones described above is essential for producing positive results both for individual healthcare consumers and for the organizations and agencies themselves. For example, such groups often have resources specifically designated for educating healthcare consumers, resources which NAACP chapters and units can use to improve the health literacy of their constituents. As they work together, organizations and agencies will become better educated about the particular needs and health concerns of the African American community, better preparing them to communicate with that constituency and encourage the utilization of their services. By facilitating the sharing of information along this two-way street, organizations and agencies have a better understanding of the needs of African American consumers. In addition, African American consumers will be better prepared to access and advocate for themselves within these agencies and organizations

and better equipped with the information they need to improve the delivery of their health care, which can lead to better health results.

By identifying and developing relationships with the many other organizations and agencies that are interested in healthcare generally and particular diseases specifically, the NAACP can broaden and diversify the voices in support of improving health outcomes in those areas. This also amplifies the message, both to healthcare consumers and providers and to policymakers, that they should prioritize these issues in their own lives and work.

Recommendations for all NAACP Health Committees

Community Education and Oversight

1. NAACP Health Committees should identify and approach voluntary healthcare organizations and healthcare and pharmaceutical companies working on issues of interest to African American healthcare consumers within a city, county, or state for the purposes of establishing contact and communication, and coordinating educational and programmatic efforts on the importance of health literacy and health services available within the community.¹⁴⁷
2. NAACP Health Committees should collaborate with state and community-level disease-specific organizations to develop and implement educational programs about diseases of particular importance within the African American community.¹⁴⁸
3. NAACP Health Committees should work with medical professional organizations, such as the American Medical Association,¹⁴⁹ the National Medical Association,¹⁵⁰ the American Nurses Association,¹⁵¹ the National Black Nurses Association,¹⁵² and the American Academy of Physician Assistants,¹⁵³ to educate their members and other stakeholders about the disparities in healthcare for African Americans and other racial and ethnic minorities, and about the importance of increasing health awareness and health literacy in the African American community.
4. NAACP Health Committees should work with medical professional associations to develop committees or projects focused on specific diseases and how they impact on African Americans and other racial and ethnic minorities. State and local entities should examine the affects of those diseases on minority communities within their own geographic area; and identify ways that their members, as direct healthcare service providers, can participate in education, prevention, and treatment efforts.
5. NAACP Health Committees should collaborate with private healthcare research and pharmaceutical companies to increase awareness in the African American community about particular diseases and the treatment options available for them.
6. NAACP Health Committees should collaborate with private healthcare research and pharmaceutical companies to provide NAACP members with information about

healthcare options, to improve access to quality medications and other treatments, and to ensure that companies distribute their information and services effectively to African American consumers.

7. NAACP Health Committees should encourage members to refer to the NAACP Health Resource guide available online at the NAACP website.¹⁵⁴ Also they are encouraged to develop and maintain their own local/state resource guide to assist them in partnering with companies and organizations in their immediate area.

Direct Service Provision

8. The NAACP Health Committees should work with private healthcare research and pharmaceutical companies to ensure that African American patients have equal access to participation in research trials.

Policy Change and Advocacy

9. The NAACP Health Committees should work in coalition with voluntary health organizations, healthcare companies, medical professional associations, and public and private health agencies to ensure that policymakers provide adequate resources and avenues to improve healthcare services for African Americans and other racial and ethnic minorities.

Ensure Access to Quality Healthcare Services

A. Increase access to quality healthcare services.

The elimination of disparities in the healthcare system and improved health outcomes of African Americans and other racial and ethnic minorities depend on increased access to a full array of quality healthcare services. Ultimately, these changes will only occur if the NAACP works with policymakers at all levels of government and in the private sector to increase our access to quality healthcare services. Our involvement is critical to the identification of solutions, the development of systems that will actually work with and for African American healthcare consumers, and the insistence that such systems be implemented and maintained over the long term.

Accomplishing these goals will require extensive and sophisticated legislative and regulatory advocacy campaigns. The NAACP cannot achieve these goals alone; instead, we must work with other key stakeholders and partners including medical associations, healthcare research and pharmaceutical companies, healthcare advocacy groups, and other civil rights and justice organizations. Developing these partnerships amplifies our voices as we seek to raise awareness of health disparities among policymakers and other relevant decision makers, and assists us in moving them to action. We plan to coordinate our efforts with those of other interested parties and recruit the involvement of those who have not yet taken a position on these goals, and/or have not begun active advocacy efforts.

Recommendations for all NAACP Health Committees^{}**

Community Education and Oversight

1. As discussed in the NAACP's Health Strategic plan, Health Summits and Critical Issues Symposia should be held at the national, regional, and state level. Participants should examine the quality of care in the relevant geographic area, and develop position papers and advocacy strategies to address problems and weaknesses.
2. State NAACP chapters should develop state health "report cards" about the quality of healthcare available within the state. Report cards should include information about the particular services and quality of care available in the various regions and localities within the state; healthcare-related legislation that has been proposed in the state, and the NAACP position on the legislation; the positions and levels of support or opposition of legislators and the governor on the legislation; and ways in which the state is using state and federal funds to address the top ten causes of morbidity and mortality among African Americans.
3. The NAACP, working in partnership with other stakeholders, voluntary healthcare organizations, healthcare companies and medical associations, should develop strategies

^{**} Many of the recommendations in this section reflect goals and action items of the NAACP's 1995-96 Report on Medicaid/Medicare Managed Care.

for ensuring that managed care systems meet the needs of African American healthcare consumers. These strategies should include community monitoring and oversight of quality of care, gathering of relevant racial and ethnic data, and patient-focused legislative and regulatory advocacy. Policy positions should include the following:

- All managed care systems include consumer education and information as part of their plan packages. This education component should include, but not be limited to, workshops which educate the consumer on the various plans available and the advantages and disadvantages of each, including information on the ability to change plans.
 - Health plans should encourage wellness and practice prevention, and provide the tools necessary to effectively manage and control chronic diseases.
 - Health plan providers should not engage in redlining. All health plan providers should include an adequate population distribution, encompassing a broad spectrum of persons with different health needs and income characteristics. This is necessary to avoid shifting all persons who may be characterized as “high risk” into one high cost plan.
 - Managed care organizations should not engage in practices that may exclude minority healthcare providers from their plans. Plans should have an evaluation process which examines criteria that terminate the service of a healthcare provider in order to ensure that minority healthcare providers are not inappropriately removed from service.
 - Managed care plans should include educational components in the area of violence and injury prevention as an aspect of the prevention services in offered plans, as these are significant health problems in African American communities.
4. NAACP Health Committees in partnership with others should raise community awareness about currently available health services and insurance programs (including Medicare and Medicaid enrollment, pharmaceutical company-sponsored patient assistance programs, Child Health Insurance Programs, and other state-level plans).
 5. Local NAACP branches should include health policy issues as part of their local voter registration and education advocacy efforts.
 6. The NAACP should organize and establish HMO and/or Medicaid managed care-monitoring groups, which will function to educate the public about managed care and consumers’ rights.

Direct Service Provision

7. Culturally appropriate healthcare, from prevention to primary care to basic emergency services, should be conveniently available at the community level. Fragmentation of health plans along socio-economic lines should be avoided.¹⁵⁵
8. Access to healthcare should be increased by promoting the utilization of, and expansion of services rendered by, primary care teams (i.e., coordinated groups of health workers

including but not limited to social workers, nurses, nurse practitioners, physician assistants, and physicians).¹⁵⁶

9. Logistical barriers to healthcare, such as lack of transportation, limited service hours and lack of primary care providers within the community, should be eliminated.

Policy Change and Advocacy

10. Federal, state, and private health plans should collect, report and monitor patient care data as a means for assessing progress in eliminating disparities, evaluating intervention efforts, and identifying potential civil rights violations. The NAACP should support the enactment of laws mandating that HMO's undergo peer review by qualified health professionals to evaluate the quality of direct patient care.¹⁵⁷
11. Highly qualified healthcare providers should be encouraged to work in underserved communities through programs such as educational loan repayment, assistance with malpractice and other insurance coverage, housing allowances, and other financial assistance.
12. The NAACP should oppose congressional Medicaid and welfare cuts, as this is believed to result in an increase in the number of persons who become uninsured and underinsured.
13. The NAACP should advocate for legislation ensuring coverage of needed support services and care for the disabled and chronically ill.
14. The NAACP should advocate for legislation ensuring access to comprehensive prevention, disease management, and public health services.
15. The NAACP should advocate for enhanced government involvement in monitoring quality and access to the healthcare delivery system. This advocacy effort should include adequate data that will allow for monitoring the market health system and enhanced funding to finance healthcare for the uninsured, since cost shifting will be limited in the future.

B. Ensure that differences between publicly funded and privately funded health insurance systems do not result in limited medical choices for minority patients.

Because African Americans and other racial and ethnic minorities are more likely to be insured through public insurance programs than are white Americans, limitations in services covered by public insurance programs can contribute significantly to disparities in healthcare options and health outcomes. Public insurance programs should provide sufficient coverage and options to ensure that the health needs of program participants are fully met. Health outcomes of participants in public insurance programs should be comparable to those of private insurance programs.

In advocating for comprehensive coverage and a full array of healthcare options for people enrolled in public insurance plans, the NAACP has the opportunity to partner with patient advocacy groups and healthcare companies to ensure that the latest medications are available and that access to them is not restricted. Because of their knowledge about the appropriateness and efficacy of certain medications and their practical availability, they can often provide information about the harms that inappropriate limitations on choices in this area can cause to consumers. Building partnerships with these and other informed stakeholders will increase our effectiveness in advocating for equitable health services for all.

Recommendations for all NAACP Health Committees

Community Education and Oversight

1. Working with the private healthcare sector, the NAACP should continuously monitor the restrictions to formularies in publicly funded health insurance systems (including Medicaid and Medicare) to ensure that they do not result in limited medical choices for minority patients.
2. The NAACP should educate its members about advocating for high standards of quality in all public healthcare programs, including Medicare and Medicaid; and all private healthcare programs, such as those provided by employers. Special emphasis should be placed on the importance of ensuring that patients are guaranteed access to medically necessary treatments, including new prescription medicines, patients' rights regarding grievances and the right to appeal and denial of care, and system-wide monitoring to ensure the scientific and clinical integrity of medical decisions by health care delivery systems.

Policy Change and Advocacy

3. The same managed care protections should apply to publicly funded HMO enrollees that apply to private HMO enrollees.¹⁵⁸

4. The NAACP should advocate for policies requiring both private and public insurance programs, including Medicare and Medicaid, to provide increased coverage for health promotion and disease prevention services.¹⁵⁹

C. Advocate for universal health insurance.

For many years, the NAACP has advocated for universal health coverage throughout the United States. This public policy would benefit our society across the board by improving our health and safety, increasing our work and educational capabilities, and positively impacting our economy. It would have particular benefit to many African Americans and other racial and ethnic minorities, however, because most minority groups and poor patients are more likely to be uninsured or insured through public programs.¹⁶⁰

The NAACP contemplates a phased-in approach to universal insurance coverage, calling first for full coverage for children, then for families with children, and then for all people in the United States.¹⁶¹ Our strategy will also emphasize the importance of meeting the needs of our senior citizens, including access to prescription and over-the-counter medications.¹⁶²

Certain principles must guide our work towards the availability of universal health in this country. In 2003, the NAACP passed a Resolution articulating some of those principles, recognizing that all healthcare coverage must include the following components:

THEREFORE, BE IT RESOLVED that any health care coverage legislation supported by the NAACP should include the following components:

- a. choice of physicians;
- b. access to efficacious medicines;
- c. care available in patient's neighborhood (Laboratories, Emergency Rooms or Hospital);
- d. preventive care covered and encouraged to include: Colonoscopy, Mammography, eye exams, physical exams, Immunizations, smoking cessation, Obesity treatment and Substance Abuse Care;
- e. mental and dental healthcare coverage with mental health on parity with medical coverage; and
- f. ... a process for racial and ethnic data collection to better determine the effectiveness of healthcare coverage and progress on ending health disparities.¹⁶³

Recommendations for all NAACP Health Committees

Community Education and Oversight

1. The NAACP Health Division should develop targeted training for branch and unit Health Committees on how to convene successful community meetings about universal health insurance and access, and how to develop state and local advocacy campaigns.¹⁶⁴
2. All NAACP Health Committees should develop a strategy for enhanced use of action alerts on this issue to help mobilize grassroots support; and build collaborative relationships with other health advocacy groups working for universal health insurance coverage.¹⁶⁵

Policy Change and Advocacy

3. National and state governments should develop and implement plans to achieve the *Healthy People 2010* target of total insurance coverage for all groups in the United States.
4. Federal, state, and local governments should identify steps that can be taken at each level of government to move towards universal health coverage.
5. The NAACP Health Division should work with NAACP Washington Bureau, regional offices, and state and local branches and units to craft and track federal and state legislation and policies promoting universal health insurance coverage.
6. NAACP Health Committees should urge their Members of Congress to support H.J.Res. 30 (introduced March 4, 2003), legislation introduced by Congressman Jesse Jackson, Jr., proposing an amendment to the Constitution of the United States declaring the right of every citizen to equal and high quality healthcare, and assigning to Congress the power and the affirmative duty to enact legislation that will provide every American with that healthcare.¹⁶⁶

D. Ensure access to individualized care.

Increased health awareness and health literacy among African Americans is a critical step to ensuring that individual patients receive the care and services that they need. This individual understanding of one's healthcare needs and options is most valuable, however, within a system that protects and ensures the integrity of the relationships between patients and their doctors.

The confidential doctor/patient relationship makes it possible for patients to access healthcare services with confidence and comfort. For many patients, the decision to visit a doctor or other healthcare provider depends on an understanding and belief that even the mere fact that a healthcare visit took place will be kept confidential. Once services are accessed, a high level of confidence in the confidentiality and trustworthiness of the provider and the process are important to a patient's ongoing participation in his or her own healthcare. A lack of confidence – whether it arises from an actual lack of competence and confidentiality, or simply a perception that the provider cannot be trusted in some way – reduces the likelihood that the person will continue to engage the process, and can lead to worse health outcomes in an individual case and in a broader community.

Confidentiality of services and access to a trusted medical provider are particularly important in sensitive healthcare areas that continue to have some societal stigma attached to them: for example, sexually transmitted diseases, including HIV; reproductive health services, including fertility services, pregnancy testing, and abortion; mental health services, including depression and substance abuse services; domestic violence; and potentially terminal disease testing, such as cancer. The cultural considerations around these and other healthcare issues are significant, making confidentiality that much more important.

A patient's trust depends in part on the provider's ability to recommend and prescribe the course of treatment he or she deems best for the particular patient's situation. Restrictions on treatment, such as time limits or formularies that disallow the prescribing of certain medications, may require a physician to choose a less-than-ideal treatment regimen for a patient. If problems arise, the patient may face worse medical outcomes; but at the very least, he or she is likely to question the competence and trustworthiness of the doctor.

Within the context of trusted and confidential provider/patient relationships, healthcare consumers are better able to advocate for their own health needs, to learn and understand information necessary for them to make their own decisions about their health, and to participate in and comply with an ongoing treatment and healthcare maintenance program. These types of relationships make it more likely that a provider will have all relevant information in diagnosing and treating a patient, and will thus result in better health outcomes.

Finally, knowledge of one's health options enables patients to engage fully in their own healthcare and allows for better health planning, resulting in the preservation of a patient's personal choices and dignity. When patients know and understand what their health concerns may be in the future, they can gather information, ask questions, and make plans prior to the emergence of a crisis situation. Documents such as living wills and advance directives around particular medical and mental health problems, as well as discussions with healthcare providers

and family members, allow individuals to maintain control over their own medical choices and to manage their health in a way that best respects their personal sense of dignity.

Recommendations for all NAACP Health Committees

Community Education and Oversight

1. In order for confidentiality protections to translate into patient confidence and willingness to access services, potential patients must be informed about the confidentiality of their medical care and medical decisions: privacy is not enough if consumers do not believe and trust that it exists. Consumers should be informed about the protections that are in place, both through general educational campaigns and by their own healthcare providers.
2. Issues of privacy and confidentiality within medical and other professional relationships are important to a broad variety of stakeholders. Patients, healthcare providers, and policymakers should work to develop coalitions of interested parties to raise awareness about the importance of these issues and ensure their ongoing protection.
3. The NAACP should conduct health advocacy trainings at the regional, state, and local levels in order to raise awareness of health and mental health justice issues and strengthen the grassroots health advocacy capacity of the NAACP.¹⁶⁷

Direct Service Provision

4. Patients should have the opportunity to see the same primary care provider and specialists on a long-term basis, particularly in publicly funded health plans, in order to increase and protect the ongoing stability of patient-provider relationships.¹⁶⁸
5. Doctors and patients should have a full range of treatment choices, and should be able to make decisions about medical treatments without inappropriate limitations from government, insurance companies, or other organizations.
6. Local healthcare organizations and community groups should provide individuals with assistance with particular strategies for managing individual healthcare issues on an ongoing basis: for example, living wills, advance directives for mental healthcare services,¹⁶⁹ etc.

Policy Change and Advocacy

7. The confidentiality of doctor/patient communications and decision-making is critical to the provision of appropriate individualized healthcare, and to patients' willingness to trust their healthcare providers and disclose relevant information completely and honestly. State and federal governments should continue to improve and protect the confidentiality of the accessing of medical services, patients' medical records, and other medical communications.

E. Increase resources for and effectiveness of research on African American health issues.

Scientific and sociological research is a never-ending part of a system of care, constantly expanding and updating the healthcare options available to patients. Research and innovation in care and treatment options are critical to the constant improvement of health outcomes, and encompasses a broad range of issues relating to the provision of healthcare. In seeking to eliminate disparities in healthcare and health outcomes, researchers should ensure that African American participants are included in all broad research studies; and should identify and examine health-related topics with particular relevance to African Americans.

A variety of topics should be examined, such as the following:

- Research on new medications and therapies, and how they affect African American patients.
- Research on new applications of existing medications and therapies, and how they affect African American patients.
- Research about biases and stereotypes, on the part of both consumers and providers, and how they impact healthcare outcomes.
- Research about ways of increasing cultural competency within healthcare systems and among healthcare providers.
- Research about how African Americans learn about and access healthcare services, and ways to eliminate barriers to care.

Clinical trials of newly developed medications and other treatment strategies are one of the critical components of most medical research programs. Not only do they provide results about the efficacy of particular new therapies; but in cases where the new developments are ultimately successful, they also provide early access to advances in the treatment and management of disease. The participation of African Americans and other racial and ethnic minorities in clinical trials is critical to ensuring that the trials identify any differences in the ways that these groups are affected by the treatment. By informing African American patients about opportunities for participation in clinical trials, researchers can ensure that African American consumers have confidence about their treatment, and can identify needs for additional treatment alternatives.

Finally, in order for them to impact positively on the greatest number of people, the results and findings of research programs cannot exist in a vacuum. Research and innovation should be encouraged and incorporated both into public and private decisions about healthcare policies and about the ways in which services and options are publicized and marketed. Individual decision-making by patients and their healthcare providers should also be educated, well-informed by relevant and current research.

Recommendations for all NAACP Health Committees

Community Education and Oversight

1. NAACP Health Committees in partnership with others should monitor the plans for research programs and trials, ensuring that they reflect the concerns and priorities of African American healthcare consumers and that African American participants are recruited and included appropriately. Such organizations should seek out the results of medical and sociological research related to healthcare for African Americans; and should work with federal, state, and local governments to disseminate that information to their constituents and to healthcare providers.
2. NAACP Health Committees in partnership with others should monitor the public and private funds allocated for healthcare research, in order to ensure that the needs and considerations of African Americans and other racial and ethnic minorities are sufficiently funded on an ongoing basis.

Direct Service Provision

3. Public and private health researchers should consider the particular needs of African Americans and other racial and ethnic minorities in all broad health and social research projects, identifying any differences in the applicability of results to these populations.
4. Public and private research entities, as well as medical schools and other institutions of higher learning, should work to increase the number of African American medical and sociological researchers.
5. Public and private health researchers should be encouraged to undertake further research on the disparities in healthcare and health outcomes experienced by African Americans and other racial and ethnic minorities. This research should include exploration of the role of societal factors (including biases and stereotyping) and should provide the basis for addressing identified problems.
6. Public and private health researchers should be encouraged to undertake further research on the availability and accessibility of healthcare services for African Americans and other racial and ethnic minorities, including barriers to services and ways to remove those barriers.
7. Public and private health researchers should be encouraged to undertake further research to develop new treatments for medical conditions that disproportionately affect African Americans.
8. African American patients should have equal access to such participation in clinical trials. Information about opportunities for participation in clinical trials should be made available to African American healthcare consumers, from public and private researchers and through their own healthcare providers.

Policy Change and Advocacy

9. Federal, state, and local governments should constantly seek out the results of medical and sociological research related to healthcare for African Americans, and should incorporate that current information into decision-making and policies.
10. Federal, state, and local governments should constantly seek African Americans and other minority providers to conduct research in the communities they serve in order to improve access to the community and raise the level of trust in that community. Funding for training of providers should be on par with funding available to other community providers and researchers.
11. Adequate public and private research funds should go towards the support of research on diseases that have particular relevance to African American consumers, and should focus on the effectiveness of treatments and medications in African American patients.

Improve Delivery of Healthcare Services

A. Increase levels of cultural competency and effective communication skills among practitioners of all races and ethnicities within the healthcare provider community.

As noted in the Institute of Medicine's recent report, educators and advocates working to eliminate health disparities must "[i]ncrease healthcare providers' awareness of disparities."¹⁷⁰ As central players in the availability and quality of healthcare services, providers' recognition that African American patients often experience barriers to adequate care, lower quality of care, and worse health outcomes makes it possible for them to participate in changing those realities. This recognition on the part of providers enlists them in the effort to eliminate disparities, both in their day to day work with their own African American patients; and also at the broader systems level.

"Cultural awareness" and "cultural differences" do not refer only to the culture of a particular patient. Healthcare providers are part of a unique culture as well, one that carries its own set of understandings and expectations, even its own language.¹⁷¹ As the Institute of Medicine notes, "when sociocultural differences between patient and provider aren't appreciated, explored, understood, or communicated in the medical encounter, the result is patient dissatisfaction, poor adherence, poorer health outcomes, and racial/ethnic disparities in care."¹⁷²

A healthcare provider's cultural competency and awareness of a patient's cultural identity makes it possible for him or her to communicate effectively throughout the provider/patient interaction. In some cases, the communication barrier may be as explicit as an actual language barrier. For many African American patients, however, the communication problems are more subtle. From the patient's perspective, there may be hesitancy or failure to provide information involving differences in understanding about what behaviors and symptoms are relevant to diagnosis and treatment; what information about personal and family life should be shared with a medical provider; or what the provider is going to do with the information provided. From the provider's perspective, there may be a lack of understanding about the patient's fears and concerns; differences in understanding about what constitutes a problem and what is desirable; cultural stigma attached to discussing certain topics; or the need for sensitivity and thoroughness in asking appropriate follow-up questions.

African Americans are significantly more likely to report that they had "poor communication" with their physician during their most recent healthcare visit.¹⁷³ Yet this communication is critical in both directions: providers have a much more difficult time accurately assessing their patients' needs and options if they do not understand the cultural context of their health concerns; and patients have a much more difficult time understanding and complying with treatment and healthcare directions if they do not understand what they are or why they are important. Many factors may contribute to effective communication during clinical encounters, including the following:

- A high level of patient anxiety.
- The presence of severe, acute illness.
- Many recommendations from the physician given in a single visit.

- A great deal of emotion in the encounter (for example, when a patient has just learned about a serious illness).¹⁷⁴

By providing both consumers and practitioners with information and training in cross cultural communication and sensitivity, accuracy in diagnosis is increased, levels of adherence with treatment and therapy regimens are raised, and health outcomes are improved.¹⁷⁵

Recommendations for all NAACP Health Committees

Community Education and Oversight

1. NAACP Health Committees in partnership with others should develop materials and awareness campaigns about the positive impact of improved cultural competency, and work with healthcare provider agencies, healthcare companies, patient organizations, and networks within their own communities to disseminate information.

Direct Service Provision

2. Cross-cultural curricula should be integrated into the education and training of all healthcare providers, both in their initial training and qualification and in ongoing continuing education programs.¹⁷⁶
3. All healthcare professionals should be trained in effective communication and patient relations skills (“people skills” or “bedside manner”), including cultural and community awareness training. This training should include strategies for checking patients’ understanding of their follow-up care, including prescriptions, needed laboratory and other follow-up tests, and self-care.
4. Service delivery should be based on an understanding of health as a state of physical, social and mental well-being, and not merely the absence of disease or physical infirmity. Healthcare programs for African American individuals, families, and communities should include intensive outreach and follow-up, use of home visits and school based services, use of culturally competent mental health services, use of immunizations for all, and flexibility.
5. Federal, state, and local government agencies, as well as public and private healthcare providers and networks, should develop methods of evaluating the cultural competence and sensitivity of their own services. Evaluation should be conducted on a regular basis, and continuing weaknesses and gaps should be addressed.
6. Federal, state, and local government agencies should train and hire culturally competent environmental health and public health workers.

B. Increase the number and percentages of minority health professionals at all levels.

Greater racial and ethnic diversity among healthcare providers results in greater patient satisfaction and confidence in the healthcare provision system.¹⁷⁷ By increasing the proportion of underrepresented U.S. racial and ethnic minorities among health professionals at all levels, we raise the likelihood that healthcare systems are welcoming to and effectively meet the needs of African American healthcare consumers.¹⁷⁸

Medical professional schools and current healthcare institutions play a key role in increasing the numbers of African Americans and other racial and ethnic minorities who enter health professions. Specific programs to recruit, enroll, maintain, and graduate minority students should be undertaken by all medical professional schools, and programs in traditionally black schools should be expanded and supported. Increases in the numbers of minority healthcare professionals cannot be accomplished by medical professional schools alone, however; educational and awareness efforts must begin as early as preschool and elementary school, creating interest among minority children in health careers. By sparking interest early and providing high quality education and support throughout a child's elementary and secondary school years, more minority students will choose to enter and complete medical training programs.

By taking both short-term and long-term steps towards increasing the numbers of minority healthcare providers, we will increase the levels of satisfaction and improve healthcare outcomes for African American patients. At the same time, we will be investing in diversifying and improving the overall quality of our healthcare system for all patients.

Recommendations for all NAACP Health Committees^{††}

Community Education and Oversight

1. NAACP Health Committees should partner with educational institutions, the private sector, and federal, state, and local agencies to disseminate information about careers in healthcare provision for African Americans and other racial and ethnic minorities.
2. Community awareness of the existence and importance of the Allied Health professions should be raised, and recruitment into these training programs increased among African Americans and other racial and ethnic minorities.
3. NAACP Health Committees in partnership with others should support the gathering of racial and ethnic data at all stages of the educational process, ensuring that efforts to prepare, recruit, and graduate minority students are sufficient to address existing disparities.

Direct Service Provision

^{††} Many of the recommendations in this section reflect goals of the NAACP's 1992 Health Resolutions on Training Health Care Professionals.

4. The number and percentages of African American healthcare providers should be increased to be proportionate at all levels, including physicians and medical researchers; nurses (RNs and LPNs) and nurses' aids; and mid-level practitioners such as midwives, physician assistants, nurse practitioners, prenatal nurse specialists. This should include proportionate increases in rates of promotion and participation in leadership roles.
5. Medical professional schools, as well as other institutions of higher learning, should ensure that all faculty search committees and student admissions committees include African American members; and should work to further diversify their Boards of Trustees, Boards of Directors, and senior-level administration.
6. Non-underrepresented faculty in medical professional schools should be trained to better understand and address barriers that African American students, staff, and faculty face, and should be prepared and supported to be advocates for achieving diversity.
7. Public and private colleges, universities, and medical professional schools should develop and adopt recruitment policies that target potential African American and other racial and ethnic minority students. Such efforts should include the development of culturally appropriate publicity and informational materials; dissemination of those materials to potential minority students; special on-campus visitation opportunities for potential minority students; assistance with admissions and financial aid application processes.
8. State and local government agencies, as well as private organizations serving African American young people, should establish mentoring and awareness programs, linking practicing healthcare professionals with students from preschool/Headstart through college. Languages, math, and science should be emphasized in order to motivate and prepare young people to consider and pursue opportunities in the health field.
9. Federal, state, and local summer and after-school jobs programs should include jobs for school-aged African-American youth that provide comprehensive exposure to and experience in the health professions, in order to influence them to choose health careers.
10. Training of African American healthcare providers should be prioritized by Health Careers Opportunity Programs, Historically Black Colleges and Universities, the National Health Service Corps, the U.S. Public Health Service Corps and other programs that support educational costs and training.

Policy Change and Advocacy

11. Federal, state, and local educational agencies should increase the financial aid resources available for preparing and retaining minority students in fields related to healthcare provision and administration.
12. Government agencies, businesses, and other private and public entities should establish fellowships, grants and scholarships for deserving students to pursue health careers.

13. Federal, state, and local governments should increase loan forgiveness programs and other incentives in order to attract African-American health workers and others to pursue careers in underserved communities (urban and rural). Similar incentives should be provided for African American healthcare graduates to become qualified in primary care research, teaching and practicing in minority, rural and underserved communities.

C. Involve African Americans and African American owned and operated companies/systems in the provision of healthcare services, in policymaking and decision-making about healthcare provision and quality, in the abatement of environmental hazards, and in all aspects of advocacy and organizing to improve the health status of African-American families and communities.

By involving African Americans and other racial and ethnic minorities in all levels of healthcare decision making and policymaking, we can ensure that the particular needs of minority communities are considered and addressed throughout our healthcare systems. Whether as employees and professionals or as impacted citizens, the constant input from underrepresented racial and ethnic groups is needed in order to establish appropriate priorities and to develop equitable policies and programs. Increased representation of African Americans, particularly in positions of leadership, makes it possible for both public and private entities to reach the African American community more broadly and to serve them more effectively.

Additionally, African American owned and operated businesses should be involved in all aspects of the provision of healthcare services, from the building of facilities, to the staffing and running of networks, to the clean-up and monitoring of environmental hazards. By ensuring that African American run entities have the opportunity to bid on public and private contracts and are professionally involved throughout healthcare systems, we increase the likelihood that the systems are placed, built, and run in ways that are best for African American consumers. This also helps to build trust of the healthcare system within the minority community. Ultimately this contributes to improved health outcomes not only by increasing diversity and effectiveness of the healthcare systems themselves; it also increases the potential for positive impact on larger societal factors that contribute to poor health outcomes, such as poverty, unemployment, and lack of health insurance.

Recommendations for all NAACP Health Committees

Community Education and Oversight

1. NAACP Health Committees in partnership with others should partner with public and private health-related entities to increase awareness in the African American community about opportunities for input, employment, training, and other involvement in the healthcare system.

Direct Service Provision

2. African Americans should be involved in all levels of policymaking and decision-making around healthcare and services. Federal, state, and local government agencies should recruit and maintain African Americans professionals and staff to work on the development and implementation of healthcare programs and policies.

3. Federal, state, and local government agencies should actively solicit the input of a wide array of members of the African American community, and should incorporate that input in setting agency health priorities, policy development, and program implementation.

Policy Change and Advocacy

4. Federal, state, and local agencies should work to ensure that African American owned and operated businesses and networks are represented in all components of healthcare provision, particularly (although not exclusively) in African American communities.
5. Federal, state, and local agencies should work to ensure that African American owned businesses bid on government projects related to environmental quality and the removal of environmental hazards, particularly (although not exclusively) in African American communities.

¹ American Medical Association website, “What Are Health Disparities?,” <http://www.ama-assn.org/ama/pub/category/7659.html>.

² *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, Brian D. Smedley, ed., Board on Health Sciences Policy, Institute of Medicine (Washington D.C.: National Academies Press, 2003), p. 82. African Americans have a mortality rate of 690.9 per 100,000 population, while whites have a mortality rate of only 452.2 per 100,000 population.

³ *Id.*

⁴ IOM report, Finding 1-1, p. 79. “Racial and ethnic disparities in healthcare exist. These disparities are consistent and extensive across a range of medical conditions and healthcare services, are associated with worse health outcomes, and occur independently of insurance status, income, and education, among other factors that influence access to healthcare. These disparities are unacceptable.”

⁵ IOM report, Finding 2-1, p. 123.

⁶ IOM report, p. 103, *citing* Smith DB, (1999). *Health Care Divided: Race and Healing a Nation*. Ann Arbor: The University of Michigan Press.

⁷ IOM report, p. 103, *citing* Smith.

⁸ *Id.* at 104.

⁹ *Id.*

¹⁰ *Id.* at 105.

¹¹ *Id.* at 105.

¹² *Id.* at 92, *citing* Bobo LD, “Racial Attitudes and Relations at the Close of the Twentieth Century,” in Smelser NJ, Wilson WJ, Mitchell F., eds. *America Becoming: Racial Trends and Their Consequences*. Vol. 1 (Washington, DC: National Academy Press, 2001), pp. 264-301.

¹³ IOM report, p. 93, *citing* Bobo.

¹⁴ IOM report, Finding 3-1, p. 159. “Evidence suggests that several sources may contribute to healthcare disparities, including healthcare providers, patients, utilization managers and healthcare systems. In the current era of healthcare delivery, clinical decision-making increasingly involves this large number of individuals, who are subject to an array of systems influences that may contribute to healthcare disparities.”

¹⁵ IOM report, pp. 131-32.

¹⁶ *Id.* at 135-36.

¹⁷ *Id.* at 136-38. While the IOM notes that “a small number of studies suggest that racial and ethnic minority patients are more likely than white patients to refuse treatment,” these differences are generally quite small and cannot fully explain healthcare disparities. *Id.*, Finding 4-2, p. 179.

¹⁸ *Id.* at 138-39.

¹⁹ *Id.* at 139-140.

²⁰ *Id.* at 143-44.

²¹ *Id.* at 144-48.

²² *Id.* at 150-59. These issues are discussed in greater detail below, “Ensure Access to Healthcare Services.”

²³ *Id.* Finding 4-1, p. 178.

²⁴ *Id.* at 162-172.

²⁵ *Id.* at 173-75.

²⁶ Borde-Perry, W, Campbell, K, Murtaugh, K et al. The Association Between Hypertension and Other Cardiovascular Risk Factors in Young Adult African Americans. *Journal of Clinical Hypertens.* 2002; 4:17-22. Available at: <http://www.medscape.com/viewarticle/428400>.

²⁷ *Id.*

²⁸ *Id.*

²⁹ *See generally, Racial Differences in Cardiovascular Health*, Pfizer Facts, 2003.

³⁰ *Id.* at 40. African Americans are about half as likely as whites to undergo CABG.

³¹ *Id.* at 42. African Americans are less than half as likely as whites to undergo PTCA.

³² *Id.* at 44. African Americans are about two-thirds as likely as whites to undergo cardiac catheterization.

³³ National Health and Nutrition Examination Survey (NHANES) 1999-2000, U.S. Department of Health and Human Services. *See also, Racial Differences in Cardiovascular Health*, Pfizer Facts, 2003, p.13.

³⁴ *Racial Differences in Cardiovascular Health*, Pfizer Facts, 2003, p. 14.

³⁵ *Id.* at 15.

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- ³⁶ 1999-2001 National Health Interview Survey and 1999-2000 National Health Nutrition Examination Survey.
- ³⁷ *Racial Differences in Cardiovascular Health*, Pfizer Facts, 2003, p. 31.
- ³⁸ www.blackhealthcare.com.
- ³⁹ www.blackhealthcare.com.
- ⁴⁰ IOM report, p. 64. "African Americans, Hispanics, and Native Americans experience a 50%-100% higher burden of illness and mortality due to diabetes than white Americans." *Id.*
- ⁴¹ www.blackhealthcare.com.
- ⁴² National Healthcare Disparities Report, p. 46.
- ⁴³ *Id.*
- ⁴⁴ *Id.*
- ⁴⁵ *Racial Differences in Cardiovascular Health*, Pfizer Facts, 2003, p. 37.
- ⁴⁶ *Id.* at 9-10, 37. "In 2000, stroke deaths accounted for 6.2% and 9.2% of deaths among black women aged 40-59 years, and 60 years and older, respectively." *Id.* at 10.
- ⁴⁷ American Heart Association, "Facts About African Americans, Heart Disease and Stroke." Available at <http://www.americanheart.org/presenter.jhtml?identifier=3007879>.
- ⁴⁸ High Blood Cholesterol and Other Lipids Statistics, American Heart Association. Available at <http://www.americanheart.org/downloadable/heart/1077868698746FS13CHO4.pdf>.
- ⁴⁹ Nelson, K, Norris, K, Mangione, CM. Disparities in the diagnosis and pharmacologic treatment of high serum cholesterol by race and ethnicity: Data from the third National health and nutrition examination survey. *Arch Intern Med.* 2002;162:929-935.
- ⁵⁰ National Healthcare Disparities Report, p. 55.
- ⁵¹ *Id.* at 56.
- ⁵² *Id.* at 55.
- ⁵³ NAACP Health Resolutions 1992.
- ⁵⁴ IOM report, p. 61.
- ⁵⁵ *Id.*
- ⁵⁶ *Id.* at 61. In a 1994 study, 63% of eligible whites received antiretroviral therapy, compared with only 48% of eligible blacks; and 82% of eligible whites received PCP prophylaxis, compared with only 58% of eligible blacks. *Id.* at 61-62.
- ⁵⁷ NAACP Health Resolutions 1998-99.
- ⁵⁸ National Healthcare Disparities Report, p. 40. As an exception to this broader finding, African American women have higher screening rates for cervical cancer.
- ⁵⁹ *Id.* at 40, *citing* Ries LAG, Eisner MP, Kosary CL, Hankey BF, Miller BA, Clegg L, Edwards BK (eds). *SEER Cancer Statistics Review, 1973-1999*, National Cancer Institute. Bethesda, MD. Available at http://seer.cancer.gov/csr/1973_1999/, 2002.
- ⁶⁰ National Healthcare Disparities Report, p. 40, *citing* Ghafoor A, Jemal A, Cokkinides V, Cardinez C, Murray T, Samuels A, Thun MJ. Cancer Statistics for African Americans. *CA Cancer J Clin.* 2002; 52:326-341.
- ⁶¹ IOM report, p. 53, *citing* Diehr P, Yergen J, Chu J, Feigl P, Glaefke G, Moe R, Bergner M, Rodenbaugh J. (1989), "Treatment modality and quality differences for black and white breast-cancer patients treated in community hospitals." *Medical Care* 27 (10): 942-959. These results were evident even when the study controlled for clinical and other demographic factors. *Id.*
- ⁶² IOM report, pp. 57.
- ⁶³ NAACP Health Resolutions 1998-99.
- ⁶⁴ ADEA Washington Update, Volume 2, No. 3, March 1, 2004.
- ⁶⁵ NAACP Health Resolutions 2001.
- ⁶⁶ *Id.*
- ⁶⁷ National Healthcare Disparities Report, p. 44-45, *citing* Barker-Cummings C, McClellan W, Soucie JM, Krisher J. Ethnic differences in the use of peritoneal dialysis as initial treatment for end-stage renal disease. *JAMA.* 1995; 274:1858-1862.
- ⁶⁸ National Healthcare Disparities Report, p. 44-45, *citing* Ayanian JZ, Cleary PD, Weissman JS, Epstein AM. The effect of patients' preferences on racial differences in access to renal transplantation. *N Engl J Med.* 1999; 341:1661-1669.

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- ⁶⁹ National Healthcare Disparities Report, p. 44-45, *citing* Kasiske B, London W, Ellison MD. Race and socioeconomic factors influencing early placement on the kidney transplant waiting list. *J Am Soc Nephrology*. 1998; 9:2142-2147.
- ⁷⁰ National Heart, Lung, and Blood Institute. *Data Fact Sheet: Asthma Statistics*. Bethesda, MD: NIH 1999. Available at <http://www.nhlbi.nih.gov/health/prof/lung/asthma/asthstat.pdf>.
- ⁷¹ *Id.*
- ⁷² <http://www.blackhealthcare.com/BHC/Asthma/Description.asp>.
- ⁷³ *Id.*
- ⁷⁴ *Id.* It is estimated that these absences result in \$1 billion per year in lost productivity for their working parents.
- ⁷⁵ National Healthcare Disparities Report, p. 62. Almost 15 million people ages 18 or over have a “serious mental illness that substantially interferes with or limits one or more major life activities.” *Id.*
- ⁷⁶ *Id.*
- ⁷⁷ U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. Preface. Available at <http://www.surgeongeneral.gov/library/mentalhealth/home.html#preface>.
- ⁷⁸ IOM report, p. 69.
- ⁷⁹ National Healthcare Disparities Report, p. 62; IOM report, p. 70.
- ⁸⁰ IOM report, p. 70.
- ⁸¹ *Id.*
- ⁸² NAACP 2001 Health Resolutions, “Expressing the Concern of Mental Health with Regard to How it Affects African-Americans Treatment, Diagnosis, Crisis Intervention and Support of Legislation at all Levels of Government.”
- ⁸³ *Racial Differences in Cardiovascular Health*, Pfizer Facts, 2003, p. 46.
- ⁸⁴ American Lung Association Fact Sheet, November 2003. Available at http://www.lungusa.org/site/apps/s/content.asp?c=dvLUK9O0E&b=34706&content_id={23A234BF-672D-4057-9E73-16AED52F4E68}.
- ⁸⁵ American Lung Association Fact Sheet, November 2003.
- ⁸⁶ *Racial Differences in Cardiovascular Health*, Pfizer Facts, 2003, p. 46.
- ⁸⁷ American Lung Association Fact Sheet, November 2003; *see also*, *Racial Differences in Cardiovascular Health*, Pfizer Facts, 2003, p. 46.
- ⁸⁸ Perry-Bottinger, Lynne. “Adult Tobacco Use,” *Smoking & African-Americans*. Available at <http://www.heartcenteronline.com/Smoking & African Americans.html>.
- ⁸⁹ American Lung Association Fact Sheet, November 2003.
- ⁹⁰ Perry-Bottinger, Lynne. “Youth Tobacco Use in African Americans.” Available at <http://www.heartcenteronline.com/myheartdr/common/articles.cfm?Artid=555&startpage=2>.
- ⁹¹ “Youth Tobacco Surveillance – United States 2000,” Centers for Disease Control and Prevention. Available at http://www.cdc.gov/tobacco/research_data/youth/ss50.04.intro.htm.
- ⁹² Gordis M.D., Enoch. “Alcohol and Minorities: An Update,” National Institute of Alcohol Abuse and Alcoholism (NIAA), January 2002.
- ⁹³ National Institute on Alcohol and Abuse and Alcoholism, <http://www.niaaa.nih.gov/publications/aa45-text.htm>.
- ⁹⁴ Gordis M.D., Enoch. “Alcohol and Minorities: An Update,” National Institute of Alcohol Abuse and Alcoholism (NIAA), January 2002.
- ⁹⁵ *Alcohol Alert*, National Institute on Alcohol Abuse and Alcoholism No. 23, PH 347, January 1994. Available at <http://www.niaaa.nih.gov/publications/aa23.htm>.
- ⁹⁶ *Id.*
- ⁹⁷ Gordis M.D., Enoch. “Alcohol and Minorities: An Update,” National Institute of Alcohol Abuse and Alcoholism (NIAA), January 2002.
- ⁹⁸ “Drug Abuse Among Racial and Ethnic Minorities.” National Institute on Drug Abuse, National Institutes of Health, September 2003, p. 10. Available at <http://www.drugabuse.gov/pubs/minorities>.
- ⁹⁹ 2002 National Survey on Drug Abuse and Health, “Past Month Illicit Drug Use among Persons Aged 12 or Older, by Race/Ethnicity: 2002.” Figure 2.8. Available at <http://www.oas.samhsa.gov/nhsda/2k2nsduh/Results/2k2Results.htm#toc>.

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- ¹⁰¹ <http://www.drugpolicy.org/reducingharm/needleexchan>. See also "Research Brief: Syringe Access," The Lindesmith Center, March 2001. Available at http://www.drugpolicy.org/docUploads/syringe_access_brief.pdf.
- ¹⁰² Department of Health and Human Services, "Substance Abuse: Closing the Gap." Available at http://www.omhrc.gov/healthgap2002/substance_abuse.htm.
- ¹⁰³ American Obesity Association, "Obesity in Minority Populations." Available at http://www.obesity.org/subs/fastfacts/Obesity_Minority_Pop.shtml.
- ¹⁰⁴ Grantmakers in Health, "Weighing In on Obesity: America's Growing Health Epidemic." Issue Brief No. 11, Grantmakers in Health, Washington, DC 2001. Available at http://www.gih.org/usr_doc/Obesity.pdf.
- ¹⁰⁵ National Center for Health Statistics, "National Health and Nutrition Examination Survey," United States, 2002, CDC, US Department of Health and Human Services. "Black women now have an obesity rate of 49%, up from 36% [between 1988 and 1994]." See also, *Racial Differences in Cardiovascular Health*, Pfizer Facts, 2003, p. 47.
- ¹⁰⁶ Salinsky, Eileen and Wakina Scott. "Obesity in America: A Growing Threat." National Health Policy Forum, July 2003, p.4.
- ¹⁰⁷ National Center for Health Statistics, "Prevalence of Overweight among Children and Adolescents: United States 1999-2000." Centers for Disease Control, US Department of Health and Human Services. Available at <http://www.cdc.gov/nchs/products/pubs/pubd/hestats/overwght99.htm>.
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- ¹⁰⁹ Healthy People 2010 "Physical Activity and Fitness." Available at <http://www.healthypeople.gov/Document/HTML/Volume2/22Physical.htm>.
- ¹¹⁰ Healthy People 2010 "Physical Activity in Adults." Available at http://www.healthypeople.gov/Document/HTML/Volume2/22Physical.htm#_Toc490380801.
- ¹¹¹ National Institute for Environmental Health Sciences, "Health Disparities Research." Available at <http://www.niehs.nih.gov/oc/factsheets/disparity>.
- ¹¹² *Health, United States, 2003*.
- ¹¹³ *Id.*
- ¹¹⁴ http://www.healthyplace.com/communities/depression/minorities_5.asp.
- ¹¹⁵ Campbell, D., Sharps, P., Gary, F., Campbell, J., Lopez, L., (January 31, 2002) "Intimate Partner Violence in African American Women" *Online Journal of Issues in Nursing*. Vol. #7 No. #1, Manuscript 4. Available at http://www.nursingworld.org/ojin/topic17/tpc17_4.htm.
- ¹¹⁶ IOM report, p. 184-5.
- ¹¹⁷ National Healthcare Disparities Report, p. 115.
- ¹¹⁸ *Racial Differences in Cardiovascular Health*, Pfizer Facts, 2003, p. 51, citing 2001 National Health Interview Survey.
- ¹¹⁹ *Racial Differences in Cardiovascular Health*, Pfizer Facts, 2003, p. 51.
- ¹²⁰ *Id.* at 52.
- ¹²¹ IOM report, p. 185.
- ¹²² National Healthcare Disparities Report, p. 115, citing Institute of Medicine. (1996). Primary care: American's health in a new era. Washington, DC: National Academy Press. Racial and ethnic minorities and people with low incomes are more likely to report that a clinic, hospital outpatient, or emergency department is their usual source of care, resulting in higher costs and less effective ongoing care. National Healthcare Disparities Report, p. 116.
- ¹²³ National Healthcare Disparities Report, p. 112, citing *Sicker and Poorer: The Consequences of Being Uninsured*, prepared for the Kaiser Commission on Medicaid and the Uninsured by Jack Hadley, Ph.D., The Urban Institute, in May 2002 (updated in February 2003). Executive summary available at <http://www.kff.org/content/2002/20020510/4051.pdf>.
- ¹²⁴ National Healthcare Disparities Report, p. 112, citing Hadley J; Steinberg EP; Feder J. Comparison of Uninsured and Privately Insured Hospital Patients: Conditions on Admission, Resource Use, and Outcome. *JAMA* 1991; 265: 374-9.
- ¹²⁵ National Healthcare Disparities Report, p. 112, citing Centers for Disease Control. Self-Assessed Health Status and Selected Behavioral Risk Factors Among Persons With and Without Health-Care Coverage, U.S., 1994-1995. *MMWR* 1998; 47:176-180.
- ¹²⁶ National Healthcare Disparities Report, p. 112, citing Franks P, Clancy CM, Gold MR, et al. Health Insurance and Subjective Health Status: Data from the 1987 National Medical Expenditure Survey. *Am J Public Health* 1993; 83:1295-9.

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- ¹²⁷ National Healthcare Disparities Report, p. 112, *citing* Freeman HE; Aiken LH; Blendon RJ; Corey CR. Uninsured Working-Age Adults: Characteristics and Consequences. *Health Services Res* 1990; 24:811-23.
- ¹²⁸ IOM report, p. 83.
- ¹²⁹ *Racial Differences in Cardiovascular Health*, Pfizer Facts, 2003, p. 54. African Americans have a 22.8% likelihood of being uninsured, compared with a 12.7% likelihood among non-Hispanic whites and 17.5% in the general population. IOM report, p. 83.
- ¹³⁰ IOM report, p. 84.
- ¹³¹ *Id.* See also, *Racial Differences in Cardiovascular Health*, Pfizer Facts 2003, p. 56.
- ¹³² *Racial Differences in Cardiovascular Health*, Pfizer Facts, 2003, p. 57.
- ¹³³ IOM report, Recommendation 2-1, p. 124.
- ¹³⁴ *Health, United States, 2001*.
- ¹³⁵ See NAACP Health Strategic Plan, Goal 9.4, Objective 9.4 a.
- ¹³⁶ American Medical Association, "Health Literacy" Available at <http://www.ama-assn.org/ama/pub/category/8577.html>.
- ¹³⁷ Weiss, BD. *20 Common Problems in Primary Care*. McGraw Hill. December 1999.
- ¹³⁸ Baker DW, Parker RM, Williams MV, Clark WS. *Health Literacy and the Risk of Hospital Admission*. *Journal of General Internal Medicine*. 1998; (13): 791-798.
- ¹³⁹ Kirsch IS, Jugebut A, Jenkins L, Kolstad A. *Adult Literacy in America: A First Look at the Results of the National Adult Literacy Survey*. Washington, DC: Department of Education 1993.
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- ¹⁴¹ Robert D. Friedland, PhD, AMA Health Literacy Media Briefing, <http://www.ama-assn.org/ama/pub/article/12208-7398.html>.
- ¹⁴² IOM report, Recommendation 2-1, p. 124.
- ¹⁴³ *Effective Communication in Health Care Setting Requires Active Participation of Both Patients and Physicians*, American Medical Association, May 7, 2003.
- ¹⁴⁴ See NAACP Health Strategic Plan, Goal 9.1, Objectives 9.1 b and 9.1 c.
- ¹⁴⁵ American Medical Association, Health Literacy Educational Kit for physicians, healthcare professionals, and patient advocates. Available for order at <http://www.ama-assn.org/ama/pub/category/9913.html>.
- ¹⁴⁶ As recognized by the Institute of Medicine, addressing health disparities in the United States requires that advocates and educators work to "[i]ncrease awareness of racial and ethnic disparities in healthcare among the general public and key stakeholders," including groups such as healthcare payors and insurers, providers, and system administrators. IOM report, Recommendation 2-1, p. 124.
- ¹⁴⁷ For example, the NAACP adopted "the eradication of Prostate Cancer as a major initiative of its National Health Program" in its 1997-98 Health Resolutions, and specifically voiced its intent to "join with the National Prostate Cancer Coalition (NPCC) and its mission: elimination of Prostate Cancer as a disease of serious concern for men and their families." Other potential partners include the American Cancer Society, National Kidney Foundation, American Diabetes Association, National Stroke Association, and National Minority AIDS Council.
- ¹⁴⁸ Objective 9.4 c of the NAACP's Health Strategic Plan states that the NAACP will "[r]estructure the Association's relationships with health care organizations devoted to specific diseases" in order to provide consistency across collaborations and ensure that they maximize the strengths of both partners.
- ¹⁴⁹ Website: www.ama-assn.org.
- ¹⁵⁰ Website: www.nmanet.org.
- ¹⁵¹ Website: www.nursingworld.org.
- ¹⁵² Website: www.nbna.org.
- ¹⁵³ Website: www.aapa.org.
- ¹⁵⁴ <http://www.naacp.org/programs/health/healthdetailreport.php>.
- ¹⁵⁵ IOM report, Recommendation 5-1, p. 184.
- ¹⁵⁶ NAACP Health Resolution on the Care of Women and Children 1992.
- ¹⁵⁷ NAACP Health Resolution on Equity in Health Care and Safety 2003.
- ¹⁵⁸ IOM report, Recommendation 5-4, p. 187.
- ¹⁵⁹ NAACP Health Resolution on the Care of Women and Children 1992.
- ¹⁶⁰ National Healthcare Disparities Report, p. 114.
- ¹⁶¹ NAACP Health Strategic Plan, Objective 9.2 a.
- ¹⁶² NAACP Health Strategic Plan, Objective 9.2 a.
- ¹⁶³ NAACP Health Resolution on Quality Healthcare for All 2003.

¹⁶⁴ NAACP Health Strategic Plan, Objective 9.2 d.

¹⁶⁵ NAACP Health Strategic Plan, Objective 9.2 c.

¹⁶⁶ NAACP Resolution in Support of a Constitutional Amendment providing for Equal High Quality and Affordable Healthcare for All Americans 2004.

¹⁶⁷ NAACP Health Strategic Plan, Goal 9.1, Objective 9.1 e.

¹⁶⁸ IOM report, p. 185.

¹⁶⁹ As recognized by the NAACP Health Resolutions 2003, “an ‘Advance Directive for Mental Health Treatment’ or ‘Advance Directive’ means a written document, or a document in a form consistent with the provisions of the Federal American with Disabilities Act (ADA), that would protect the mental health consumer’s choice when the mental health consumer is in a crisis mode and cannot articulate clearly or cogently.” Such a document can address issues such as the patient’s desires concerning use of medications, restraints, and other emergency interventions, as well as provide information about prior experiences and current needs. The purpose of an Advance Directive “is to empower the consumer to indicate directives and preferences for treatment, balanced with the duty and desire of the provider to render ethical, effective treatment which is consistent with community standards”

¹⁷⁰ IOM Report, Recommendation 2-2, p. 124.

¹⁷¹ IOM report, p. 200.

¹⁷² *Id.*

¹⁷³ National Healthcare Disparities Report, p. 123. “[M]easures of poor communication included: reporting that the provider did not listen to everything, that the patient did not understand everything, or that the patient had questions that they did not ask.”

¹⁷⁴ *Effective Communication in Health Care Setting Requires Active Participation of Both Patients and Physicians*, American Medical Association, May 7, 2003.

¹⁷⁵ *Id.*

¹⁷⁶ IOM Report, Recommendation 6-1, p. 214.

¹⁷⁷ IOM report, p. 186.

¹⁷⁸ IOM report, Recommendation 5-3, p. 186.