HEALTH FOR ALL:

California's Strategic Approach to Eliminating Racial and Ethnic Health Disparities

SUMMARY

November 2003

Developed by
The California Campaign to Eliminate Racial and Ethnic Disparities in Health

The American Public Health Association would like to acknowledge the following individuals and institutions for their leadership and contribution to the *California Campaign to Eliminate Racial and Ethnic Disparities in Health*:

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HEALTH FOR ALL:
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ACKNOWLEDGEMENTS

THE AMERICAN PUBLIC HEALTH ASSOCIATION (APHA) produced *Health for All: California's Strategic Approach to Eliminating Racial and Ethnic Health Disparities* and co-chairs the *California Campaign*. APHA is an association of individuals and organizations working to improve the public's health and to achieve equity in health status for all.

PREVENTION INSTITUTE was the primary author of the report and coordinates the *Campaign*. While the Executive Committee shaped the content of this report, Prevention Institute assumes responsibility for the final product. Prevention Institute is a nonprofit, national center dedicated to improving community health and well-being by building momentum for effective primary prevention.

THE CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY and department personnel provided significant staffing resources in support of the *Campaign*.

The *California Campaign* was made possible with support from:

THE CALIFORNIA ENDOWMENT: The California Endowment has provided generous support for this effort. The Endowment's mission is to expand access to affordable, quality health care for underserved individuals and communities, and to promote fundamental improvements in the health status of all Californians.

THE CALIFORNIA WELLNESS FOUNDATION: The *Campaign* is funded in part by a grant from The California Wellness Foundation (TCWF). Created in 1992 as an independent, private foundation, TCWF's mission is to improve the health of the people of California by making grants for health promotion, wellness education, and disease prevention programs.

KAISER PERMANENTE: Kaiser Permanente is America's largest not-for-profit health care organization. An integrated health delivery system, Kaiser Permanente organizes and provides or coordinates members' care. As a not-for-profit organization, Kaiser Permanente is driven by the needs of its members and a social obligation to provide benefit for the communities in which it operates.

This summary and other *Campaign* materials are available electronically at www.apha.org and www.preventioninstitute.org/healthdis.html

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THE CALIFORNIA CAMPAIGN: BACKGROUND AND METHODOLOGY

Background

This strategy was developed by the *California Campaign* as a guide to further statewide work by underscoring the critical need for addressing disparities through prevention and intervention and urging action that will make a difference.

The California Endowment, Kaiser Permanente, and The California Wellness Foundation provided initial funding for the formation of the *California Campaign*, which was first convened in July 2001. Grantland Johnson, Secretary of the California Health and Human Services Agency and Dr. Georges Benjamin, APHA Executive Director, are the *California Campaign*'s co-chairs. The *California Campaign* Executive Committee has approximately 30 members charged with developing the strategy. The *California Campaign* Leadership Council consists of another 16 key organizations charged with providing support to the education and grassroots organizing efforts that must accompany the strategy's implementation.

Methodology

California's Strategic Approach to Eliminating Racial and Ethnic Health Disparities both reflects the research literature and advances the vision of a broad group of stakeholders. Its development included a review of relevant literature, analysis of health-related data, a consensus-based deliberative process, and interviews with key stakeholders. An Executive Committee was charged with shaping an overall direction for the strategy. Members reviewed draft documents and were taken through a facilitated process in which they described the problem, overall strategy, and specific objectives. The Executive Committee created a 13-member Subcommittee whose members reflected a wide range of expertise in health and health care. The Subcommittee met between Executive Committee meetings to discuss terms, explore theories, synthesize detailed information, and refine the strategic approach. The Subcommittee conducted an extensive review of literature on disparities. In addition, they analyzed data from the State to determine California's Priority Medical Issues. They developed criteria to narrow down the common themes and created the notion of 'critical pathways.' The critical pathways (behavioral and medical services) were finalized using the following criteria: health impact, prevention impact, treatment impact, political salience, statewide support, equity, and the 'Pow Factor,' which promotes the public understanding that there is systemic responsibility for health disparities and that there are social and community factors that impact health conditions. The Subcommittee utilized a consensus-based deliberative process that included brainstorming, clustering of concepts and information, and prioritization. The 20 key factors and 4 clusters were identified based on a review of peer-reviewed literature and relevant reports as well as interviews with practitioners and academics. The review began with California's Priority Medical Issues and McGinnis' and Foege's 'actual causes of death,' and searched for subsequent information that linked California's Priority Medical Issues with social, behavioral, and environmental elements. Following the production of a draft summary report and review by the Executive Committee, staff conducted interviews with and received written input from Executive Committee and Subcommittee members to finalize the *Strategic Approach*.

HEALTH FOR ALL:
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INTRODUCTION: PROMOTING HEALTH FOR ALL IN A DIVERSE STATE

California has long been a leader in health—and has developed tremendous capacity in health research, treatment, and prevention. The stage is set for California to lead the nation in improving health for all and eliminating health disparities. Far too frequently, Californians become unnecessarily ill or injured from preventable conditions. Without effective medical treatment, these health problems are then exacerbated and cause greater suffering, disability, and premature death. People of color in California consistently face higher rates of morbidity and mortality than whites. These higher rates are experienced not just for one or two diseases, but across a very broad spectrum of illnesses and injuries. Racial and ethnic disparities in health are "large, persistent, and even increasing in the United States."[1]

All members of a community are affected by the poor health status of its least healthy members.[3]

—Unequal Treatment, Institute of Medicine

The *California Campaign to Eliminate Racial and Ethnic Disparities in Health* was initiated in April 2001 to address this inequity. Formed through a partnership between the American Public Health Association and the California Health and Human Services Agency, the *Campaign* is a statewide coalition of leaders from the public and private arenas of policy, health care, public health, and philanthropy. Its approach is three-fold: to better understand the roots and pathways to health disparities, to determine what can be done, and to set a process in motion to reduce and eliminate health disparities in California.

The National Institutes of Health defines health disparities as "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."[2] By far the greatest disparities—in terms of number of people affected and width of the gaps—are experienced by people of color. Racial and ethnic health disparities are generally not the result of people experiencing a *different* set of illnesses than those affecting the general population. Rather, the diseases and injuries that affect the population as a whole affect people of color more frequently and more severely.

Addressing health disparities requires a multi-faceted strategy because the underlying factors producing health disparities are complex. Disparate health outcomes are

not primarily due to one microbe or one genetic factor. Rather, a broad range of social, economic, and community conditions interplay with individual factors to exacerbate susceptibility and provide less protection. These conditions, such as deteriorated housing, poor education, limited employment opportunities and role models, limited household resources, and ready availability of cheap high-fat foods, are particularly exacerbated in low-income neighborhoods where people of color are more likely to live. Research has now shown that after adjusting for individual risk factors, there are neighborhood differences in health outcomes.[4]

These neighborhood conditions are related to a history of bias directed against people of color. (*See Table 1.*) Therefore, it is not surprising that there are disparities in health. In fact, it is the relationship of place, ethnicity, and poverty that can lead to the greatest disparities.

There is a risk that prevalence of disparities may increase in California as the population becomes even more multicultural. By the year 2040, it is expected that two out of three Californians will be people of color. As the state becomes increasingly diverse, the reality of a healthy and productive California will increasingly rely on the ability to keep all Californians healthy and eliminate racial and ethnic disparities by improving the health of communities of color. Healthcare is among the most expensive commitments of government, businesses, and individuals. Illness and injury also generate tremendous social costs in the form of lost productivity and expenditures for disability, worker's compensation, and public benefit programs. Eliminating racial and ethnic health disparities is imperative both as a matter of fairness and economic common sense. This tremendous challenge can—and must—be met with a focused commitment of will, resources, and cooperation to institute change.

People affected by health disparities more frequently live in environments with:

- Toxic contamination
- Inadequate access to affordable, nutritious food, places to play and exercise, effective transportation systems, and accurate, relevant health information
- Violence
- Joblessness, poverty
- Targeted marketing and excessive outlets for unhealthy products
- Community norms that do not support protective health behaviors

TAKING ACTION TO ELIMINATE RACIAL AND ETHNIC HEALTH DISPARITIES

The *California Strategic Approach* delineates how the resources of diverse governmental and private institutions can be marshaled to work with communities to make significant progress towards eliminating health disparities in California. It illuminates the critical pathways that affect health and the key points for intervention to ensure health for all. Two primary goals emerged from the findings of the *Campaign*:

Goal 1: Prevent the development of illness and injury by fostering healthy behaviors, healthy community environments, and institutional support of good health outcomes.

Health can be enhanced and disparities reduced through greater attention to prevention. Nearly half of all deaths are preventable.[5] Improving health-related behaviors such as tobacco use, poor nutrition and lack of physical activity, unsafe sex, and drug and alcohol use, and fostering health-supporting community environments is fundamental for effective prevention.

A broad and intensive strategy to address socioeconomic inequality, concentrated poverty in many racial and ethnic minority communities, inequitable and segregated housing and educational facilities, individual behavior risk factors, as well as disparate access to the use of healthcare services is needed to seriously address racial and ethnic disparities in health status.[6]

—Unequal Treatment, Institute of Medicine

TABLE 1.
SOURCES OF HEALTH DISPARITIES

Housing

- Sub-prime loans (loans with excessive mortgage fees, interest rates, and penalties) are five times more likely in African American neighborhoods than in white neighborhoods. Fully 39% of homeowners in upper-income African American neighborhoods have sub-prime loans compared to only 18% of homeowners in low-income white neighborhoods.[7]
- Minorities tend to be segregated in neighborhoods characterized by lower-quality schools and public services, limited access to quality healthcare, and greater exposure to environmental-based health hazards.[8]

Education

- Schools serving large concentrations of low-income students—African Americans, Latinos, and Native Americans—often have many teachers with emergency teaching permits who lack the expertise to teach. These teachers often teach at sites in poor states of maintenance and that lack proper instructional support materials. High professional staff turnover is also common.[9]
- Nearly four of ten Hispanics (39%) have less than a high school education, compared with one of ten whites (11%).[10] In California, the 2001-2002 dropout rates for American Indians (14.4%), Pacific Islanders (11.0%), Hispanics (14.8%), and African Americans (18.9%) exceeded dropouts for all races combined (10.9%).[11]

Labor

- Of senior-level male managers in Fortune 1000 industrial and Fortune 500 service industries in 1995, almost 97% were white, 0.6% were African American, 0.3% were Asian, and 0.4% were Hispanic.[12]
- In California the August 2003 unemployment rate among whites was 6.1 compared to 8.9 among non-whites, 11.7 among African Americans, and 7.7 among Hispanics.[13]

Economics

- In 1997, 41% of Hispanic, 35% of African American, and 45% of Native American non-elderly lived in a family experiencing food problems (i.e., skipping meals for lack of money to buy food), compared to 23% for all races.[14]
- While 26% of whites and 29% of Asians are low-income, the rate is 49% for African Americans, 54% for Native Americans, and 61% for Hispanics.[15]

Technology

- White (46%) and Asian American (57%) households continue to have internet access at levels more than double those of African American (24%) and Hispanic (24%) households.[16]
- Most U.S. colleges have access to T-3 internet lines, while only 1 of 32 American Indian tribal colleges has this access.[17]

Criminal Justice

- In 1997 African Americans, Hispanics, Asian Americans, and American Indians constituted about one-third of juveniles in the U.S. yet represented two-thirds of detained and committed youth in juvenile facilities.[18]
- While the prevalence of both crack and powder cocaine use is higher among whites than African Americans, almost 97% of all crack cocaine defendants are African American or Latino.[19]
- In the 1990's, the chance an African American U.S. born male would be imprisoned for a felony sometime in his life approached 30%, while the chance for a white male was 4.4%.[20]

Transportation

- California commuter systems requiring equipment to serve largely wealthier, suburban populations receive funding while urban bus transit systems requiring funding for repair, maintenance and operations experience cutbacks.[21]

Environmental

- People of color suffer environmental burdens more than whites[22]: They experience 27% more exposure to toxic chemicals and 32% more cancer risk from hazardous air pollutants.
- Nearly twice as many toxic waste Superfund Sites per square mile are in neighborhoods of color, along with more than twice as many facilities emitting air pollutants.[23]

Goal 2: Reduce the severity of illness and injury by providing high-quality medical care to all.

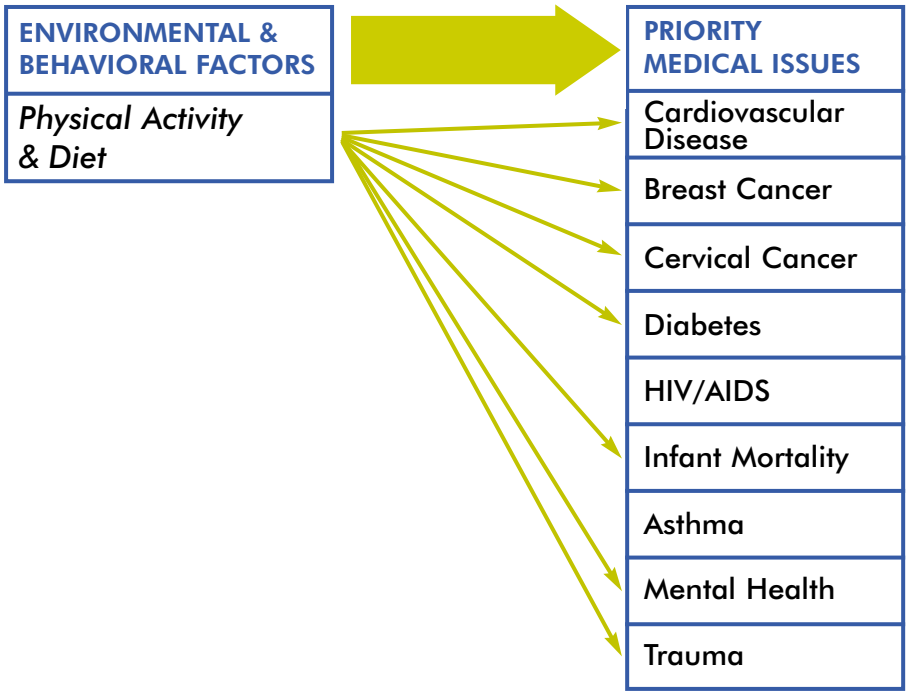
High-quality health care can prevent the onset of some medical conditions, diagnose problems early, reduce the severity of symptoms, and slow the progression of secondary conditions. People of color consistently have less access to health care and receive worse quality care. Access to timely screening, appropriate diagnosis, and culturally competent, high-quality treatment will maximize quality of life and lifespan.

NINE PRIORITY MEDICAL ISSUES FOR CALIFORNIA

Nationally and in California, rates of illness, injury, and death are disproportionately higher for people of color compared to whites across a number of health concerns. The *California Campaign* identified nine Priority Medical Issues which cause significant morbidity and/or mortality among people of color and are associated with the achievable objectives outlined in *Healthy People 2010*. They are: 1) cardiovascular disease, 2) breast cancer, 3) cervical cancer, 4) diabetes, 5) HIV/AIDS, 6) infant mortality, 7) asthma, 8) mental health, and 9) trauma (including intentional and unintentional injury). (*These are described in more detail in Table 2.*)

FIGURE 1. THE RELATIONSHIP BETWEEN PHYSICAL ACTIVITY AND DIET AND PRIORITY MEDICAL ISSUES

Poor nutrition and/or a lack of physical activity is a risk factor for many Priority Medical Issues. Healthy diets and regular activity can prevent them.



EXAMPLE: THE ROLE OF INSTITUTIONS IN PROMOTING PHYSICAL ACTIVITY

Nutrition and physical activity levels are influenced by environmental conditions. Governmental, non-governmental, and community-based institutions have a role to play in reducing barriers and promoting access, as the following examples illustrate.

- **Government institutions** can ensure consideration of bicycle and pedestrian needs in all transportation, land use, and zoning decisions; promote bike and pedestrian-friendly routes by improving street design with curb extensions, enhancing medians, implementing traffic calming techniques, improving aesthetics by adding plants, trees, and public art, developing local shops, parks, services, and parks in all neighborhoods; and foster 'micro-development' around transit stops.
- **Health care institutions** can increase awareness about the importance of physical activity among patients, give patients monitors to track their physical activity, support relevant policies, and encourage walking groups.
- **Training institutions** can train teachers about effective physical activity programs and train physicians to promote physical activity among patients.
- **Schools** can offer quality physical education each day, complementing it with health education and giving students the knowledge and skills to maintain physically active lifestyles. Efforts to improve the quantity of physical education should focus on ensuring that students receive at least the minimum number of minutes of physical education to obtain the associated health benefits.
- **Businesses** can ensure that stairwells are clean and well lit, aesthetically pleasing, and have encouraging signs; subsidize employee memberships to exercise facilities; and grant employees flexible leave time each week for physical activity.
- **Community** efforts can advocate for transit design that promotes safe physical activity; form walking groups; and promote organized recreational activities and safe play spaces for children.

The Priority Medical Issues were identified as the highest priorities based on available data. Improvements are still needed in data collection systems to fully understand the extent and causes of disparities. For example, it is difficult to look within a racial or ethnic group at health outcomes for people at different levels of income.[24] Since poverty is associated with worse health outcomes, and a disproportionate number of people of color live in poverty, it is difficult to disentangle the different contributions of ethnicity and class on health. Further, racial and ethnic categories are not homogenous. While as a group Asian/Pacific Islanders "have indicators of being one of the healthiest population groups in the United States... health disparities for some specific groups are quite marked."[25] Women of Vietnamese origin have very high rates of cervical cancer compared to the average for Asian/Pacific Islanders and whites.[26] Data is also dependent on reporting methodology. For example, the California Health Interview Survey (CHIS) relies on self-reports of diagnosis, and therefore people not utilizing health care would probably be less likely to report a problem.

TABLE 2.
PRIORITY MEDICAL ISSUES

1. Cardiovascular Disease

African Americans have the highest death rates from both heart disease and stroke in California (683 and 169 per 100,000 population, respectively) compared to whites (476 and 121 per 100,000 population, respectively), Hispanics (324 and 87 per 100,000 population, respectively), Asians/Pacific Islanders (294 and 118 per 100,000 population, respectively), and American Indians and Alaska Natives (213 and 51 per 100,000 population, respectively).[27,28] Risk of heart disease and stroke can be reduced by following a 'heart healthy diet,' engaging in regular activity, not smoking, and consuming alcohol only in moderation.[29] Disparities in medical care and treatment are documented[30] and issues of access to quality care, access to specialists, unequal treatment, disparities in diagnosis, and insurance coverage must be critically examined to formulate solutions among African Americans and other affected racial/ethnic groups.

2. Breast Cancer

African American women in California have the highest breast cancer mortality rates (32.4/100,000).[31] White women have the highest rates of new breast cancer cases (117.4/100,000) yet have lower mortality rates than their African American counterparts, suggesting real disparities in diagnosis and treatment.[32] One out of every three cancer deaths is thought to result from "poor diet, obesity, and [lack of] physical activity."[33] Early breast cancer screening and detection improve prognosis and survival rates and disparities in screening rates are at least part of the reason that African American, Latina/Hispanic, and Asian/Pacific Islander women have not experienced improvements in mortality rates on a par with the reduced mortality rates experienced by white women.

3. Cervical Cancer

Latina/Hispanic and Asian/Pacific Islander women in California have the highest risk of developing cervical cancer and "cervical cancer is a major problem for many women recently immigrating to California."[34] Cervical cancer is the most common form of cancer among Laotian women,[35] and nationally, Vietnamese American women have the highest rates of cervical cancer, with incidence rates estimated at five times higher than white women.[36] Latinas in California have the highest incidence of, and are more than twice as likely as white women to develop, cervical cancer.[37] African American women suffer disproportionately from cervical cancer related mortality both nationally and in California.[38] Death from cervical cancer is highly preventable with regular Pap tests, and survival rates improve dramatically when cancer of the cervix is detected in its early stages. Improving access to Pap tests has been a key focus for reducing disparities in cervical cancer mortality.

4. Diabetes

Diabetes—California's fifth leading cause of death and a significant contributor to kidney and heart disease (the leading cause of death)—costs California about $12 billion, annually.[39] African Americans have the highest prevalence of diabetes in California for adults ages 18 and older. Diabetes prevalence for ages 50-64 are consistently higher amongst African Americans (20.5%), American Indian and Alaska Natives (19.6%), and Latinos (17.9%) as compared to whites (8 %) and Asian/Pacific Islanders (10.9%),[40] and high rates in this age group contribute to a major loss of productivity. Significant increases in Type II diabetes among children and youth are also a major concern. Poor nutrition and sedentary behavior are important risk factors for Type II diabetes.[41]

5. HIV/AIDS

According to the California Department of Health Services, "the challenge of the disproportionate impact of the AIDS epidemic in California's communities of color is clearly evident."[42] The rate of HIV infection among African Americans of all ages combined is almost four times higher than whites or Latinos while Latinos have the highest rates of new infection among California residents under the age of 30.[43] As of April 30, 2002, the cumulative number of reported AIDS cases by race/ethnicity and age show that 40.5% of the adult/adolescent cases and 72% of the pediatric cases occurred in people of color.[44] Latinos represented 31.9% of total AIDS cases, and African Americans represented 23.4% of reported California AIDS cases in 2001.[45] African Americans in California are still more than three times as likely to die from HIV/AIDS than their white counterparts.[46] Men who have sex with men continue to experience the greatest number of HIV/AIDS cases, but among people of color, injection drug use has been an important and significant mode of transmission and suggests a valuable avenue of prevention.

TABLE 2.
PRIORITY MEDICAL ISSUES, continued

6. Infant Mortality

In 1999, the infant death rate for African Americans in California was 12.9/1,000 live births compared to 5.2/1,000 for Hispanic/Latinos, and 4.8/1,000 for whites.[47] The infant mortality rate for African Americans in California fails to meet the Healthy People 2000 objective for African Americans nationally and has been persistently higher than for other races/ethnicities in California for the past decade. Most of the disparity in infant mortality among African Americans is attributed to three factors: large numbers of infants born at low birth weight and/or pre-term, complications at pregnancy, and Sudden Infant Death Syndrome.

7. Asthma

American Indian and Alaska Native children ages 0-17 have the highest asthma prevalence of all racial/ethnic groups (25.5%) in California, compared to 22.3% for Native Hawaiian and other Pacific Islanders, 21.1% for African Americans, 14.3% for whites, 11.7% for Asian, 9.7% for Latinos and 15.6% for Others.[48] In 2000, a higher percentage of Latinos, African Americans, and American Indian and Alaska Natives, required emergency room visits for their asthma as compared to Asians or whites.[49] Reducing exposure to environmental triggers, including air pollutants, tobacco smoke, dust mites, cockroaches, and molds—which are disproportionately present in low-income neighborhoods—can reduce asthma episodes. Continuous access to medical care is also critical for managing asthma symptoms and controlling attacks; however, data suggests a key disparity in access to medical care and treatment.[50] Costs due to hospitalization for asthma were $350 million in 1997, nearly half of which rested with the Medi-Cal programs and asthma rates and related costs are increasing dramatically.

8. Mental Health

In California, approximately 5 million persons have a mental illness and approximately 1.3 million Californians experience severe mental illness.[51] Unlike the other eight Priority Medical Issues, it is difficult to establish a racial/ethnic profile of mental health in California and nationally generated data is typically more helpful. Rates of death attributed to mental health related factors are rarely reported, with the exception of suicide. Nationally, Native American women ages 25-44 and Asian women over the age of 65 have the highest rates of suicide among all women.[52] The Surgeon General's report points to striking disparities in mental health care for racial/ethnic minorities in terms of access and availability of services and treatment quality,[53] and these issues make it hard to determine actual incidence rates of mental health problems. However, African Americans "are more likely to experience a mental illness than their white counterparts," American Indian/Alaska Natives "appear to suffer disproportionately from depression" and Asian American and Pacific Islanders appear to be "more likely to be misdiagnosed as 'problem-free'."[54] The California Institute of Mental Health identifies some important factors that must be addressed to reduce or eliminate racial and ethnic disparities in mental health: "Mental health issues are complicated with overlapping social and physical health problems," for example African Americans are overrepresented among HIV+, homeless, and foster care populations.[55]

9. Trauma

Trauma includes both intentional (e.g., homicide) and unintentional (e.g., motor vehicle crashes) injuries and is preventable. African Americans are the most impacted by fatal intentional injuries; Native Americans are the most impacted by fatal unintentional injuries. When combining all fatal injuries in California for 2000, African Americans had the highest rate with 65 injury deaths per 100,000 population compared to 52/100,000 for whites, 51/100,000 for Native Americans, 33/100,000 for Latinos and 25/100,000 for Asians.[56] African Americans faced the highest rates of fatal assaults with 27/100,000 population compared to 8/100,000 for Latinos and 3/100,000 for whites, Asians, and Native Americans combined in California.[57] Race-specific rates for unintentional injuries in California in 2000 were as follows: Native Americans 40/100,000, whites 33/100,000, African Americans 29/100,000, Hispanic/Latinos 20/100,000 and Asians 15/100,000.[58] Death rates from all causes of motor vehicle related crashes take the greatest toll on Native Americans who died at a rate of 13/100,000.[59] Nationally, although Hispanic/Latino and African American males tend to travel fewer vehicle miles, they are more than twice as likely to die in a motor vehicle related crash than their white counterparts.[60]

DEVELOPING A STRATEGIC APPROACH: UNDERSTANDING THE CRITICAL PATHWAYS TO HEALTH

The frequency and severity of injury and illness is not inevitable. An analysis of the underlying causes of medical conditions reveals a trajectory by which health outcomes develop and worsen. By analyzing the pathways from root factors to illness and injury experienced by people of color, the necessary actions to prevent these medical conditions are illuminated. Nearly 50% of annual deaths—and the impaired quality of life that frequently precedes them—are preventable[61] because they are attributable to external environmental and behavioral factors. These *actual causes* of death can be modified, in contrast to inborn (largely genetic) factors that cannot be altered.[62] Strengthening the quality and availability of medical care can save additional lives.

The following diagram delineates the pathways by which root factors such as oppression and discrimination increase the frequency and severity of injury and illness. An analysis of the underlying causes of the nine Priority Medical Issues reveals three stages in the trajectory to poor health outcomes. First, people of color are born into a society that discriminates against them and are disproportionately subject to living in impoverished communities. Second, these fundamental conditions shape behaviors and the social and physical environment which people encounter. Third, lack of access to medical care and lower quality diagnosis and treatment for people of color leads to higher rates of sickness, disability, and mortality. Understanding these pathways in greater detail clarifies what action is needed to eliminate health disparities.

A further value of focusing on the critical pathways is that it illuminates the roots of not just one but multiple medical conditions. The Centers for Disease Control and Prevention's study of 'syndemics'—two or more afflictions interacting with each other—confirms the interplay of many factors contributing to the excess burden of a disease in a population.[63] As described by Arline Geronimus, the impact of social, economic and political exclusion results in a 'weathering' whereby health reflects cumulative experience rather than chronological or developmental age.[64] Stresses such as discrimination, inadequate incomes, unsafe neighborhoods, lack of neighborhood services, and multiple health problems all contribute to a wearing

Despite steady improvement in the overall health of the U.S. population, racial and ethnic minorities, with few exceptions, experience higher rates of morbidity and mortality than non-minorities....The reasons for these health status disparities are complex and poorly understood, but may largely reflect socioeconomic differences, differences in health-related risk factors, environmental degradation, and direct and indirect consequences of discrimination. Differences in access to healthcare are also likely to play a role in these health disparities.[65]

—Unequal Treatment, Institute of Medicine

down of the physical body and subsequent poor health. The significance of this process was underscored in an October 2003 *New York Times* article about the urban poor, many of whom are people of color: disproportionate health problems "make you wonder whether there is something deadly in the American experience of urban poverty itself."[66]

While much of the attention to reducing disparities has focused on improving access and quality of health care, there is a tremendous opportunity to prevent many of the medical conditions in the first place. A primary prevention strategy examines underlying causes of disease and injury and works to intervene along the pathways before they arise.

GOAL 1: PREVENT THE DEVELOPMENT OF ILLNESS AND INJURY BY FOSTERING HEALTHY BEHAVIORS, HEALTHY COMMUNITY ENVIRONMENTS, AND INSTITUTIONAL SUPPORT OF GOOD HEALTH OUTCOMES

The *California Campaign* identified several key behaviors along the pathways to the Priority Medical Issues: tobacco use, poor nutrition and lack of physical activity, unsafe sex, and drug and alcohol use. McGinnis and Foege also identified these behaviors among the *actual causes* of death contributing to premature mortality.[67] Each of these behaviors is associated with more than one health problem. For example, smoking, high fat diets, and sedentary behavior are all risk factors for heart disease, stroke,[68] and cancer. Alcohol use/abuse can result in poor judgment[69] and is related to trauma such as traffic injuries and violence, as well as HIV/AIDS transmitted through unprotected sex.

Altering these behavioral pathways requires action at several levels. Individuals need to be equipped with the knowledge, skills, and motivation to make changes. Key community institutions such as health care, workplaces, schools, and faith-based organizations are ideal venues for reaching individuals; they also offer built-in systems of social support that are associated with higher likelihood of maintaining healthier behaviors. While education plays a valuable role in influencing these individual behavioral choices, it is important not to 'blame the victim' by focusing strictly on lifestyle choices. Addressing the social and physical environment that influences behavioral choices is an essential element of a strategy to change behavioral patterns throughout a population.

Evidence is emerging...that societal-level phenomena are critical determinants of health....Stress, insufficient financial and social supports, poor diet, environmental exposures, community factors & characteristics, and many other health risks may be addressed by one-to-one intervention efforts, but such interventions do little to alter the broader social and economic forces that influence these risks.[70]

—Promoting Health, Institute of Medicine

The Impact of the Environment on Behavior

Far more than air, water, and soil, the environment refers to the broad social and community context in which everyday life takes place. As Henrik Blum noted, "Individual behavior is most markedly affected, if not generated, by various aspects of the environment...Getting people to behave...encompasses only a small fraction of the routes to risk reduction and does not stand alone without significant support from major societal mechanisms."[71]

Focusing only on individual responsibility for lifestyle changes ignores larger environmental factors that can work against the educational message. While noting that lower income levels are associated with a higher prevalence of risky behaviors, such as tobacco use, physical inactivity, and high-fat diets, Adler and Neuman note that behaviors are "shaped and constrained by social and physical environments linked to socioeconomic status."[72] For example, "limited education may mean less exposure to information about risk, but the same people may live in neighborhoods with poor recreational facilities, fewer stores selling fresh produce, and more advertising for tobacco and alcohol"[73]—all of which may contribute to negative health behaviors and poor health outcomes. The media, through entertainment, news, and advertising, presents strong images of social norms that are frequently contrary to healthy choices. For example, the use of high profile hip-hop entertainers and sports icons to sell soda and fast food gives these products a positive image among youth.

Social connections within a community are also important. One study showed that children were mentally and physically healthier in neighborhoods where adults talked to each other.[74] Other research supports links between high levels of social support and a number of positive health benefits among Latinos.[75] Strong social support helps people make and maintain positive health changes. For example, social networks produce and enforce social sanctions and controls to diminish negative behavior and reduce the incidence of crime, juvenile delinquency, and access to firearms within communities.[76,77]

To prevent disease, we increasingly ask people to do things that they have not done previously, to stop doing things they have been doing for years, and to do more of some things and less of other things...It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change.[78]

—Promoting Health, Institute of Medicine

ENVIRONMENTAL CONTRIBUTIONS TO BEHAVIOR

Tobacco use:

Three major African American publications received proportionately higher profits from cigarette advertisements than did other magazines.[79] The tobacco industry sponsors African American and American Indian/Alaskan Native cultural events and makes contributions to minority higher education institutions, elected officials, civic and community organizations, and scholarship programs.[80] Tobacco use has been linked to cardiovascular disease, cervical cancer, and low birth weight, which may contribute to infant mortality. Tobacco use can also exacerbate asthma.

Poor nutrition and lack of physical activity:

Low-income African American and Latino residents in Los Angeles have less access to supermarkets[81] which influences nutritional intake.[82] Children are more active when there are play spaces near their homes.[83,84] Adults are more active if there are recreational facilities close to their homes, if they are in transit-oriented neighborhoods, and if they perceive the neighborhood as safe.[85] Poor nutrition and lack of physical activity are linked to cardiovascular disease, breast and cervical cancers, diabetes, infant mortality, mental health, and trauma (unintentional injury).

Unsafe sex:

Television exposes children to sex but does not show the risks and results.[86] Sex is often shown as consequence-free and rarely planned. Alcohol billboards exacerbate irresponsible sexual behavior by associating it with their promotion of alcohol.[87] Unsafe sex is linked to cervical cancer, HIV/AIDS, and infant mortality.

Alcohol use:

Greater densities of liquor stores are found in segregated communities of color.[88] Predominantly African American census tracts have significantly more liquor stores per capita than predominately white communities.[89] Drug and alcohol use are linked to breast and cervical cancer, HIV infection, infant mortality, and trauma (i.e., suicide, homicide, and motor vehicle injuries). Drug and alcohol use is also associated with mental health problems.

The Direct Impact of the Environment on Health and Illness

In addition to shaping behavior, the environment also has direct influences on health. The quality of air, water, and soil tends to be worse in areas in which the population is either low-income or primarily people of color. Toxic sites are concentrated in areas where low-income and minority populations reside,[90] and the housing is more likely to be a source of lead, insect dust, and other harmful contaminants.[91] Further, low-income people of color may have higher exposure to industrial hazards in their workplaces.[92]

Beyond specific toxins, other physical and social neighborhood conditions can directly affect health by producing higher stress levels which can contribute to poorer mental health and health outcomes. For example, one study showed that children who heard gunshots were twice as likely to experience asthmatic symptoms.[93] Chronic stress may contribute to other poor health outcomes such as cardiovascular disease and some forms of cancers.[94]

KEY COMMUNITY FACTORS FOR REDUCING HEALTH DISPARITIES

Given the influence of the environment on health and health behaviors, it is critical to specifically identify those factors that have the greatest impact on the development of health disparities. These factors comprise the pathways through which root factors play out on the community level and, if ameliorated, can help to reduce and eliminate disparities. Twenty key factors '*cluster*' into four areas: built environment factors, social capital factors, services and institutions, and structural factors.[95] (*See Table 3 for a list of factors by cluster and the Methodology section for how they were selected.*)

No epidemic has ever been resolved by attention to the affected individual.[105]

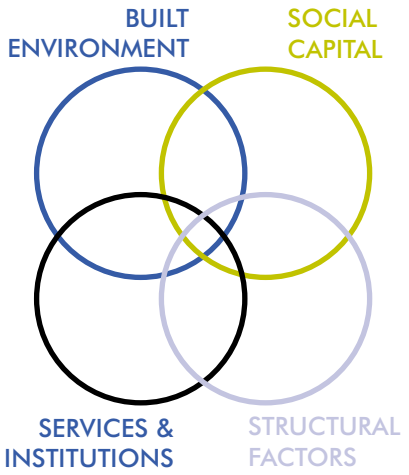
—Dr. George Albee

Built Environment Factors

The built environment is the man-made infrastructure of a community such as street design, public transportation, and permitted uses of buildings. Design and use influences behavior, including physical activity/nutrition, tobacco use, and alcohol use. It also affects the Priority Medical Issues, such as asthma, mental health, and trauma. Factors that influence these health-related behaviors and outcomes include safe places for incidental or recreational physical activity; safe, affordable, healthy food; safe, affordable housing; safe and accessible transportation; clean air, water, and soil; limited availability of harmful products, such as alcohol and tobacco; and a welcoming and culturally appropriate environment.

For example, in regards to diet and activity patterns, greater access to supermarkets can positively impact fruit and vegetable consumption,[96] and children's physical activity levels are positively associated with the number of play spaces near their homes.[97,98] Quality housing can reduce triggers for asthma such as exposure to molds and pests[99] and reduce psychological stress.[100]

COMMUNITY CLUSTERS



Social Capital Factors

Social capital includes the "connections among individual-social networks and the norms of reciprocity and trustworthiness that arise from them,"[101] as well as standards for behavior that are socially dictated. These standards, or behavioral and gender norms, strongly influence behavioral choices about alcohol consumption, tobacco and sexual activity. Further, elements of social capital are associated with improved mental health and trauma outcomes, as well as with securing resources for the community, such as healthy food outlets. Social capital factors include trust and cohesion; willingness to take action for the community's benefit; community engagement, such as through voting or volunteering; behavior norms; and gender norms.

Research associates social capital with a number of health outcomes.[102] Strong social networks and connections correspond with significant improvements in mental health and lower rates of homicide, suicide, and alcohol and drug abuse.[103,104] One mechanism for this health-enhancing effect is that networks produce and enforce social sanctions and controls which diminish negative behavior such as violence and

substance use.[106,107] When people come together for the common good, communities have reduced levels of violence[108] and improved food access.[109] Community service can provide mentors for high-risk youth and has been associated with decreases in violence, substance use, and teen pregnancy.[110] Civic participation also has benefits for youth volunteers, such as lower rates of teen pregnancy and illicit drug use,[111] which contribute to decreased infant mortality and HIV/AIDS rates. Social forces can also have a negative effect. Typically, male gender norms are associated with a variety of poor health behaviors, including drinking, drug use, risky driving, and engaging in unsafe sex.[112]

Services and Institutions

The availability of and access to high quality, culturally competent, and appropriately coordinated public and private services and institutions is a critical element for good health. Public and private services and institutions include local government, health, public health, social services, education, public safety, community groups and coalitions, community-based organizations, faith institutions, businesses, and arts institutions. Services and institutions can both promote healthy behaviors, such as clinics distributing walking monitors, and strengthen a broad range of health-promoting elements in a community. For example, public safety efforts can increase perceptions of safety so that people feel safe walking around a neighborhood and community coalitions can ensure that community members have the range of services they need. Research has shown that an artistic environment, such as gardens, murals, and music, promotes healing. This has been demonstrated in hospitals and other health care facilities, where the incorporation of arts into the building's spaces has reduced patient recovery time and assisted in relief for the disabled, infirm, and their caregivers.[113] The availability of public and community-based services may be particularly important in low-income communities of color, as residents may not have access to or be able to afford paying for such services.

Structural Factors

Structural factors are overarching in nature, and rooted in broader systems or structures that have an impact on people and communities everywhere. Examples include employment and economic opportunities and marketing and advertising practices. For example, economic capital, including adequate living wage employment opportunities, job training, local ownership of businesses, homeownership, access to loans, and investment capital can be encouraged and promoted at a local level. These activities promote local access to resources, increased local capital that can be reinvested into the community, and stability among residents. Increases in local business are associated with reduced crime, and achieving living wages may be correlated with reduced stress levels and better housing. Media has an enormous impact on shaping perceptions about what is 'normal' in society and influencing behaviors ranging from contraceptive use,[114] to consumption of high-fat foods and sodas, to engaging in acts of violence.[115,116]

TABLE 3. 20 COMMUNITY FACTORS

Built Environment

1. Activity-Promoting Environment
2. Nutrition-Promoting Environment
3. Housing
4. Transportation
5. Environmental Quality
6. Product Availability
7. Aesthetic/Ambiance

Social Capital

8. Social Cohesion and Trust
9. Collective Efficacy
10. Civic Participation and Engagement
11. Social and Behavior Norms
12. Gender Norms

Services and Institutions

13. Public Health, Health, and Human Services
14. Public Safety
15. Education and Literacy
16. Community-Based Organizations
17. Cultural and Artistic Opportunities

Structural Factors

18. Economic Capital
19. Media and Marketing
20. Ethnic, Racial, and Intergroup Relations

GOAL 2:
REDUCE THE SEVERITY OF ILLNESS AND INJURY BY PROVIDING HIGH-QUALITY MEDICAL CARE TO ALL.

Once injuries and diseases do occur, their impact can be reduced through accessible, high quality care. In addition, many conditions can be prevented by quality medical services. The *California Campaign* identified two major healthcare issues along the pathways to the Priority Medical Issues: 1) late diagnosis (in part due to lack of access) and 2) improper treatment (including unequal care). These are influenced by access to care, quality of care, and culturally and linguistically appropriate services.

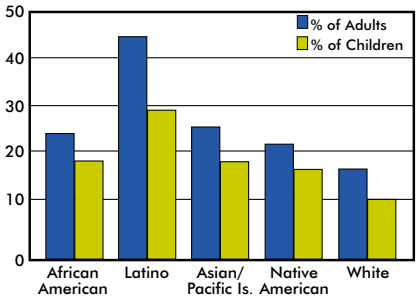
Lack of health insurance is a barrier to receiving care. In 1999, 6.8 million Californians were uninsured, with Latinos having the highest uninsurance rate at 28% and also having the lowest rate of job-based insurance at 42%.[117] (*See Figure 2.*) Among women, the disparities worsen as 45% of Latinas and 26% of Asian American women are uninsured, compared to 15% of white women.[118] In addition, nationally 21% of Asian/Pacific Islanders and 34% of Mexican Americans aged 18-64 reported having no usual source of care compared to 17% of whites.[119] People of color are more likely to work in lower-wage jobs that do not provide insurance and have insufficient income to purchase it. Even in situations where people have health insurance, the working poor and middle class do not have coverage for their families. Another barrier to access is the fear that immigrant families face—even legal immigrants—of stigma and discrimination when seeking health care.

In its groundbreaking document, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, the Institute of Medicine documents serious discrepancies in the quality of care received by people of color, noting that "Evidence of racial and ethnic disparities in healthcare is, with few exceptions, remarkably consistent across a range of illnesses and healthcare services."[120] *Unequal Treatment* reveals that differences in diagnosis, quality of care, and treatment methods lead to consistently poorer health outcomes among people of color.[121] These include lower frequencies of cancer diagnostic tests, treatments, and analgesics as well as prescriptions of anti-retroviral therapy for HIV.[122] For example, white patients in Los Angeles County were more likely to receive surgery, and in fact race emerged with greater significance as a predictor for use of surgery than did income.[123]

Racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access related factors, such as patients' insurance and income, are controlled. The sources of these disparities are complex, are rooted in historic and contemporary inequities, and involve many participants at several levels.[124]

—Unequal Treatment, Institute of Medicine

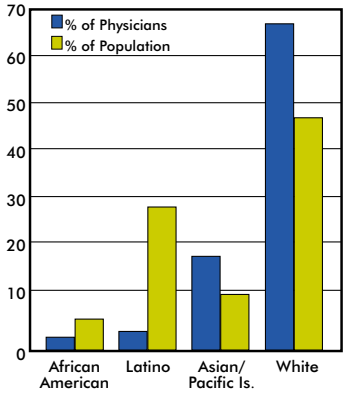
FIGURE 2: UNINSURED ADULTS AND CHILDREN IN CALIFORNIA



Source: University of California, San Diego, 2000

Culturally and linguistically appropriate care is needed to ensure excellent communication with patients and to enable providers to address health concerns within the cultural context of the patient. A culturally competent system of care is measured both by achieving the desired health outcome and patient satisfaction with medical encounters.[125] The Commonwealth Fund's 2001 Health Care Quality Survey reported that 33% of Latinos and 27% of Asian Americans said they faced difficulty in communicating with physicians, particularly for Korean Americans (41%).[126,127] Data from the California Managed Risk Medical Insurance Board indicated that the percentage of Medicaid/managed care members expressing satisfaction with their health care was less for non English-speaking Asian/Pacific Islanders than for Spanish- and English-speakers. The Commonwealth Fund study showed that satisfaction was also low for English-speaking Asian/Pacific Islanders. An element of culturally appropriate care is a diverse workforce. The vast majority of medical professionals, including physicians, registered nurses, and mid-level providers such as nurse practitioners and physician assistants are white, exceeding the percentage of whites in the general population. (*See Figure 3.*)

FIGURE 3: RACE & ETHNICITY OF U.S. PHYSICIANS



Source: AMA, Physician Characteristics and Distribution in the US 2001-2002

THE TWO GOALS, IMPROVING ENVIRONMENTS AND MEDICAL CARE, ARE COMPLEMENTARY

Strengthening community environments and improving access and quality of health care are not only necessary elements in the strategy to reduce health disparities but are mutually supportive.

High quality, accessible health care contributes to improving community environments. Providing timely and effective diagnosis and treatment not only reduces demands on the medical system, it also better enables people to contribute to the community environment through such activities as work and civic participation. Further, an effective health care institution will provide preventive care and will be active in encouraging the kinds of community services and policies that keep people healthy. An effective health care institution can also improve the local economy by purchasing local products and employing local residents.

Positive behaviors and environments equally improve the success of treatment and disease management. For example, healthy eating and activity habits are not only critical for prevention but also for disease management of Priority Medical Issues such as diabetes, cardiovascular disease, HIV/AIDS, as well as cancer treatment. Improved air quality—indoors and outdoors—reduces asthma triggers. A reliable, affordable, and accessible transportation system transports people to screening and treatment appointments. Literacy improves the ability to read and understand prescription labels—both directions and warnings. Strong social networks are associated with people looking out for each other and taking care of each other during treatment and recovery.

The productivity of the workforce is closely linked with its health status, yet if some segments of the population, such as racial and ethnic minorities, receive a lower quality and intensity of healthcare, then these groups are further hindered in their efforts to advance economically and professionally.[128]

—Unequal Treatment,
Institute of Medicine

ENGAGING STAKEHOLDERS IN CALIFORNIA'S STRATEGIC APPROACH

Improving health behaviors, strengthening community environments, and improving access and quality of health care cannot be achieved by any one organization, or by addressing one individual at a time. Eliminating racial and ethnic health disparities and improving health outcomes requires participation from key public and private institutions working in partnership with communities.

Institutions, including banks, businesses, government, schools, health care, and community service groups, have a major influence on community environments. The decisions they make—such as whether to accommodate pedestrian and bicycle travel on city streets, where to locate supermarkets or alcohol outlets, or what efforts to take to reduce hazardous emissions—influence health behaviors and health outcomes. As employers, investors, and purchasers, each has impact on the local economy. As providers of services, they influence what is and is not available to community residents. As prominent facilities within communities, they help establish norms for students, employees and the general public. By providing activity breaks, creating welcoming stairwells, or ensuring healthy affordable food options, these facilities can create an atmosphere that supports healthy behavior. Schools are an important community resource and an excellent venue for reaching families. While meeting educational needs, they can both promote healthy behaviors and link students to services and support. (*See Table 4 for a list of sample activities, by sector, to improve health and reduce disparities.*)

Engaging all communities in shaping solutions and taking action for change is critical. Communities need to be involved in identifying the health problems of greatest concern, examining the critical pathways to illness and injury, and working to alter these pathways. There are many strengths in communities of color upon which to anchor an effective strategy. Strong family ties and social networks, trust and respect among community members, and health-promoting traditions such as active lifestyles or high fruit and vegetable diets are all resilience factors which need support and enhancement for reducing health disparities.

In many cases, these decisions are made without awareness of their relationships to health outcomes. When communities and institutions make decisions more explicitly, they can improve health and reduce disparities.

Given the broad roots of this problem, it is only with combined efforts of all sectors and disciplines of society—the public and private sectors, business and labor, non-profit and community-based organizations, educational institutions, the faith community and others—that we can hope to eliminate racial and ethnic disparities.[129]

—Call to the Nation to Eliminate Racial and Ethnic Disparities in Health

TABLE 4.
SAMPLE ACTIONS BY SECTOR TO IMPROVE HEALTH AND REDUCE DISPARITIES

Health Care Sector: Health care—including institutional providers, insurers and health plans, labor unions/health care workforce, professional schools, and research institutions—have a clear role to play particularly in addressing health care disparities but also in prevention. Recruitment and training of diverse professionals, clinical standards and procedures, health care coverage, and facility locations all influence the access and quality of care provided to people of color. In certain areas community health centers have provided exemplary leadership including enhanced outreach (such as through the use of community health workers), cultural competence, and linguistic appropriateness. The health care sector can also integrate prevention screening and health education into routine care for all, provide quality mental health services, and develop a strong system of referrals to community programs to support treatment and disease management. Equally important, the health care sector is looked to as the expert on resolving health problems and can advocate for specific solutions. Further, as a service provider and employer, health care institutions reach large numbers of the public and can serve as model environments for health supporting behaviors. As a large business, health care can also have a major impact on the local economy through decisions about hiring, location, investment, and purchases.

Community-Based Organizations: Community-based organizations encompass a broad range of institutions including faith-based organizations, youth groups, services groups, community coalitions, and local advocacy groups. They serve multiple roles—as gathering places, spiritual centers, advocates for change, and important sources of service and support to community members. As core community assets, community-based organizations possess both the credibility and networks to serve as a focal point from which community members can be engaged and leadership can be fostered. They both inform and serve as important channels for the community voice to advocate for priority needs and resources and demand change. They also provide critical services—mentoring, youth activity, tutoring, mental health, substance abuse treatment, food, help with accessing benefits—and have facilities that the community can use for multiple purposes.

Schools: Schools are an essential element of community life that touch most children and their families. In addition to teaching basic academic skills, schools can institute health education programs that are reinforced through practices in the school environment. By providing nutritious food options and limiting unhealthy ones and encouraging physical activity through physical education and recess, schools support what is being taught about health in the classroom. School facilities are an important community resource. Opening recreational areas for community use before and after school and establishing joint use agreements for other community services are both ways schools can enrich their contribution to neighborhoods. Schools can identify students in need and provide or link to culturally competent mental health services.

State and Local Government: Government plays a prominent role in shaping community conditions through diverse roles in making policy, monitoring and enforcement, providing training and services, and through its own organizational practices. Government is the largest investor in community infrastructure and services. Government is also frequently the health care provider of last resort, and thus serves people who are most at risk for the worst health outcomes. Government can support data collection and research to track and assess problems and progress in reducing disparities. The establishment of the California Health Interview Survey has been a tremendous collaborative effort—and an important first step—to ensuring that quality data is available. As a large employer and purchaser, government influences local economies and practices. Government also impacts community norms through policies instituted in its facilities such as healthy options in vending machines or opening staircases to foot traffic. There are many different governmental sectors that have a role to play in eliminating racial and ethnic disparities in health. They range from health and public health to transportation, planning, social services, criminal justice, education, and economic and workforce development. Within each of these, government can provide training and institute formal or informal health impact assessments to ensure that decisions reduce health disparities and do not exacerbate them. For example, planning departments and commissions can analyze zoning and land-use decisions to reduce air pollution and toxic exposures in neighborhoods, support walking and biking, active recreation, and access to healthy food, minimize marketing and availability of alcohol and tobacco, and promote downtown growth and safety.

Business: Businesses and labor unions have a vested interest in and many influences on health inequities—through job creation, workforce diversification, community investments, and purchase and provision of needed goods and services. Working conditions, wages, and benefits (e.g., health insurance) all influence health outcomes. Worksites with health-oriented policies influence behaviors of all employees. Where businesses locate—and the provision of loans and insurance—influences the economic vitality of neighborhoods. Businesses can ensure necessary services—supermarkets, banking, health care—are available in communities of color. Depending on the nature of the business, specific decisions, such as what foods to carry or what advertisements to display, also influence health behaviors. Media is a key business and can examine advertising policies and institute reporting practices that support public health efforts and positive health outcomes. Finally, businesses and labor unions have a role to play in advocacy with policymakers.

CONCLUSION: TOWARD A HEALTHY AND PRODUCTIVE CALIFORNIA

Achieving health for all Californians is both a moral imperative and a matter of good economics. The cost of poor health is far greater than the cost of preventing it. Illness and injury is not only a concern for doctors and patients; it has far reaching implications for on well-being, productivity, and the quality of life for everyone. The health of the state depends, literally, on the health of all its residents.

The *California Campaign* has delineated a strategy for ensuring health for all and reducing health disparities. The Priority Medical Issues represent significant health concerns across the state. As the *Strategic Approach* describes, there are specific pathways leading from root factors to behaviors and environmental factors to medical services that either exacerbate or reduce these health problems. Understanding these pathways provides the roadmap for action.

This roadmap points the way towards interventions California and Californians must take. Government, institutions, and communities all have a central role to play. Action is needed to strengthen community environments and shift behaviors to prevent disease and injury. Action is needed to ensure health services are high quality, accessible, and culturally competent. While the pathways have been described, it is important that communities are engaged in identifying the health concerns and key factors of greatest priority in their neighborhoods. Efforts must build on community strengths—their healthy traditions, their resilience, their diversity, and their committed institutions.

The vision of a healthy, productive California must be translated into commitment. There is a critical job for the health sector to improve the availability and quality of medical care for all California's ethnic and racial groups. It is also vital that every public and private institution step forward to improve the environments that beget good health. The next step is to coordinate action by institutions and in communities across the state. Now that the pathways to health for all have been described, taking action to alter them is essential.

The ideas of one generation become the instincts of the next.

—D.H. Lawrence

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Developed by
The California Campaign to Eliminate Racial and Ethnic Disparities in Health

HEALTH FOR ALL:
California's Strategic Approach to Eliminating Racial and Ethnic Health Disparities
SUMMARY

All members of a community are affected by the poor health status of its least healthy members.

Unequal Treatment, Institute of Medicine

A broad and intensive strategy is needed to seriously address racial and ethnic disparities in health status.

Unequal Treatment, Institute of Medicine

Despite steady improvement in the overall health of the U.S. population, racial and ethnic minorities, with few exceptions, experience higher rates of morbidity and mortality than non-minorities.

Unequal Treatment, Institute of Medicine

Evidence is emerging…that societal-level phenomena are critical determinants of health….Stress, insufficient financial and social supports, poor diet, environmental exposures, community factors and characteristics, and many other health risks may be addressed by one-to-one intervention efforts, but such interventions do little to alter the broader social and economic forces that influence these risks.

Promoting Health, Institute of Medicine

Racial and ethnic minorities tend to receive a lower quality of health care than non-minorities….The sources of these disparities are complex, are rooted in historic and contemporary inequities, and involve many participants at several levels.

Unequal Treatment, Institute of Medicine

Given the broad roots of this problem, it is only with combined efforts of all sectors and disciplines of society…that we can hope to eliminate racial and ethnic disparities.

Call to the Nation to Eliminate Racial and Ethnic Disparities in Health