ELIMINATING DISPARATE HEALTH CARE ACCESS FOR RACIAL AND ETHNIC MINORITIES IN ILLINOIS

A WHITE PAPER BY THE RACIAL AND ETHNIC HEALTH DISPARITIES ACTION COUNCIL

"*Adelle has been on dialysis for twenty years, since she was thirty-one. Her kidneys failed, she figures, because of a series of kidney infections she suffered as a young woman in San Antonio. She never saw a doctor. She and her husband, Mexican immigrants, worked the kind of low-skill jobs that usually do not offer insurance, and she had little money for medical care. 'I would have had to pay out of my own pocket,' she said in a calm, unflinching way, sounding as if, presented with the same circumstances today, she would make the same choice.*

Three years ago, Adelle's situation improved for what may sound like an unlikely reason: her husband of thirty-three years, whom she still cares for, moved out. 'Once we separated I qualified for everything,' she said. Before that, she was only eligible for the Department of Public Health program, which, though it covers the portion of dialysis treatments leftover by Medicare, does not pay for anything else. On her own, Adelle became eligible for monthly Supplemental Security Income (SSI) payments for elderly and disabled people who have no other means of support. Eligibility for SSI automatically made her eligible for Medicaid, which pays for the medication she needs each month. Her husband's job as a shipping clerk had disqualified her in the past from receiving either of these benefits.

Though her husband still faithfully picks her up from dialysis – 'He likes to take me home because I don't feel so good' – Adelle said they have no plans to live together any time soon."

Laurie Kaye Abraham, *Mama Might Be Better Off Dead,* Pp 37-38.

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Not for Distribution

INTRODUCTION

Over the past several years, eliminating racial and ethnic health disparities has become a high profile issue at the national, state, and local level. According to the National Institutes of Health (NIH), health disparities are the differences in incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States (NIH, 2000). Substantial research demonstrates the existence and persistence of racial and ethnic health disparities, however, less is known about the causes of such disparities. Research suggests that poverty, differences in access to health care resources, the historical effects of racism and segregation, and living and occupational conditions are likely sources of disparities (CDC, 2002).

The Illinois Public Health Institute (IPHI) has worked through partnerships since 1997 to promote prevention and improve the public health system to maximize health and quality of life for the people of Illinois. The partnership includes business, insurance, faith, social service, philanthropic, academic, labor, consumer, advocacy, and public sector organizations. During the summer of 2003, IPHI began exploring approaches to address racial and ethnic health disparities in Illinois by interviewing its partners, which led to the creation of its Racial & Ethnic Health Disparities Action Council (REHDAC). REHDAC was organized as a forum for stakeholders and unique partners to address the following tasks:

- disseminate data related to racial/ethnic health disparities;
- identify limitations in the public health system that hinder progress in reducing racial/ethnic health disparities;
- develop recommendations to improve the health of minorities and reduce racial/ethnic health disparities in Illinois; and
- advocate for inclusion of REHDAC recommendations in statewide health improvement planning.

REHDAC consists of over 30 traditional and non-traditional minority health stakeholders from public and private organizations across the state. The first goal of REHDAC was to develop an action plan, addressing strategic priorities to reduce and ultimately eliminate racial and ethnic health disparities in Illinois. This report extends some of REHDAC's work by focusing on the current problem of disparate health care access for racial and ethnic minorities in Illinois.

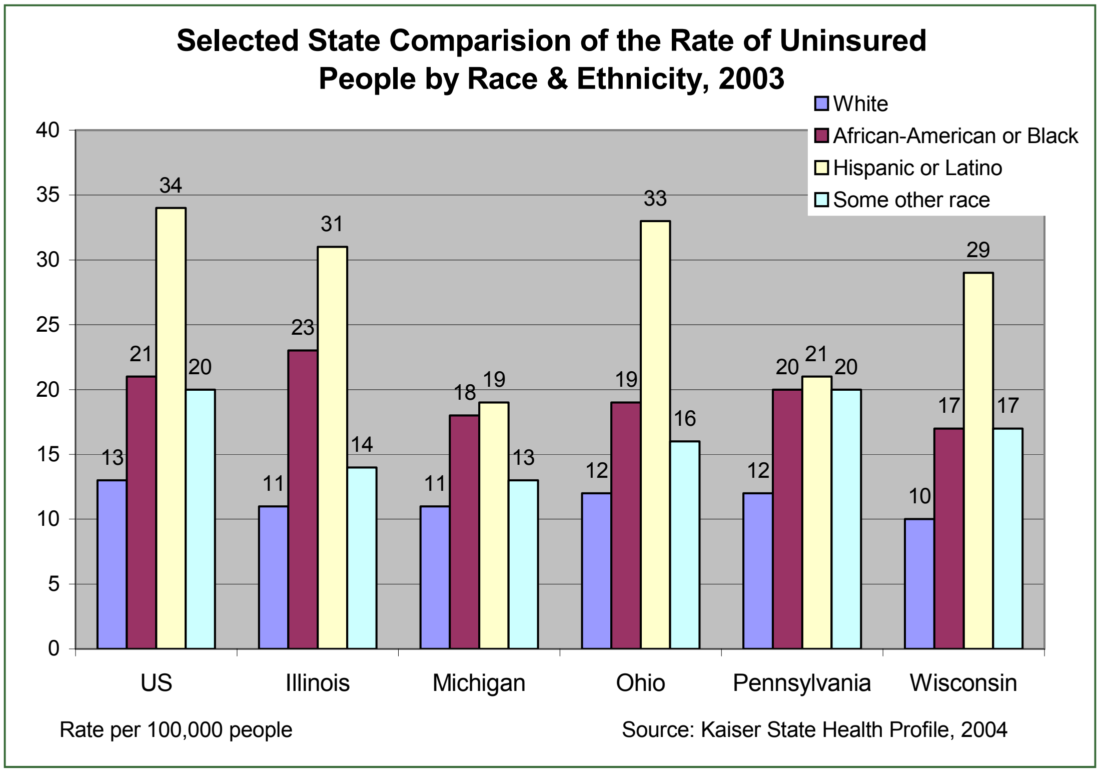
DECREASING ACCESS TO HEALTH CARE

In the past five years, the poor economy created a health care problem for many people across the country. Since the economic downturn began in 2001, the number of employer-sponsored health insurance and pension plans have decreased. The number of medically uninsured grew to over 45 million, almost 18% of the US population; an estimated one in six adults between the ages of 18-64 years are uninsured (Kaiser 2004). These national trends have replicated themselves in Illinois. In 2004, the number of medically uninsured people in Illinois increased to almost two million, 16.2% of the population (Gilead 2004).

In 2004, the number of medically uninsured people in Illinois increased to almost two million, 16.2% of the population.

The rate of uninsured is highest in Chicago (22.5% or 495,251 people), but the rest of the state also has experienced increasing growth in the number of people who are uninsured. In the metropolitan area surrounding Chicago, there are 776,333 (14.9%) people without health insurance. The downstate region has 530,255 (14.4%) uninsured people (Gilead 2004).

In the US, the most common method to pay for heath care services is through employer-sponsored health insurance. Created as an employment incentive in the early part of the 1900s, employers pool the resources of their employees, often providing a contribution of their own, to purchase health insurance for all employees and their families (Starr 1982). Because of the economic downturn, rising health care costs, and increased adherence to liberal economic policies, employers are reducing or eliminating health insurance benefits from employment benefit packages, causing individuals to pay higher premiums (Quadagno 2005). Hardest hit are people with lower paid, service-oriented jobs – jobs predicted to become a more important factor in the future economy.



As employers reduce health insurance benefits for their employees, social welfare programs, like Medicaid, Medicare, and SCHIP are burdened with filling the gaps in health care coverage. Children, pregnant women, and people over 65 have maintained their coverage under these programs; however, adults between 18-64 suffer dramatically from lack of health care. With fewer health care resources, many adults live without any means to access affordable, quality health care services.

UNEQUAL ACCESS FOR RACIAL AND ETHNIC MINORITIES

There are multiple levels of interaction within the health care system, each having their own impact on the disparate access experienced by racial and ethnic minorities. Micro-level factors center on the issue of discrimination perpetuating unequal health care access. Organizational, or meso-level, factors highlight the way the health care system is organized to inadvertently heighten health care disparities. Macro-level, structural factors examine the way history and current social contexts shape the situations in which racial and ethnic minorities live. Together, these factors result in disparate health care access and outcomes.

Individual-level Factors: Health care professionals are not more likely than the general public to express prejudice. However, unconscious bias and stereotyping of racial and ethnic minorities influence diagnosis and treatment, perpetuating disparate quality and access to care.

Research on individual discrimination indicates bias, stereotyping, and clinical uncertainty affect a physician's interaction with minority patients (IOM 2002). Studies conducted in a clinical setting found doctors more likely to ascribe negative racial stereotypes to minority patients. Researchers found physicians attributing negative stereotypes to patients of racial and ethnic minorities even when taking into account differences between minority and non-minority patients' education, income, and personality characteristics (van Ryn and Burke 2000). Physicians are more likely to make negative comments about minority patients when discussing their case (Finucane and Carrese 1990).

When doctors fail to help racial and ethnic minorities with their health care problems, they will seek care at lower rates, mistrust clinicians, and comply less frequently with physicians requests.

Although most physicians will claim they do not operate with overt bias, research demonstrates that unconscious bias influence their interaction with racial and ethnic patients. Health care professionals err in decisions about care for racial and ethnic minorities more often than in decisions about Whites' health care (IOM 2002). Physicians can understand the symptoms of White patients better than those of racial and ethnic minorities (Mushlin et al. 1997, IOM 2002).

A great deal of the research on individual discrimination focuses on the unequal treatment racial and ethnic minorities receive from clinicians. Few researchers make the connection to health care access; however, physicians' bias, stereotyping, and misinterpretation of symptoms results in lower-quality health care, patient confusion, and wasteful doctor visits. Racial and ethnic minorities seek care less often, mistrust clinicians, and comply less frequently with physicians' requests when doctors fail to help them with their health care problems (IOM 2002).

Organizational-level Factors: Racial and ethnic minorities face discrimination and exclusion from the health care system, which limits their access to health care. Health care systems discriminate against racial and ethnic minorities through passive means – stereotyping, patient confusion, and exclusion due to financial resources. The way the system is structured puts racial and ethnic minorities at a disadvantage. For example, because of increasing pressure from managed care organizations, doctors rush through patient visits and quickly make assumptions about health based on population characteristics rather than individual signs and symptoms, exacerbating the effects of unconscious bias.

Health care systems are not always user-friendly and often confuse people. Individuals' access to health care is a complex issues, influenced by health insurance, patients' rights, and skyrocketing costs; racial and ethnic minorities' struggles are exacerbated by cultural and language differences. Although all hospitals in Illinois must have translation services available for patients, many non-English speaking patients continue to report having difficulty accessing these services. The financial fragmentation of the health care system threatens all people, especially those with limited financial resources.

Health care professionals do not intend to treat patients differently based on race. Instead, the way the system is structured puts racial and ethnic minorities at a disadvantage.

Because the majority of recipients of social welfare programs are racial and ethnic minorities, the failures of these health care programs demonstrate another kind of organizational-level discrimination. Medicaid is exceedingly vulnerable to state and federal budget cuts; next year's Federal budget reduces Medicaid spending in the midst of slow job growth, rising uninsured rates, ever-increasing health care costs, and limited state funds to cover federal gaps. Medicaid cutbacks build more barriers for people struggling to access health care services. In addition, the payment procedures used by Medicaid and Medicare often are said to pay providers at cost or below, making it difficult for them to turn a profit and, at times, hindering the maintenance of health care institutions that serve the poor. Those institutions that do serve people without health care sometimes engage in “cost-shifting,” covering costs of uninsured, Medicaid, and Medicare patients by charging privately insured patients higher rates. This increases health care premiums and can end up squeezing more people out of health insurance.

> In the early 1970s, the jobs and educational opportunities racial and ethnic minorities struggles to secure for the previous two hundred years began moving out of the cities, often overseas, as multinational corporations shifted their manufacturing to countries where they could pay workers less. With the loss of jobs came a decreasing tax base for education and other social supports.

Structural Factors: The most difficult kind of discrimination for many people to perceive is that which exists within the fabric of the US society. Researchers often call this “institutional racism.” In the context of health care access, it is important to understand the historical context in which race and ethnicity has shaped the distribution of economic and educational resources in the US. Drs. Michael Omi and Howard Winant (1989) developed the prevailing understanding of how structural discrimination exists in today’s society. Although the US government and Illinois state government prohibits active discrimination, the residual effects of years of racial and ethnic discrimination created unequal distributions of wealth and education.

During the 1910-20s, immigrants, especially Mexican migrants, began working farm jobs that many White workers moving West considered “their jobs.” Asian immigrants’ movement East across the country, often working on the inter-continental railroads, also clashed with many White Americans’ migration West for farming and other opportunities. Immigrants have been considered a threat to the job market and second-class citizens ever since. In addition, Jim Crow laws legitimatized the denial of equal access to education, employment, and public services for racial and ethnic minorities throughout more than half of the 1900s.

By the 1960s, the disgust with discrimination finally came to a head. Primarily African-Americans, but also other racial and ethnic minorities, fought against discriminatory practices. These struggles forced the passage of the Civil Rights Act of 1964, a statement certifying the US government would not tolerate discrimination based on race or ethnicity. The passage of the Civil Rights Act protected racial and ethnic minorities against discrimination in workplace practices, educational opportunities, and public accommodations. Racial and ethnic minorities thus could obtain well-paid blue-collar factory jobs and, with a secure job and steady income, they could send their children to an integrated public school to learn skills for a better future (Omi & Winant 1989). Equality was on the horizon for racial and ethnic minorities.

Shifts in the US economy changed all this. In the early 1970s, the jobs and educational opportunities that racial and ethnic minorities had struggled to secure during the previous two hundred years began moving overseas, as multinational corporations shifted their manufacturing to countries where the corporations could pay lower wages. With the loss of jobs and an increase in White flight from the cities, many of the educational opportunities that minorities were granted after the Civil Rights Act were exhausted as the public school systems of many cities suffered from a decreasing tax base. Whites have consistently been ahead of other racial and ethnic minorities in obtaining higher education and better jobs because of the historical effects of discriminatory practices. These effects have been passed down from one generation to the next, creating residual problems for racial and ethnic minorities today (1989).

Despite the efforts of affirmative action policies and more acceptance of racial and ethnic minorities, educational admissions and hiring practices still under-represent racial and ethnic minorities. This disproportion translates into unequal economic divisions. The vast majority of people born into poverty, mostly racial and ethnic minorities, remain in or near poverty throughout their life (Drum Majority 2004). These inequalities translate into what one physician in Laurie Abraham's story of families struggling with health care access in Chicago calls sociomas, "social problems that range from not having a ride to the doctor's office, to drug addiction, to homelessness, to the despair that accompanies miserable life circumstances."

With a concentration of racial and ethnic minorities disadvantaged by the historic situations that shaped today's society, the neighborhoods in which they live have developed without sufficient infrastructure to support positive health care. Kirby and Kaneda (2005) examined health care access to find that residents in neighborhoods with high poverty rates, high rates of unemployment, and low educational attainment levels were less likely to have consistent access to health care despite their race or ethnicity. However, many of the neighborhoods they studied were composed of racial and ethnic minorities. In other words, a person's race or ethnicity does not directly affect their access to health, but because racial and ethnic minorities are concentrated in disadvantaged neighborhood, they have limited access to health care. The socio-historical factors that created US housing and neighborhood development have locked many racial and ethnic minorities into locations where they are unable to obtain proper health care.

Disadvantaged neighborhoods exacerbate disparate access to care for racial and ethnic minorities. Neighborhoods with limited resources tend to create poor quality environments, constituting a direct threat to health (Bullard 1990). A decreasing breadth of municipal services present in a neighborhood also impacts a neighborhood's environment, making it less conducive to health (Wallace and Wallace 1990; Roberts 1998). Neighborhoods with a police station can have low crime rates, but still might not provide important health care for neighborhood residents. In addition, many organizations supportive of a health care infrastructure, such as churches and community groups, lack necessary resources in neighborhoods with high concentrations of poor people.

Despite strides to end health disparities, studies show they have increased in many urban areas, including Chicago. A study by Sinai's Urban Health Foundation (2004) found racial and economic health disparities increased in Chicago through the 1990s. Racism, environmental stressors, inequality in access to education and health care, income inequality, and other social factors create barriers to accessing quality health care. Without addressing discrimination at all levels of interaction, health disparities will continue.

At all levels of interaction, racial and ethnic minorities face discrimination. Physicians often misdiagnose them because of unconscious bias and stereotyping. Health care systems make it nearly impossible to understand and access a doctor, especially if they do not have health insurance. Socio-historic conditions create structural racism, which limits racial and ethnic minorities' access to resources critical to health care.

DOES HEALTH CARE ACCESS EQUAL HEALTH INSURANCE?

Although health insurance is not the only means to measure health care access disparities, numerous studies show that persons with health insurance and a regular source of care are more likely to access preventative, primary, and specialty care services (IOM 2002). A lack of health insurance accounts for much of the variation that racial and ethnic minorities have in access to a regular source of care. Health insurance deficiencies explain a statistically significant portion of the access gap in almost all of the studies for Hispanics and African Americans (Lillie-Blanton & Hoffman 2005). In other words, health insurance greatly increases a person's likelihood of having access to consistent health care.

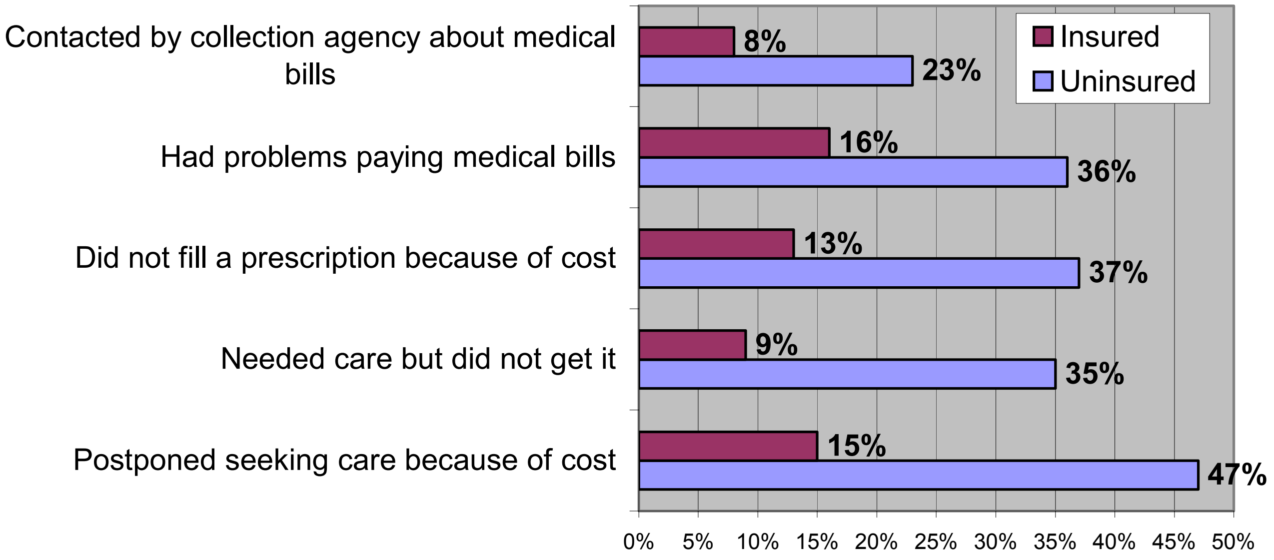
Obtaining health insurance is not just a problem for unemployed workers. Most of the uninsured are of working families; 69% of the uninsured come from households with at least one full-time worker and another 12% have at least one part-time worker (Kaiser 2004). In Illinois, over 15% (793,487) of employed, full-time workers are uninsured (Gilead 2004). Because of the historical and current income and educational disparities, racial and ethnic minorities, on average, have limited incomes, lower education, and less access to health care. Nationally, Hispanics are more likely to be uninsured than African-Americans; African-Americans are also more likely to be uninsured than Whites (Finegold & Wherry 2004). Illinois mirrors these trends.

Social barriers keep people from accessing quality health care. When people without health insurance get sick, they put off seeking care, which exacerbates their health problems. If they seek care, they do so later in the illness when worsened conditions result in more difficult procedures and higher health care costs. The delay in care increases the cost of care, putting more stress on their already limited pool of resources. In addition, these barriers are more likely to affect minority Americans (Commonwealth 2002).

Many lower-income workers cannot afford their share of private insurance and therefore decline their employer-sponsored health benefits. Without health insurance, they are less likely to go to a doctor for general check-ups because they must pay out of pocket. As a result, many diseases and other maladies go undiagnosed until they become serious or fatal issues. The uninsured are significantly more likely to postpone health care, not fill prescriptions, and not seek care when they need it because they lack health insurance (Kaiser 2004).

Health insurance does not solve all the problems of health care access. Many times, even with health insurance, people face problems with accessing adequate health care. A study from the Institute of Medicine (2000) found that between 10%-25% of the people with health insurance lack adequate health care.

Barriers to Health Care by Insurance Status, 2003

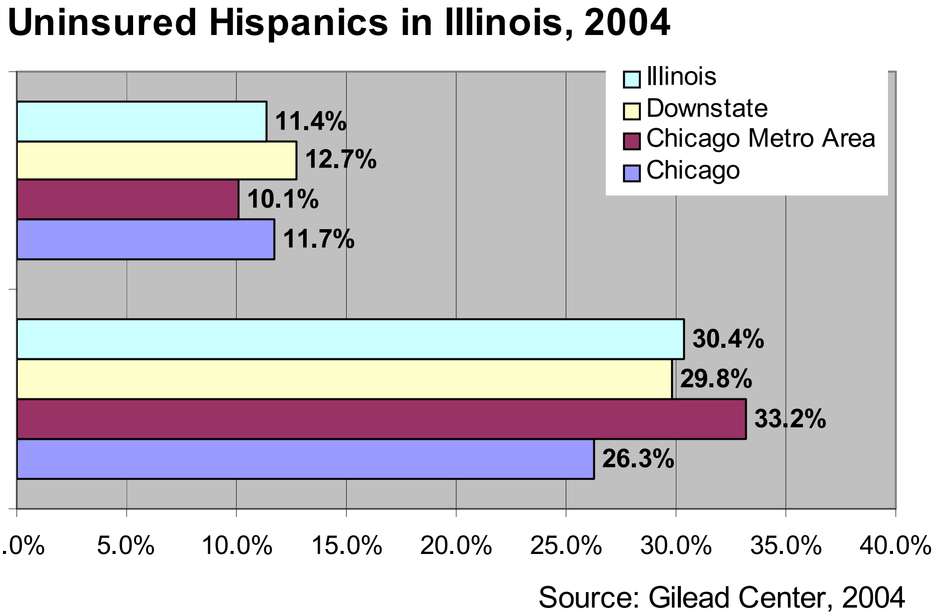


Source: Kaiser State Health Facts, 2003

HOW DOES HEALTH CARE ACCESS & HEALTH INSURANCE AFFECT RACIAL AND ETHNIC MINORITIES?

Social and cultural barriers to health care access affect each racial and ethnic minority differently. In Illinois, Latinos have the highest percentage of uninsured (30.4%), followed by African Americans (25%) and other racial and ethnic minorities combined (15.5%)

Latinos*: Nationally, 37% of Latinos are uninsured; they comprise 12% of the population but one quarter of the uninsured in the US (Kaiser 2004). These trends are similar in Illinois. Hispanics make up 12.3% of the total population and 30.4% of the uninsured in the state. In Chicago, 11.7% (75,736) of the Hispanic population is uninsured. There are more uninsured Hispanics outside of Chicago than in the city: 33.2% (279,921) of the Hispanics in the metropolitan area around Chicago and 29.8% (22,908) in the downstate region are without health coverage (Gilead 2004). This dispels the belief that uninsured rates and resultant access limitation for Latinos in Illinois is an issue isolated to the city. It is increasingly a state-wide issue.



Source: Gilead Center, 2004

One of the major explanations for the higher rates of uninsured among Latinos is that they are less likely than other minorities to receive health insurance from their job. Even though employment rates for Latinos are relatively high, almost 60% of Latino families live below 200% the Federal Poverty Level (FPL); they work low wage jobs that provide few benefits and often do not make enough to afford their share of an employer's health insurance plan even if they were offered insurance (Kaiser 2004).

Without employer-based health insurance and a means to afford private insurance, Latinos use Medicaid and other public health care services – 18% of all Latinos in the US use these public services. However, the need for services greatly exceeds the use. Many public health services are unavailable to undocumented Latinos; undocumented Latinos fear extradition if they use public services. Latinos in the process of seeking legal status are also fearful of public services. In addition, legal immigrants who entered the country after 1996 are generally not eligible for Medicaid until they have been in the US five years. Some Latinos may go to neighborhood health clinics, but even these clinics usually require some form of payment or reimbursement plan, which many Latinos cannot

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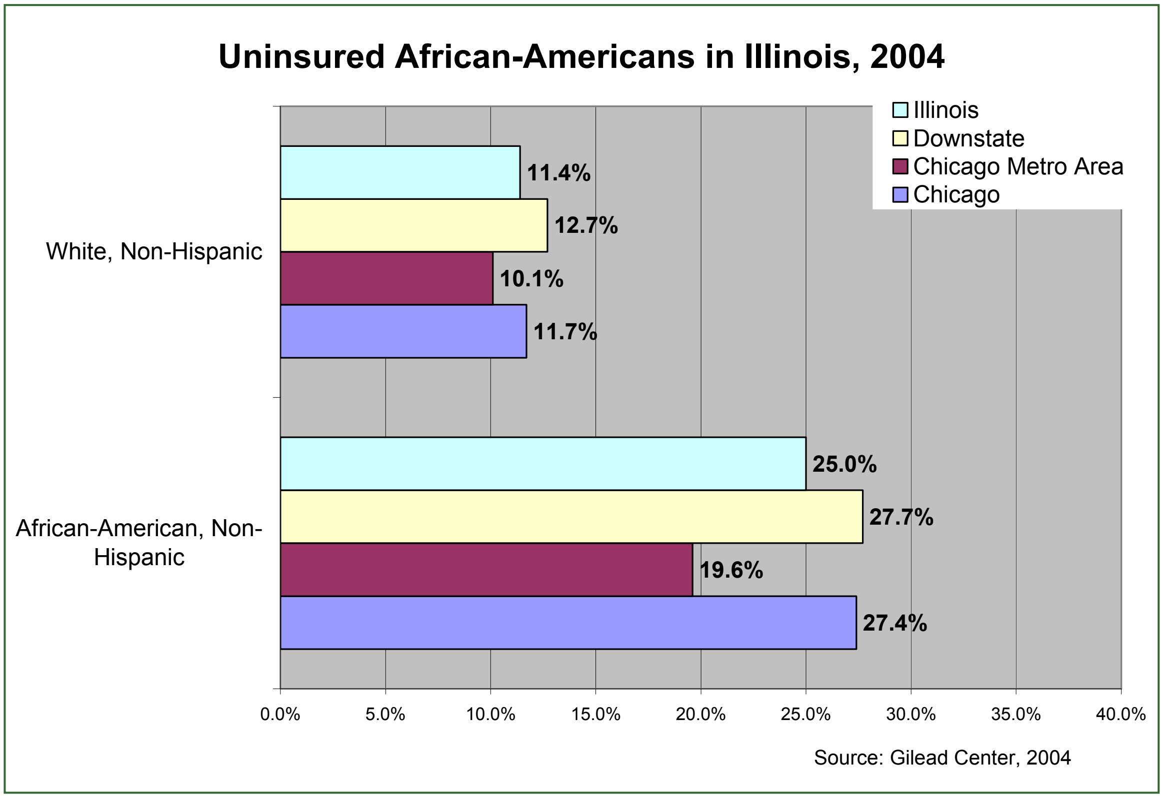
* Data sources used for this paper refer to the same population by different names— Latino and Hispanic. This paper uses the terms interchangeably to uphold the integrity of the original data source.

afford (Kaiser 2004).

A majority (57.4%) of the Hispanics in Illinois without health insurance are non-citizens (Gilead 2004). The US health care system denies undocumented immigrants adequate services even though they pay taxes. All workers pay taxes on their income; all property taxes are incorporated in rent payments; all drivers pay gas taxes; all consumers pay sales taxes. The myth that undocumented immigrants do not pay taxes was shattered this year when the Social Security Administration released estimates that undocumented workers paid over $7 billion annually into Social Security, benefits which they will never receive because of their citizenship status.

With higher uninsured rates and limited access to health care, Latinos have poorer health outcomes. Nationally, a quarter of Latino adults and 32% of Latino children have no consistent source of health care. Among uninsured Latino adults, 24% of women and 40% of men have not visited a doctor in over five years. With limited or no regular access to health care, Latinos are more likely to have poor health and die earlier (Kaiser 2004).

African-Americans: The uninsured rate for African-Americans is more than one and a half time the rate for Whites; 23% of all African-Americans in the US are uninsured (Kaiser 2004). In Illinois, one quarter (431,077) of all African-Americans are uninsured (Gilead 2004). This percentage remains constant across the state; 27.4% in Chicago, 19.6% in the metropolitan Chicago area, and 27.7% of downstate African-Americans have no health coverage (Gilead 2004).



Source: Gilead Center, 2004

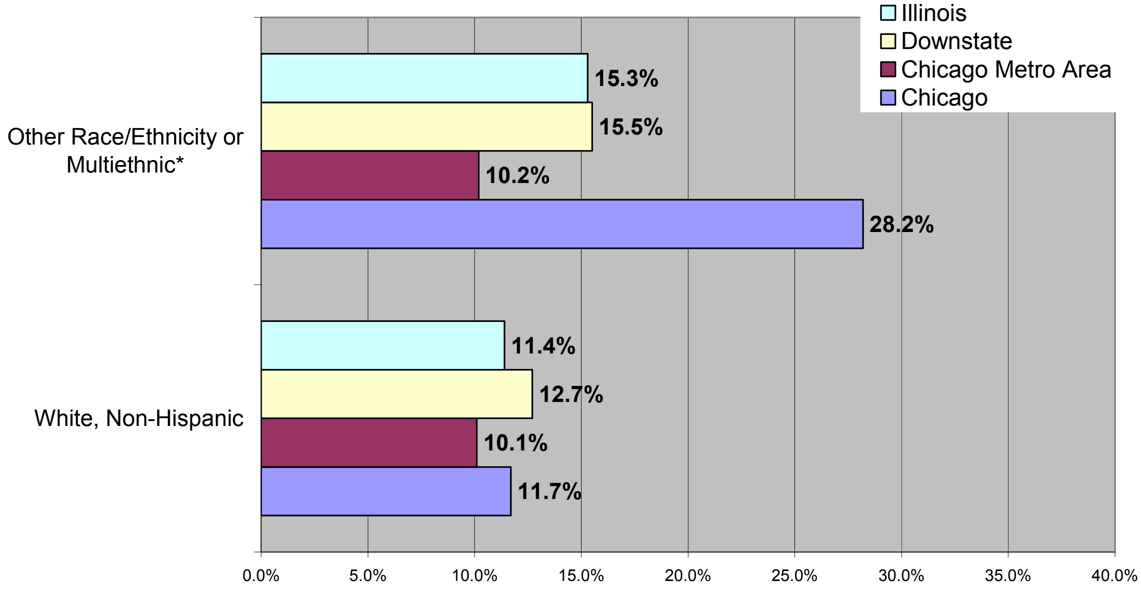
Despite the fact that over 8 in 10 African-American households are working families, like Latinos, they still have low insurance rates due to the type of employment. Many African-Americans are working lower-skilled service jobs, service-oriented jobs that lack health insurance benefits or an adequate income to purchase private health insurance.

Nationally, 21% of African-Americans use Medicaid or some other form of social welfare programs for health care (Kaiser 2004). Health insurance provides access and consistent contact to the health care system, which is proven to improve health. Uninsured African-Americans are much less likely to have seen a physician in the last year than their White counterparts with private insurance or Medicaid coverage (Kaiser 2004).

American Indians and Alaska Natives: The Federal government guarantees all federally recognized American Indian and Alaska Native tribes health care through the Indian Health Service (IHS); however, these services never provide adequate health care access. Because the majority (an estimated 70%) of American Indians and Alaska Natives live in urban settings outside of reservations, they have limited access to IHS offered on all reservations. Since 1976, the federal government has also provided money for tribal health care and urban Indian health centers. Many tribal and urban health centers serve small populations, leading to fewer resources and services. In addition, all American Indians must prove their heritage through blood quantum in order to receive these health services; this proved a difficult problem for many urban American Indians. When American Indians or Alaska Natives need to obtain complex health care procedures, they either go to their home reservation for IHS, which can be hundreds or thousands of miles away, or access public services.

Only 49% of American Indians and Alaska Natives have employment-based health insurance; 25% used Medicaid or other public services, excluding IHS. Medicaid is a particularly important source of health coverage for them to pay for private health insurance (Kaiser 2004).

Uninsured Asian/ Pacific Islanders, Native Americans, and all other Ethnicities in Illinois, 2004



* Includes Asian/Pacific Islanders, Native Americans, and all other race/ethnic minorities

Source: Gilead Center, 2004

Without access to IHS or job-based health insurance, American Indians and Alaska Natives face the same issues as other racial and ethnic groups struggling to obtain health care (Kaiser 2004). When they do have a primary health care provider and a consistent link to health care, they are more likely to seek health care when needed and more likely to have improved health. Nationally, over a third of uninsured American Indians and Alaska Natives (35%) report they do not have a regular source of health care. Only a quarter of uninsured American Indians and Alaska Natives meet the minimum standards of routine physician care, many of these through IHS. Even when American Indians and Alaska Natives use IHS, they are less likely to have obtained the minimum recommended number of doctor visits for their age and health status (Kaiser 2004).

Asian/Pacific Islanders: The Asian/Pacific Islander population is an amalgamation of different ethnic subgroups, and health care coverage differs for each. Statisticians rarely disaggregate data for each

Asian ethnicity; it is difficult to discuss the important differences of each group. As a whole, Asian/ Pacific Islanders have an uninsured rate of 21% (Kaiser 2004). The reason for the health care coverage differentials in the Asian/ Pacific Islander population is due to the lower rates of employer-based insurance coverage. As a whole, 64% of Asian/Pacific Islanders have job-based health insurance but this rate varies for different ethnic groups, from a low of 48% for Korean Americans to 77% among Japanese Americans. Asian/Pacific Islanders without job-based insurance are more likely to purchase health insurance than other racial/ethnic groups (Kaiser 2004).

Uninsured Asian/ Pacific Islanders are more likely than those who are insured to lack regular physicians' visits. Nationally, over half of the Chinese and Japanese do not have a usual source of health care (Kaiser 2004). In the Asian/ Pacific Islander community, children and adults are less likely to meet the minimum standards for physician visits than do Whites of the same age group. For example, about 30% of Asian/ Pacific Islander men aged 18-64 years do not meet the minimum standard for physician visits in the US, as compared to 20% of White men (Kaiser 2004).

The uninsured rate for Asian/ Pacific Islanders, American Indians and Alaska Natives, and all other racial and ethnic groups often are condensed for statistical necessity. However, they still present important variables to understand health care access disparities. As an aggregate, this group comprises 15.3% of the uninsured population (Gilead 2004). This percentage varies from region to region across the state: 28.2% in Chicago, 10.2% in the metropolitan Chicago area, and 15.57% of downstate Asian/Pacific Islanders, American Indians and Alaskan Natives, and all other minority groups have no health coverage (Gilead 2004).

HOW CAN WE END DISPARITIES IN HEALTH CARE ACCESS FOR RACIAL AND ETHNIC MINORITIES?

- **Expand health care safety nets to serve all people living in the US** – A major issue for many immigrants is their inability to qualify for federal and state health services. Undocumented immigrants fear that using public health care services, even when they are eligible, will jeopardize their living situations or progress towards naturalization. Some fear their physician will discover their citizenship status and report them into Immigration and Naturalization Services. By expanding health care safety nets, our government would expand a basic right to all people living in the US despite their citizenship status.

- **Measure health care access disparities for all racial and ethnic minorities** - Many of the difficulties with documenting the problems with racial and ethnic health disparities stems from the lack of data about the issue. State and local government health departments must take the initiative to begin assessing health care access disparities. Consistent, documented evidence of health care disparities will help provide the impetus for creating change across the state.

- **Provide universal health care for all US residents** – Health care should be considered a mandatory human right, not a marketplace commodity. Unlike the education system in the US, the health care system is a commodity available only for people who can afford it. Wealthy communities may have better educational opportunities for their young, but all children are entitled to education. There is a minimum standard by which we strive to assure basic education; there is no minimum standard for health care.

- **Improving Medicaid funding** - As the US Congress debates and decides on the 2006 budget, Medicaid funding must be increased. The reduction of $35 billion over the next five years for several benefit programs came from ending the automatic increase required for most benefits programs.

Congress singled out Medicaid for a $10 billion reduction in the four-year period beginning in 2007, giving states a one year grace period to develop cost saving strategies before the cuts begin. In the past, states have dealt with similar Medicaid cuts by changing Medicaid services and tightening eligibility rules, causing the ranks of the uninsured to rise. States like Missouri have already dropped over 90,000 Medicaid recipients in preparation for the federal cuts.

- **Provide interpreters and translation services in the delivery of health care** - All health care facilities must ensure the quality of and access to health care services for people with limited English proficiency. Language differences must not be a barrier to health care. Interpreters and translated materials are critical for providing effective health care and for reducing health disparities among minority populations.

- **Establish culturally sound data collection methods** – Many state agencies fail to collect data for all racial and ethnic minorities in Illinois. The data they do collect combines several racial and ethnic minorities into one category. This strips the data of its utility in helping to explain health disparities in each racial and ethnic community. Illinois must develop data collection methods that are culturally sound and linguistically appropriate for all health care users. At each collection encounter, interpreters should be available, when needed, to avoid a patient's misunderstanding and fear in stating their race, ethnicity and primary language.

- **Implement scientifically proven, culturally competent prevention services** – Preventable illnesses cause up to fifty percent of health care costs. Cultural and social factors contribute to the behavioral patterns underlying these illnesses. Without information about these factors, health prevention programs cannot work. Administrators and legislators should encourage investigation into social science research which explores the cultural and social factors of racial and ethnic minority communities. There is anecdotal evident that government funding for such investigations is being restricted based on ideological objections. Such restrictions impede the prevention of illness.

- **Increase resources for the American Indian health care services** – Because IHS has limited resources typically relegated to reservations, American Indians and Alaska Natives living in urban areas cannot easily obtain health care services. In addition, there is no central registry for the location of IHS centers. Without adequate data on the number and location of American Indians and Alaska Natives, it is impossible to assure they have access to IHS. In addition, the lack of communication about the services is confusing for American Indians and Alaska Natives. Legislators must create legislation that guarantees American Indians and Alaska Natives health care.

- **Support initiatives that improve opportunities for racial and ethnic minorities** – The disparities in health care access will not disappear without true economic, educational, and employment equality. Affirmative action, improvement in education, and other initiatives that reduce poverty and other socio-economic barriers help elevate racial and ethnic minorities to the same status as Whites. Without the long-term changes that these initiatives attempt to accomplish, racial and ethnic minorities will never have equal access to health care, education, and employment.

- **Support the work of the Racial and Ethnic Health Disparities Action Council (REHDAC)** – For all the reasons discussed in this report, REHDAC advocates for universal access to high quality health care and preventive services in Illinois. With stakeholders from all sectors of the public health system, REHDAC works to eliminate all racial and ethnic health disparities in Illinois.

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