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COMMON GROUND: EXPLORING POLICY APPROACHES TO ADDRESSING RACIAL DISPARITIES FROM THE LEFT AND THE RIGHT

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Although the existence of racial and ethnic disparities is increasingly recognized, a complete understanding of the causes and solutions to these problems remains elusive. Part One of this paper provides a historical overview of the origins of these disparities. Part Two outlines fundamental challenges to achieving a clear understanding of the problem and briefly discusses current policy strategies espoused by conservative and liberal proponents. Finally, Part Three provides an in-depth discussion of one promising approach with significant bipartisan support.

I. ORIGINS AND CAUSES OF DISPARITIES

A. International Origins

During the past decade, an increasing amount of scientific evidence has documented a disparity in health status among racial and ethnic groups in the United States.¹ There is mounting evidence that these differences have not only medical but also social, behavioral, and environmental causes.² The existence of disparities around the globe and the link between non-medical factors and health outcomes is nothing new. The earliest reported observation of a hypothesized association between socio-environmental risk factors and health outcomes occurred over three hundred years ago, when Bernardino Ramazzini described an abnormally high incidence of breast cancer in Italy's Catholic nuns.³ In 1775,

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1. *E.g.*, INSTITUTE OF MEDICINE, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 5-6 (Brian D. Smedley et al., eds. 2003) (discussing studies on health care disparities in receipt of cardiovascular care, cancer diagnostic tests, AIDS therapies, diabetes care, and kidney transplantation) [hereinafter IOM].

2. *E.g.*, *id.* at 6-21; Michael C. Gibbons, *A Historical Overview of Health Disparities and the Potential of eHealth Solutions*, 7 J. MED. INTERNET RES. e50 (2005), <http://jmir.org/2005/5/e50>.

3. Joseph F. Fraumeni, Jr., Nat'l Cancer Inst., Genes and the Environment in Cancer Etiology, Keynote Address to the Roundtable on Environment Health Science, Research, and Medicine (May 16, 2001), in *ROUNDTABLE ON ENVIRONMENT HEALTH SCIENCE, RESEARCH, AND MEDICINE*, INST. OF

British surgeon Sir Percival Pott documented a cluster of scrotal cancer cases among chimney sweeps in England.⁴

By the mid-nineteenth century, epidemiologic evidence started to support these earlier findings. In 1840, Edwin Chadwick, an English civil servant and statistician, determined there were significant disparities in mortality rates among Liverpool's social classes,⁵ which he attributed to poverty and lifestyle factors common to poorer groups.⁶ In 1849, German physician Rudolph Virchow went a step further by asserting that because diseases of the populace are traceable to defects in society, the focus of medicine should not be changing the individual but bettering society.⁷ Finally, in France, physician Louis Villerme recommended improving school and working conditions to remedy disparities in class mortality rates.⁸ Thus, by the beginning of the twentieth century in Europe, scientific publications clearly documented the existence of class variations in illness and mortality.⁹

Socio-environmental health disparities have continued well into the twentieth century. Richard Titmuss and W.P.D. Logan, two English researchers, independently evaluated regional class-based mortality trends from 1910-1950 and concluded that the disparity in infant mortality rates between upper- and lower-class infants had continued to rise.¹⁰ In 1942, the British government responded to this data, as well as the Depression and World War II, by establishing the welfare state and introducing a multitude of policies with the hope of addressing the "five giants of Want, Disease, Ignorance, Squalor and Idleness."¹¹ Despite these initiatives, the problems of social inequality and inadequate access to health care remained. By the mid 1970s, more than thirty years after these reforms, the evidence suggested that the problems continued to grow and that the quality of health in England was falling behind health of other industrialized countries.¹² In

MED., CANCER AND THE ENVIRONMENT: GENE-ENVIRONMENT INTERACTION 15 (Samuel Wilson et al. eds., 2002); Gibbons, *supra* note 2.

4. Fraumeni, Jr., *supra* note 3, at 15-16.

5. EDWIN CHADWICK, REPORT ON THE SANITARY CONDITIONS OF THE LABOURING POPULATION OF GREAT BRITAIN 225 (M. Flinn ed., Edinburgh Univ. Press, 1965) (1842). Chadwick found that the average age of death for laborers, mechanics, and servants was fifteen years, compared to twenty-two and thirty-five years for tradesmen and professional persons, respectively. *Id.*

6. *Id.* at 422-23.

7. *Introduction to SOCIETY AND HEALTH* 3-4 (Benjamin C. Amick III et al., Oxford University Press 1995).

8. *Id.* at 4.

9. Sally Macintyre, *The Black Report and Beyond: What Are the Issues?*, 44 SOC. SCI. & MED. (SPECIAL ISSUE) 723, 723-25 (1997).

10. *Id.* at 725.

11. INDEP. INQUIRY INTO INEQUALITIES IN HEALTH, BRITISH DEPARTMENT OF HEALTH, REPORT 4 (The Stationary Office 1998) (quoting WILLIAM BEVERIDGE, COMM. ON SOC. INS. & ALLIED SERV., REPORT ON SOC. INS. & ALLIED SERV. (1942)).

12. *Id.* at 5.

1977, the British government responded by forming the Research Working Group on Inequalities in Health, headed by Sir Douglas Black.¹³ Three years later the committee issued its report. The Black Report represents a national government's first attempt to study systematically, understand, and explain health inequalities among members of different classes.¹⁴ Recommendations stressed the need to improve the physical and social environment inhabited by impoverished classes.¹⁵

B. Domestic Recognition

In the United States, results of several studies indicated the socio-environment's significance in determining health outcomes. Researchers showed that despite treating patients who were clinically similar, there was a substantial amount of non-random practice variability between clinical practices throughout New England.¹⁶ Recognizing that the general populous was becoming aware of the situation, the U.S. government became involved.¹⁷ In 1983, the U.S. Department of Health and Human Services (HHS) issued "Health, United States," a report on the country's health.¹⁸ It showed that although the overall health of the nation improved significantly between 1950 and 1983, "there was a continuing disparity in the burden of death and illness experienced by Blacks and other minority Americans as compared with our nation's population as a whole."¹⁹

In 1985, the disparities identified in the report prompted the HHS Secretary to create a Task Force on Black and Minority Health, which was the first time that the federal government brought experts together to research minority health problems.²⁰ The release of the Task Force's Report on its findings significantly raised awareness of the disparate health among the country's minority groups.²¹

Soon thereafter, large epidemiologic studies were conducted. The Harvard Medical Practice study, for example, showed that a significant portion of patient

13. *Id.*

14. *Id.*

15. *Id.*

16. *E.g.*, Benjamin A. Barnes et al., *Report on Variation in Rates of Utilization of Surgical Services in the Commonwealth of Massachusetts*, 254 JAMA 371, 371 (1985); Klim McPherson et al., *Small-Area Variations in the Use of Common Surgical Procedures: An International Comparison of New England, England, and Norway*, 307 NEW ENG. J. MED. 1310, 1310-13 (1982); *see Gibbons, supra* note 2.

17. *See Gibbons, supra* note 2.

18. NAT'L CENTER FOR HEALTH STATISTICS, PUB. HEALTH SERVS., HEALTH, UNITED STATES, 1983 (1983) [hereinafter HEALTH STATISTICS].

19. U.S. DEP'T OF HEALTH & HUMAN SERVS., REPORT OF THE SECRETARY'S TASK FORCE ON BLACK & MINORITY HEALTH ix (1985) [hereinafter TASK FORCE]; HEALTH STATISTICS, *supra* note 18, 84-1232 (1983).

20. TASK FORCE, *supra* note 19, at 2.

21. Robert M. Mayberry et al., *Racial and Ethnic Differences in Access to Medical Care*, 57 MED. CARE RES. & REV. (SUPPLEMENT) 108, 109 (2000).

injury could be shown to result from substandard care.²² Moreover, there was a correlation between substandard care and health care centers treating substantial numbers of poor and minority patients.²³

The growing problems of differential outcomes and health status were not confined to the poor and minorities. As early as 1978, the Whitehall studies of a large cohort of British civil servants indicated that social class-based health differences existed even between persons in administrative, executive, and clerical positions.²⁴ Additionally, it was found that certain community and societal-level factors, including stress,²⁵ fetal environmental factors,²⁶ social capital,²⁷ and income inequality²⁸ seemed to exert significant effects on health and disease outcomes, independent of personal behavior.²⁹

By the late 1990s, scientific research seemed to demonstrate that disparities, practice variation, substandard care, and socio-environmental determinants of health might all be associated with the quality of health care that patients receive. In 2000, Kevin Fiscella published the paper *Inequality in Quality* and proposed that health care quality and racial and ethnic health care disparities be treated as issues related to health care organizational capacity.³⁰ Furthermore, he argued that national attempts to end racial and ethnic disparities in health care and national health care quality improvement initiatives were two inseparable parts of providing good health care to all.³¹

22. Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 NEW ENG. J. MED. 370 (1991).

23. See, e.g., Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 NEW ENG. J. MED. 370 (1991); Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence Care in Hospitalized Patients*, 103 TRANSACTIONS AM. ASS'N PHYSICIANS 137 (1990); Lucian L. Leape et al., *The Nature of Adverse Events in Hospitalized Patient: Results of the Harvard Medical Practice Study II*, 324 NEW ENG. J. MED. 377 (1991).

24. See M. G. Marmot et al., *Employment Grade and Coronary Heart Disease in British Civil Servants*, 32 J. EPIDEMIOLOGY & CMTY. HEALTH 244, 244, 247 (1978).

25. See, e.g., M. G. Marmot, *Does Stress Cause Heart Attacks?*, 62 POSTGRADUATE MED. J. 683, 685 (1986); Robert M. Sapolsky & Glen E. Mott, *Social Subordination in Wild Baboons Is Associated with Suppressed High Density Lipoprotein-Cholesterol Concentrations: The Possible Role of Chronic Social Stress*, 121 ENDOCRINOLOGY 1605, 1608 (1987).

26. See, e.g., Ira B. Tager et al., *Longitudinal Study of the Effects of Maternal Smoking on Pulmonary Function in Children*, 309 NEW ENG. J. MED. 699, 699 (1983).

27. See HEALTH DEVELOPMENT AGENCY, U.K. NATIONAL HEALTH SERVICE, *SOCIAL CAPITAL 2* (2004).

28. See, e.g., R. G. Wilkinson, *For Debate: Income Distribution and Life Expectancy*, 304 BRIT. MED. J. 165, 165 (1992); Richard G. Wilkinson, *National Mortality Rates: The Impact of Inequality?*, 82 AM. J. PUB. HEALTH 1082, 1082 (1992).

29. See RICHARD WILKINSON, *UNHEALTHY SOCIETIES 2* (1996).

30. Kevin Fiscella et al., *Inequality in Quality: Addressing Socioeconomic, Racial, and Ethnic Disparities in Health Care*, 283 JAMA 2579 (2000).

31. *Id.* at 2583.

C. Synthesizing the Scientific Evidence on Health Disparities

While there are multiple definitions, health disparities usually are considered to be population differences in 1) environment, 2) access to, utilization of, and quality of care, 3) health status, or 4) a particular health outcome warranting scrutiny.³² Within the U.S. health care system, these differences have been shown compellingly across racial and ethnic lines (whites vs. minorities). However, studies of other categorizations, including location (urban vs. rural),³³ gender (male vs. female),³⁴ socioeconomic status (poor vs. non-poor),³⁵ and age (non-elderly vs. elderly)³⁶ have also described health disparities..

While many medical and non-medical factors have been described as “causes” of health disparities and are most likely significant, there is not enough scientifically-validated evidence of definitive causal pathways and the underlying biologic mechanisms.³⁷ To better describe these issues, the Institute of Medicine (IOM) has published several reports that discuss scientific evidence on issues of differential health status, culture, behavior, communication, substandard care and medical errors, and health care quality.³⁸ IOM’s work on disparities issues

32. Olivia Carter-Pokras & Claudia Baquet, *What is a “Health Disparity”?*, 117 PUB. HEALTH REP. 426, 427 (2002).

33. E.g., Mark S. Eberhardt & Elsie R. Pamuk, *The Importance of Place of Residence: Examining Health in Rural and Nonrural Areas*, 94 AM. J. PUB. HEALTH 1682, 1684-85 (2004); SANDRO GALEA & DAVID VLAHOV, *Epidemiology and Urban Health Research*, in HANDBOOK OF URBAN HEALTH: POPULATIONS, METHODS AND PRACTICE 259, 261-262 (Sandro Galea & David Vlahov eds., 2005).

34. E.g., Barbara Burns McGrath & Elayne Puzan, *Gender Disparities in Health: Attending to the Particulars*, 39 NURSING CLINICS OF N. AM. 38-39 (2004); Thomas C. Quinn & Julie Overbaugh, *HIV/AIDS in Women: An Expanding Epidemic*, 308 SCI. 1582 (2005).

35. E.g., Nancy E. Adler & Joan M. Ostrove, *Socioeconomic Status and Health: What We Know and What We Don’t*, 896 ANNALS N.Y. ACAD. SCI. 3 (1999); Monica J. Federico & Andrew H. Liu, *Overcoming Childhood Asthma Disparities of the Inner-City Poor*, 50 PEDIATRIC CLIN. OF N. AM. 655 (2003).

36. E.g., Marsha A. Pyle & Eleanor P. Stoller, *Oral Health Disparities Among the Elderly: Interdisciplinary Challenges for the Future*, 67 J. DENTAL EDUC. 1327 (2003).

37. E.g., Robert G. Evans et al., *If Not Genetics, Then What? Biological Pathways and Population Health*, in WHY ARE SOME PEOPLE HEALTHY AND OTHERS NOT? THE DETERMINANTS OF HEALTH OF POPULATIONS 161, 161-62 (Robert G. Evans et al. eds., 1994).

38. COMM. ON IDENTIFYING PRIORITY AREAS FOR QUALITY IMPROVEMENT, INST. OF MED., PRIORITY AREAS FOR NATIONAL ACTION TRANSFORMING HEALTH CARE QUALITY 1-13 (Karen Adams & Janet M. Corrigan eds., 2003); COMM. ON COMM’N FOR BEHAVIOR CHANGE IN THE 21ST CENTURY: IMPROVING THE HEALTH OF DIVERSE POPULATIONS, INST. OF MED., SPEAKING OF HEALTH: ASSESSING HEALTH COMMUNICATION STRATEGIES FOR DIVERSE POPULATIONS (2002); COMM. ON THE NAT’L QUALITY REP. ON HEALTH CARE DELIVERY, INST. OF MED., ENVISIONING THE NATIONAL HEALTH CARE QUALITY REPORT (Margarita P. Hurtado et al. eds., 2001); COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (2001) [hereinafter CROSSING THE QUALITY CHASM]; COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., 2000); COMM. ON CANCER RESEARCH AMONG MINORITIES AND THE MEDICALLY UNDERSERVED, INST. OF MED., THE UNEQUAL BURDEN OF CANCER: AN ASSESSMENT OF NIH RESEARCH FOR ETHNIC MINORITIES AND THE MEDICALLY UNDERSERVED (M. Alfred Haynes & Brian D. Smedley eds., 1999).

culminated in 2003 when it published a report entitled “Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare,” authored by the IOM Committee on Understanding and Eliminating Racial and Ethnic Disparities in Healthcare.³⁹ The Committee was charged with assessing the extent and potential sources of racial and ethnic disparities in health care that were “*not* otherwise attributable to known factors such as access to care (e.g., ability to pay or insurance coverage).”⁴⁰ The Committee was also asked to synthesize the data and provide recommendations for potential interventions that might diminish some of these disparities.⁴¹ The Committee discovered that significant racial and ethnic disparities exist within the United States today, even among those individuals with access to care.⁴² In addition, these disparities were found to be related to historic—as well as contemporary—patterns of social and economic inequality, discrimination, and a fragmented system of health care in the United States.⁴³ Thus the Committee suggested, as did the British Whitehall studies, that racial and ethnic disparities in access to primary care are not fully explained by differences in sociodemographics or health insurance status. Simply put, health disparities are not only found among individuals who have no source of health insurance or live below the poverty line. Those who do live below the poverty line or without health insurance, however, often have the most severe disparities.

D. Health Care Utilization and Disparities

Differential utilization of health care services has also been implicated as a cause of disparities. With only a relative handful of exceptions, African-Americans with Coronary Artery Disease or Acute Myocardial Infarction are significantly less likely to receive appropriate cardiac procedures or therapies⁴⁴ and are less likely to

39. IOM, *supra* note 1.

40. *Id.* at 3 (emphasis added).

41. *Id.*

42. *Id.* at 5-6.

43. *Id.* at 5-7.

44. E.g., John Z. Ayanian et al., *Racial Differences in the Use of Revascularization Procedures After Coronary Angiography*, 269 JAMA 2642, 2644-45 (1993); John G. Canto et al., *Relation of Race and Sex to the Use of Reperfusion Therapy in Medicare Beneficiaries with Acute Myocardial Infarction*, 342 NEW ENG. J. MED. 1094, 1095, 1097 (2000); David M. Carlisle et al., *Racial and Ethnic Differences in the Use of Invasive Cardiac Procedures Among Cardiac Patients in Los Angeles County, 1986 through 1988*, 85 AM. J. PUB. HEALTH 352, 354 (1995); Edward L. Hannan et al., *Access to Coronary Artery Bypass Surgery by Race/Ethnicity and Gender Among Patients Who Are Appropriate for Surgery*, 37 MED. CARE 68, 75 (1999) [hereinafter Hannan et al. 1999]; Edward L. Hannan et al., *Interracial Access to Selected Cardiac Procedures for Patients Hospitalized with Coronary Artery Disease in New York State*, 29 MED. CARE 430, 434-35 (1991) [hereinafter Hannan et al. 1991]; Nancy R. Kressin & Laura A. Petersen, *Racial Differences in the Use of Invasive Cardiovascular Procedures: Review of the Literature and Prescription for Future Research*, 135 ANNALS INTERNAL MED. 352, 363 (2001); I. Steven Udvarhelyi et al., *Acute Myocardial Infarction in the Medicare Population: Process of Care and Clinical Outcomes*, 268 JAMA 2530, 2534 (1992).

receive certain life saving cardiac treatments and/or medicines.⁴⁵ These findings occur in both teaching and non-teaching hospitals. Cumulatively, the studies have accounted for age, sex, disease severity, symptom expression, co-morbidity, health insurance or payer, and physician specialty.⁴⁶ While some have attempted to attribute these differences to personal patient preferences,⁴⁷ there is little empirical evidence to accept this notion.⁴⁸ Additionally, in some cases receipt of services requires physician referral and cannot be obtained by patients based on their own preferences.

E. Organizational and Systems Factors

Several aspects of the health care system, including the organization of the system and the relative ease of accessing services, have been postulated to impact patient care and outcomes, particularly among racial and ethnic minority groups.⁴⁹ The Institute of Medicine concluded that the current health care system is too poorly organized to provide high quality comprehensive care to all individuals with chronic conditions.⁵⁰

The utilization of certain medical devices such as the implantable cardioverter-defibrillator (ICD) and hospital-based procedures has increased markedly over the past fifteen years.⁵¹ Nevertheless, there are indications that these technologies are not used equally in different racial groups, with the rate of implantation among white patients consistently exceeding the rate among blacks.⁵² The root causes of these disparities may be related to geographic differences in the availability of medical technology. Black patients may be less likely to receive some medical technologies because they live in areas where the technologies are underutilized⁵³ or unavailable.⁵⁴ Other data indicates that this discrepancy may be

45. *E.g.*, Canto et al., *supra* note 44, at 1097.

46. *E.g.*, Hannan et al. 1999, *supra* note 44, at 75 (adjusting for gender, age, and insurance status); Hannan et al. 1991, *supra* note 44, at 440 (controlling for severity of illness); Kressin & Petersen, *supra* note 44; Udvarhelyi et al., *supra* note 44, at 2534 (controlling for co-morbidities).

47. Jeff Whittle et al., *Do Patient Preferences Contribute to Racial Differences in Cardiovascular Procedure Use?*, 12 J. GEN. INTERNAL MED. 267 (1997).

48. Kressin & Petersen, *supra* note 44, at 362.

49. IOM, *supra* note 1, at 140.

50. See CROSSING THE QUALITY CHASM, *supra* note 38, at 3–4.

51. Mark A. Hlatky et al., *Utilization and Outcomes of the Implantable Cardioverter Defibrillator, 1987 to 1995*, 144 AM. HEART J. 397, 399 (2002).

52. *E.g.*, Kressin & Petersen, *supra* note 44, at 363.

53. See, *e.g.*, Lucian L. Leape et al., *Underuse of Cardiac Procedures: Do Women, Ethnic Minorities, and the Uninsured Fail to Receive Needed Revascularization?*, 130 ANNALS OF INTERNAL MED., 183, 189 (1999).

54. Katherine Baicker et al., *Geographic Variation in Health Care and the Problem of Measuring Racial Disparities*, 48 PERSP. BIOLOGY & MED. (WINTER SUPPLEMENT) S42, S43 (2005); Katherine

related to racial differences in travel patterns. For example, when the nearest hospitals do not include the most advanced technologies, whites are more likely than blacks to travel longer distances to the nearest high-technology hospital.⁵⁵

F. Racism and Bias

In 1990, the American Medical Association (AMA) weighed in on the problem of racial and ethnic disparities in health care. While noting the likely roles of socioeconomic status and sociocultural factors and the limitation of previous research, it also acknowledged that “[d]isparities in treatment decisions may reflect the existence of subconscious bias” that has not been fully eradicated.⁵⁶

Several studies particularly in the cardiovascular research literature suggest the existence of such bias. Among private physicians, African-Americans who are clinically appropriate for certain cardiac procedures have been shown to receive the procedure significantly less often than similarly clinically appropriate white patients among private physicians.⁵⁷ In contrast, in the Veterans Administration hospital system, where decisions about these same procedures are made by a committee of cardiologists and cardiothoracic surgeons without knowledge of the patients’ race, blacks and whites received these procedures at approximately the same rates.⁵⁸

G. Sociocultural Factors

Increasingly, various sociocultural factors, including culturally oriented diets and body appearance norms, are being recognized as contributors to the problems of observed racial and ethnic disparities in obesity, hypertension, and diabetes rates.⁵⁹ The belief that health outcomes are ordained by God and therefore cannot be changed, also referred to as fatalism, has been documented as a cultural factor among African-Americans.⁶⁰ It has been suggested that this belief may impact

Baicker et al., *Who You Are and Where You Live: How Race and Geography Affect the Treatment of Medicare Beneficiaries*, 23 HEALTH AFF. (VARIATIONS SUPPLEMENT) VAR33, VAR37-VAR42 (2004).

55. Jan Blustein & Beth C. Weitzman, *Access to Hospitals with High-Technology Cardiac Services: How is Race Important?*, 85 AM. J. PUB. HEALTH 345, 348 (1995).

56. H. Jack Geiger, *Racial and Ethnic Disparities in Diagnosis and Treatment: A Review of the Evidence and a Consideration of Causes*, in IOM, *supra* note 1, at 419; COUNCIL ON ETHICAL AND JUD. AFFAIRS, AM. MED. ASS’N., *Black-White Disparities in Health Care*, 263 JAMA 2344, 2346 (1990).

57. See IOM, *supra* note 1, at 5.

58. *Id.* at 150.

59. Kressin & Petersen, *supra* note 44, at 352.

60. *Id.* at 363 (discussing J.A. Ferguson et al., *Racial Disparity in Cardiac Decision Making: Results from Patient Focus Groups*, 158 ARCH. INTERNAL MED. 1450, 1450-53 (1998)).

decision making among African-American patients and contribute to disparities; however, definitive studies are lacking.⁶¹

H. Biological Factors

Identifiable clinical differences in response to pharmacotherapy occur within many homogenous and non-homogenous populations.⁶² Scientific data suggest that response variability to hypertensive medications occurs between African-American and white populations.⁶³ In terms of morbidity and mortality, several biologic factors are believed to be important in the genesis of cardiovascular disease disparities.⁶⁴ These complex biologic factors and social realities are interrelated and difficult to separate. In the future, studies that attempt to elucidate the biologic mechanisms underlying the socially-oriented determinants of cardiovascular disease will be needed.

I. Communication Problems and Disparities

An extensive literature base exists that examines many facets of the complex relationship between health care and communication. Much of the “early” (pre-1990) research came from Western (British, Dutch, and American) studies. The medical and communication models originating in these traditions considered the ideal doctor-patient relationship to be paternalistic, with the patient passively receiving and obeying medical instructions.⁶⁵ These studies revealed that a high

61. *E.g.*, Jeffrey A. Ferguson et al., *Racial Disparity in Cardiac Decision Making: Results from Patient Focus Groups*, 158 ARCH. INTERNAL. MED. 1450, 1452-53 (1998).

62. James R. Sowers et al., *Hypertension-Related Disease in African-Americans: Factors Underlying Disparities in Illness and its Outcome*, 112 POSTGRAD. MED. 24, 33 (2002).

63. *See* Derek V. Exner et al., *Lesser Response to Angiotensin-Converting-Enzyme Inhibitor Therapy in Black as Compared with White Patients with Left Ventricular Dysfunction*, 344 NEW ENG. J. MED. 1351, 1355 (2001) (concluding that enalapril therapy reduces heart failure significantly in white but not black patients); Pinhas Sareli et al., *Efficacy of Different Drug Classes Used to Initiate Antihypertensive Treatment in Black Subjects: Results of a Randomized Trial in Johannesburg, South Africa*, 161 ARCH. INTERN. MED. 965, 968 (2001) (asserting that thiazides are more effective hypertensive drug treatment among black patients); Matthew R. Weir et al., *Differing Mechanisms of Action of Angiotensin-Converting Enzyme Inhibition in Black and White Hypertensive Patients*, 26 HYPERTENSION 124, 126 (1995) (finding that trandolapril was effective in lowering diastolic blood pressure among both blacks and whites, but that blacks required higher doses to achieve similar results as whites); Clyde W. Yancy et al., *Race and the Response to Adrenergic Blockade with Carvedilol in Patients with Chronic Heart Failure*, 344 NEW ENG. J. MED. 1358, 1361 (2001) (stating that carvedilol reduced risk of death by 56% in blacks, and by 68% in non-blacks).

64. *See, e.g.*, Yancy et al., *supra* note 63, at 1364 (discussing the importance of certain biological factors in response variability, such as age, genetic disposition, and biologic susceptibility to hypertension).

65. L.M.L. Ong et al., *Doctor-Patient Communication: A Review of the Literature*, 40 SOC. SCI. & MED. 903, 905 (1995); DEBRA L. ROTER & JUDITH A. HALL, *DOCTORS TALKING WITH PATIENTS/PATIENTS TALKING WITH DOCTORS* 25 (1992).

degree of variability in quality of care exists among providers and that approximately 70% of the variability could be related to communication factors during the visit.⁶⁶

Communication problems between providers and patients who speak different languages are the most widely recognized type of communication problem. Approximately 18 million adults were identified by the 2000 census as having limited English proficiency.⁶⁷ Although most are immigrants, one-tenth of persons with limited English proficiency were born in America.⁶⁸ On average, these patients are more likely than others to report “being in fair or poor health, delay defer seeking needed medical care, leave the hospital against medical advice, miss follow-up appointments, or experience more drug complications; they are also less likely to have a regular health care provider.”⁶⁹

A recent study provides evidence that communication problems exist beyond those patients with limited English proficiency, reporting that 19% of all Americans with a health care visit in the last two years experienced at least one problem communicating with their physicians.⁷⁰ The same study reports that a greater degree of communication problems exist among minority patients; 23% of African-Americans, 27% of Asian-Americans, and 33% of Hispanics reported communications problems with providers.⁷¹ Researchers studying doctor-patient communication among patients and providers who both speak English have defined two important aspects of communication. First, “instrumental communication” focuses on the so-called “cure” aspects of treatment (i.e., signs, symptoms, tests, treatments, side effects).⁷² On the other hand, “socio-emotional communication” focuses on the so-called “care” oriented behaviors (i.e., feelings, emotions, daily functioning, coping).⁷³ Several studies have found that physicians deliver less information, less supportive talk, and less proficient clinical performance to black and Hispanic patients and patients of lower economic class than they do to more advantaged patients, even in the same care settings.⁷⁴

66. ROTER & HALL, *supra* note 65, at 115.

67. Leighton Ku & Glenn Flores, *Pay Now or Pay Later: Providing Interpreter Services in Health Care*, 24 HEALTH AFF. 435, 437 (2005).

68. *Id.* at 437-38.

69. *Id.* at 436.

70. Cindy Brach et al., *Crossing the Language Chasm: An In-depth Analysis of What Language-Assistance Programs Look Like in Practice*, 24 HEALTH AFF. 424, 424 (2005).

71. *Id.* (citing KAREN SCOTT COLLINS ET AL., THE COMMONWEALTH FUND, DIVERSE COMMUNITIES, COMMON CONCERNS: ASSESSING HEALTH CARE QUALITY FOR MINORITY AMERICANS 22 (2002)).

72. Ong et al., *supra* note 65, at 906.

73. *Id.*

74. See, e.g., Loretto M. Comstock et al., *Physician Behaviors That Correlate with Patient Satisfaction*, 57 J. MED. EDUC. 105, 108 (1982) (finding that Hispanic patients rated doctor communication skills less favorably than did whites); Lisa Cooper-Patrick et al., *Race, Gender, and*

Additionally, African-American patients are more likely to experience shorter, physician dominated and less patient-centered visits than are white patients.⁷⁵

This information is of importance because patients may modify treatment plans as a means of asserting control when they are dissatisfied with some part of the doctor-patient relationship.⁷⁶ Perceptions of provider caring is cited as an important factor in motivations of African-American men with hypertension to return for further care. Among this population, the ways in which providers communicated a sense of caring were through eye contact, not looking at the watch, looking at the patient and not just at the chart, tone of voice, asking questions, sitting down, and talking in non-medical, understandable terms.⁷⁷

J. Health Literacy

Health literacy, another dimension of communication, is defined as the ability to read and understand health-related materials⁷⁸ and has been implicated as a cause of health disparities. The results of the 1992 National Adult Literacy Survey reveal that approximately 40 million Americans adults, roughly 25% of the U.S. population, cannot read.⁷⁹ Studies of patients with low levels of literacy suggest that they are less likely to understand hospital discharge instructions, read instructions on medication bottles, or comprehend essential information about diseases such as hypertension, diabetes, and asthma.⁸⁰ Low literacy skill is a significant obstacle to full access to effective medical care.⁸¹ Patients with low

Partnership in the Patient-Physician Relationship, 282 JAMA 583, 586-87 (1999) (finding that African-American patients rated their physician visits as significantly less participatory than did whites); Lisa A. Cooper & Debra L. Roter, *Patient-Provider Communication: The Effect of Race and Ethnicity on Process and Outcomes of Healthcare*, in IOM, *supra* note 1; Arnold M. Epstein et al., *Effects of Patients' Socioeconomic Status and Physicians' Training and Practice on Patient-Doctor Communication*, 78 AM. J. MED. 101, 104-05 (1985) (finding that communication problems arose more frequently between doctors and members of lower economic classes); ROTER & HALL, *supra* note 65, at 49.

75. See Cooper-Patrick et al., *supra* note 74, at 562, 587.

76. David E. Hayes-Bautista, *Modifying the Treatment: Patient Compliance, Patient Control and Medical Care*, 10 SOC. SCI. & MED. 233, 234 (1976).

77. Linda E. Rose et al., *The Contexts of Adherence for African Americans with High Blood Pressure*, 32 J. ADV. NURS. 587, 591-92 (2000).

78. David W. Baker, *Reading Between the Lines: Deciphering the Connections Between Literacy and Health*, 14 J. GEN. INTERN. MED. 315, 315 (1999). According to Baker, health literacy, rather than general literacy, reflects information learned during years of schooling and ability to read and comprehend new information. *Id.*

79. Barry D. Weiss & Cathy Coyne, *Communicating with Patients Who Cannot Read*, 337 NEW ENG. J. MED. 272, 272 (1997) (citing I.S. KIRSCH ET AL., U.S. DEP'T OF EDUC., ADULT LITERACY IN AMERICA: A FIRST LOOK AT THE RESULTS OF THE NATIONAL ADULT LITERACY SURVEY (1993)).

80. See David W. Baker et al., *Health Literacy and the Risk of Hospital Admission*, 13 J. GEN. INTERN. MED. 791, 795-96 (1998) (suggesting that illiterate patients are more likely to struggle with comprehending both written and oral communications and have greater risks of hospitalization).

81. Weiss & Coyne, *supra* note 79, at 272.

literacy skills have poorer health, higher rates of hospitalizations, and incur higher health care costs than those patients with adequate literacy.⁸²

The realization that communication, though accomplished via language, is often influenced by broader social and cultural norms that may not immediately be recognized by those from a different group has led to the notion of cultural competence and the assertion that lack of cultural competence itself is an important factor in the causation of health disparities.⁸³ Despite being in its infancy, cultural competence has already emerged as an important approach largely because the United States is rapidly becoming much more ethnically diverse and because of the previously cited growing realization of relationship between socio-cultural factors and effective communication.⁸⁴

Thus, a voluminous and complex body of literature exists documenting the existence of disparities in health and health care, despite a lack of broad consensus regarding the underlying causes of these disparities.

II. FUNDAMENTAL CHALLENGES & POLICY STRATEGIES

A. Challenges to Understanding and Addressing Disparities

Several important factors militate against a complete understanding of the disparities problem. One such factor is the philosophical perspective from which these problems are addressed. For example, early scientists and investigators trained in the clinical and bench sciences consider discreet, quantitative exposures (viral, bacterial, toxicological, psychological, etc.) as the etiologic agents of disease.⁸⁵ Historically, these exposures often have been studied in isolation from the broader socio-behavioral contexts in which they exist. In contrast, many policy and social scientists often consider more qualitative social factors like poverty, socioeconomic status, and racial segregation as the key determinants of health.⁸⁶

82. *Id.*

83. Cultural competence is an approach to health care that emphasizes “the importance of culture and cross-cultural dynamics” when treating patients from different socio-cultural backgrounds, and advocates for greater assessment, awareness, and treatment according to these differences. Joseph R. Betancourt et al., *Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care*, 118 PUB. HEALTH REP. 293, 294 (2003).

84. Joseph R. Betancourt et al., *Cultural Competence and Health Care Disparities: Key Perspectives and Trends*, 24 HEALTH AFF. 499, 499-500 (2005); Betancourt et al., *supra* note 83, at 294.

85. *See, e.g.*, IAGO GALDSTON, *THE MEANING OF SOCIAL MEDICINE* 46 (1954) (discussing the medical profession’s focus upon the “germ causes” of disease).

86. *See generally* LISA F. BERKMAN & ICHIRO KAWACHI, *SOCIAL EPIDEMIOLOGY* (2002) (applying sociological factors, such as socioeconomic position and racial discrimination, in the context of personal health and susceptibility to disease contraction). *See also* RACE, ETHNICITY, AND HEALTH: A PUBLIC HEALTH READER (Thomas A. LaVeist ed., 2002) (emphasizing the importance of qualitative social factors as the chief causes of health care disparities).

They often assert that more quantitative exposures are factors that alter the nature of the association between the social factor and a given health outcome.⁸⁷ When social scientists are describing causal factors, they draw a distinction between proximal social factors, which they define as the settings in which people live (family, work, school, and neighborhood), and distal social factors, which they define as the pervasive forces in society (culture, socioeconomic status, and race relations).⁸⁸ To clinical scientists, the terms proximal and distal are used to describe the relative relationship or distance of one object to another (i.e., a body part in relation to the heart).⁸⁹

Another problem relates to our collective use of the term “disparities.” In both popular and academic literature, the terms “health disparities” and “health care disparities” are often used interchangeably. While certainly related to one another, the terms are not identical. Health disparities refer to population differences in health status or health outcomes.⁹⁰ Health care disparities, in contrast, refer to population differences in access or utilization of a health care product.⁹¹ The relationship between access to a health service and a specific health outcome is not always clear, and the evidence for a direct causal association is often tenuous.⁹²

This distinction represents far more than semantic minutia and is reflected in recent papers by Senate Majority leader Bill Frist entitled *Overcoming Disparities in U.S. Health Care*⁹³ and a companion paper by Senator Edward Kennedy entitled *The Role of the Federal Government in Eliminating Health Disparities*.⁹⁴ The term used is important because it begs several critically important questions. For example, what is the relationship between health care utilization and health outcomes? What role, if any, should the health care system play in addressing the non-medical determinants of health or health care disparities? Given the potential impact of non-medical determinants, should government programs like Medicare

87. SOCIETY AND HEALTH, *supra* note 7, at 3-12 (examining the effect that differing degrees of exposure to certain social factors has upon personal health and well-being).

88. *Id.* at 9.

89. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 553, 1530 (30th ed. 2003).

90. Mary Anne Bobinski, *Health Disparities in the Law: Wrongs in Search of a Right*, 29 AM. J.L. & MED. 363, 364 (2003).

91. Marsha Lille-Blanton et al., *Site of Medical Care: Do Racial and Ethnic Differences Persist*, 1 YALE J. HEALTH POL'Y L. & ETHICS 15, 15-16 (2001).

92. June Eichner & Bruce C. Vladeck, *Medicare as a Catalyst for Reducing Health Disparities*, 24 HEALTH AFF. 365, 373 (2005).

93. William H. Frist, *Overcoming Disparities in U.S. Health Care*, 24 HEALTH AFF. 445 (2005).

94. Edward M. Kennedy, *The Role of the Federal Government in Eliminating Health Disparities*, 24 HEALTH AFF. 452 (2005).

and Medicaid attempt to ensure equity for health outcomes, health care utilization, or both?⁹⁵

The answers to these questions are profoundly affected by one's notion of a "health" disparity problem or a "health care" disparity problem and which problem is to be addressed. Without precise and open discourse, and multidisciplinary science, evidence-based policy solutions designed to systematically and effectively address disparities under either term (health or health care) likely will remain elusive.

B. Conservative Approaches to Addressing Disparities

Many conservatives frame the disparities problem in terms of "health care" disparities, and view their causation in terms of patient behavior, responsibility, empowerment, and health care quality for all patients.⁹⁶ According to this school of thought, the best solutions involve policies designed to improve the quality of health care delivered to all patients through enhancing access to high quality care, improving cultural understanding and competency, and speeding the transition from scientific discovery to bedside cures.⁹⁷ To accomplish these goals, conservative advocates propose to improve health care quality through increasing health information technology, improving the existing health care safety net, and implementing health care savings accounts.⁹⁸ Health Savings Accounts (HSAs) were created by Public Law 108-173, the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003," signed into law by President Bush on December 8, 2003.⁹⁹ HSAs are designed to help individuals save for qualified medical and retiree health expenses on a tax-advantaged basis.¹⁰⁰ Any adult who is covered by a high-deductible health plan (and has no other first-dollar coverage) may establish an HSA.¹⁰¹ Funds distributed from the HSA are not taxed if they are used to pay qualified medical expenses.¹⁰²

For conservatives, enhancing health professional training by providing instruction about sociocultural dimensions of health is the best mechanism to enhance cultural competency in the health care system. In addition, shifting the

95. See generally Eichner & Vladeck, *supra* note 92 (addressing how Medicare could potentially reduce racial and ethnic health disparities and the issues that would arise from such action).

96. E.g., Frist, *supra* note 93, at 447-49 (addressing the problem of disparities in relation to access, and asserting that solutions need to promote personal responsibility among patients).

97. *Id.* at 447-50.

98. *Id.*

99. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, 42 U.S.C.A. §§ 1395w-101-52 (West 2000 & Supp. 2005).

100. Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers Under HIPAA Titles I & IV, 69 Fed. Reg. 78,734 (Dec. 30, 2004).

101. *Id.*

102. *Id.*

focus of science and medicine from generating new knowledge to that of translating current knowledge is believed to hold promise for bringing high quality care to more patients.¹⁰³

C. Liberal Strategies for Addressing Disparities

While conservatives tend to frame the disparities problem in terms of patient behavior, responsibility, empowerment, and health care quality, liberals tend to view the problem as one of disparities in “health.” In general, liberals believe that disparities emanate primarily from current and residual effects of larger social and societal problems, such as racism, poverty, and segregation. They assert that these societal forces lead to poor access (insurance status) and low quality health care delivered to minority patients.¹⁰⁴ Those who hold this perspective tend to frame the problem largely in social justice and civil rights terms. From this perspective, policy remedies generally revolve around a focus on cultural competency, health literacy, improved data collection, monitoring and enforcement of existing civil rights laws, increasing health workforce diversity, investing in public health infrastructure, and some form of universal health insurance.¹⁰⁵ Clearly, past legislative efforts to introduce universal health insurance were unsuccessful, and the prospect is minimal in the context of a Republican-controlled White House and Congress. Accepting this reality, Democrats tend to advocate expansions of government-backed public insurance programs such as Medicaid and the State Children’s Health Insurance Program (SCHIP)¹⁰⁶ as incremental, short-term steps toward universal coverage.

III. A BIPARTISAN STRATEGY FOR ADDRESSING DISPARITIES

On the surface, there appears to be little upon which both Democrats and Republican policymakers can agree. However, upon closer inspection, a few areas of common ground begin to emerge from the rhetoric. Both Democrats and Republicans agree that the quality of health care currently provided to many Americans needs to be improved. Similarly, both sides indicate that the cultural aspects of our health care delivery system will need to be addressed to improve the quality of health care services received by patients. This improvement may best be accomplished at the local community level. One intervention specifically supported by both Democrats and Republicans is the utilization of patient navigators or community health workers (CHWs).¹⁰⁷

103. *E.g.*, Frist, *supra* note 93, at 447-50.

104. *See* Kennedy, *supra* note 94, at 454-55.

105. *Id.* at 453-57.

106. *Id.* at 454.

107. Frist, *supra* note 93, at 449; Kennedy, *supra* note 94, at 454.

A. Background and Origins of the Community Health Worker Model

All of the world's cultures have a lay health care system, comprised of natural helpers or community members to whom neighbors can turn for social encouragement and assistance.¹⁰⁸ The origins of the development of a CHW workforce may in part be traced to the work of seventeenth century Russian Feldshers. Feldshers were lay citizens who underwent a year-long training program in preparation to care for Russian civilian and military populations.¹⁰⁹ Later, the same model was seen in the work of the Chinese "barefoot doctor" program¹¹⁰ and in the Village Health Worker model of the World Health Organization.¹¹¹

The CHW concept has its domestic roots in the War on Poverty and the New Careers movement of the late 1950s and early 1960s.¹¹² Opportunities for these workers significantly expanded with the passage of the federal Migrant Health Act of 1962 and the Economic Opportunity Act of 1964.¹¹³ Both pieces of legislation mandated the utilization of such outreach and community-based service workers in many neighborhoods and migrant worker camps.¹¹⁴ As a result of these laws, community-based health aides were trained and hired for the provision of health services.¹¹⁵ Currently it has been estimated that at least 600 programs across the United States utilize more than 12,000 CHWs in community-based health activities.¹¹⁶

108. Dawn Satterfield et al., *The "In-Between People": Participation of Community Health Representatives in Diabetes Prevention and Care in American Indian and Alaska Native Communities*, 3 HEALTH PROMOTION PRAC. 166, 168 (2002).

109. See ENCYCLOPAEDIA BRITANNICA PREMIUM SERVICE, *medicine*, ENCYCLOPAEDIA BRITANNICA, available at <http://www.britannica.com/eb/print?tocId=35490&fullArticle=true> (last visited Mar. 2, 2006).

110. See Lisa Leiman, Comment, *Should the Brain Drain be Plugged? A Behavioral Economics Approach*, 39 TEX. INT'L L.J. 675, 688 (2004).

111. See Deborah E. Bender & Kathryn Pitkin, *Bridging the Gap: The Village Health Worker as the Cornerstone of the Primary Health Care Model*, 24 SOC. SCI. & MED. 515, 516 (1987). A village health worker (VHW) is described as a "health worker who serves as the 'interface' between the formal health care system and the community." *Id.*

112. See Janice M. Nittoli & Robert P. Giloth, *New Careers Revisited: Paraprofessional Job Creation for Low-Income Communities*, 28 SOC. POL'Y 44, 45 (1997) (explaining that the New Careers movement was "one of the most thoughtful, comprehensive, and controversial efforts to launch public employment labor force planning").

113. 42 U.S.C.A. § 2701 (West 2003 & Supp. 2005); Migrant Health Act of 1962, Pub. L. No. 87-692, 76 Stat. 592 (1962) (current version at 42 U.S.C.A. § 254(b) (West 2003 & Supp. 2005)).

114. Martha N. Hill et al., *Enhancing the Role of Community-Health Workers in Research*, 28 IMAGE J. OF NURSING SCHOLARSHIP 221, 221 (1996).

115. *Id.*

116. NAT'L CTR. FOR CHRONIC DISEASE PREVENTION & HEALTH PROMOTION, CTR. FOR DISEASE CONTROL AND PREVENTION, COMMUNITY HEALTH WORKERS/PROMOTORES DE SALUD: CRITICAL CONNECTIONS IN COMMUNITIES 4 (2005), <http://www.cdc.gov/diabetes/projects/comm.htm>.

To date, the most effective systemic use of the skills of CHWs in the United States was established in 1972, when the Indian Health Service adopted the Community Health Representative Program from the Office of Economic Opportunity.¹¹⁷ The program was designed to “bridge gaps between people and resources and to integrate basic medical knowledge about disease prevention and care with local knowledge.”¹¹⁸ Today, approximately 1,400 community health representatives work with programs in over 560 federally-recognized American Indian and Alaska Native peoples.¹¹⁹

In scientific literature, CHWs have been referred to by more than thirty different names, including lay health advisors, health aides, promotoras, cosejeras, dumas, and patient navigators. Patient Navigators comprise a subset of CHWs whose care coordination activities focus on the clinical encounter and do not generally focus on patient outreach, case findings, primary prevention, or post-therapeutic case management.¹²⁰ While patient navigator activities may indeed occur in the community, they are primarily designed to facilitate timely and appropriate utilization of the health care system.

There are several generally-recognized reasons why the Patient Navigator approach is promising. First, few of the millions of dollars that are spent on low-income communities each year fund employment for residents of those communities.¹²¹ Secondly, indigenous workers are better able to reach and communicate with community residents and thereby provide culturally-appropriate outreach and cultural linkages between communities and delivery systems. Because they are better equipped to provide culturally-appropriate services, well-designed and implemented CHW programs can reduce costs by providing health education screening, detection, and basic emergency care. They may also improve quality by contributing to patient-provider communication, continuity of care, and

117. INDIAN HEALTH SERVICE, U.S. DEP'T. OF HEALTH AND HUMAN SERVICES, GENERAL CHR INFORMATION, <http://www.ihs.gov/NonMedicalPrograms/chr/history.cfm> (last visited Apr. 2, 2006). In 1967, the Office of Economic Opportunity began funding what would develop into the CHR program by 1972. *Id.*

118. NAT'L CTR. FOR CHRONIC DISEASE PREVENTION & HEALTH PROMOTION, *supra* note 116, at 3.

119. *Id.*; see also INDIAN HEALTH SERVICE, *supra* note 117.

120. Patient Navigator Outreach and Chronic Disease Prevention Act of 2005, Pub. L. No. 109-18, 119 Stat. 340 (2005) (to be codified at 42 U.S.C. § 340A) (stating that navigators shall facilitate the delivery of care in communities by 1) acting as coordinators of health care services and provider referrals; 2) establishing community outreach programs targeting individuals at high risk for chronic diseases; 3) notifying individuals of clinical trials; 4) helping patients overcome barriers within the health care system; and 5) ensuring that health ombudsman programs provide insurance coverage information to individuals).

121. See generally Jacqueline J. Kirby, *Welfare to Work Transition*, 1 HUMAN DEV. & FAM. LIFE BULL. (1995), <http://www.hec.ohio-state.edu/famlife/bulletin/volume.1/bull14a.htm> (observing that studies show that many recipients of this type of traditional governmental aid “go from welfare to the working poor”).

consumer protection.¹²² Finally, many CHW jobs have the potential to provide entry into long-term careers for low-income workers.¹²³

B. CHW Training and Certification – The Early Years

There is a great deal of variability in the published literature regarding the exact training and certification of CHWs and Patient Navigators. Briefly, training programs span the spectrum from protracted courses of academic study over several years at an institution of higher learning to none at all.¹²⁴ As early as the mid-1960s, Stanley Budner was training indigenous, unskilled individuals for employment in mental health services.¹²⁵ He developed a twelve-week program in which the training was focused on development of pragmatic skills, which directly related to performance-oriented job activities.¹²⁶ Trainees received “hands on” training while the use of routine didactic lectures was minimized.¹²⁷

Similarly, in 1976 Joseph Teicher employed a six-month alcohol abuse prevention training program that involved weekly didactic and workshop-type sessions covering topics such as principles of learning theory and family contracting.¹²⁸ Trainees were required to read texts and complete manuals on behavioral therapy.¹²⁹ Trainees also watched films and had to complete three observed encounters prior to completion of the training, after which they rendered supervised treatment of affected families.¹³⁰ Of the ten CHWs who began the training, six either dropped out or were unwilling or unable to complete the program.¹³¹ Of the remaining four CHWs who completed the training, post-tests suggested a significant increase in knowledge.¹³² The CHWs themselves

122. See Anne Witmer et. al., *Community Health Workers: Integral Members of the Health Care Work Force*, 85 AM. J. PUB. HEALTH 1055, 1056 (1995).

123. See Nittoli & Giloth, *supra* note 112, at 46.

124. For a list of institutions and community colleges offering technical training as well as degree programs for lay health advisors, see COMMUNITY HEALTH WORKER PROGRAM RESOURCES, SOUTH TEXAS HEALTH RES. CTR., <http://www.family-health-fdn.org/CHWRResources/Training%20resources.htm> (last visited Mar. 5, 2006). For an example of program success, see Matthew H. Liang, *An Introductory Course in Prescription Drugs For Community Health Workers Developed by a Systems Approach*, 66 AM. J. OF PUB. HEALTH 290 (1976) (documenting the success of a 16-hour training program for CHWs on the effects of prescription drugs).

125. Stanley Budner et al., *The Plan and the Reality: Training and Utilization of Paraprofessionals for Service to the Retarded*, 61 AM. J. PUB. HEALTH 297, 297-98 (1971).

126. *Id.* at 301.

127. *Id.*

128. Joseph D. Teicher et. al., *Training Community-Based Professionals as Behavior Therapists with Families of Alcohol-Abusing Adolescents*, 133 AM. J. PSYCHIATRY 847, 848 (1976).

129. *Id.*

130. *Id.*

131. *Id.* at 849.

132. *Id.*

acknowledged the benefits of the training and found the textbooks and didactic materials useful.¹³³

In a review of training CHWs in behavior modification, Balch and Solomon described several programs that used a variety of formats and training strategies. Some programs were as short as six hours and involved only discussions between trainees and professionals, while others were three to four weeks and involved variable combinations of seminars, on the job community-based training, role playing, guided observation, and required reading.¹³⁴ The authors cite a study suggesting that complex and long training techniques may not be justified.¹³⁵ Balch and Solomon also found that practical, on-the-job oriented trainings were usually employed to train CHWs and that training programs designed to produce CHWs who can perform in a relatively unsupervised setting used substantively different teaching and evaluation methodologies from those programs with more limited objectives.¹³⁶ Similar insights and recommendations have been cited by several authors.¹³⁷

C. CHW Training and Certification – The Contemporary Experience

Over the years, some investigators have employed training strategies that tended to emphasize social support and individual and community empowerment as the dominant skills needed by CHWs to perform effectively. These investigators saw the role of “natural helping” and provision of socio-emotional support as most important.¹³⁸ As such, CHW training under this model included topics such as empathetic listening, showing trust and concern, relational communication, coalition building, and interpersonal skills.¹³⁹ The programs

133. *Id.*

134. Philip Balch & Richard Solomon, *The Training of Paraprofessionals As Behavior Modifiers: A Review*, 4 AM. J. CMTY. PSYCHOL. 167, 169-71 (1976).

135. *Id.* at 175 (citing D.R. Laws et al., *Reduction of Inappropriate Social Behavior in Disturbed Children By an Untrained Paraprofessional Therapist*, 2 BEHAVIOR THERAPY 519, 519-533 (1971)).

136. *Id.*

137. See Judith D. DePue et al., *Training Volunteers to Conduct Heart Health Programs in Churches*, 3 PREVENTIVE MED. 51, 55 (1987) (reporting that volunteers found that specialized training sessions and small group discussions facilitated their learning process); Jo Anne L. Earp et al., *Lay Health Advisors: A Strategy for Getting the Word Out About Breast Cancer*, 24 HEALTH EDUC. & BEHAVIOR 432, 439-40 (1997); Dennis A. Frate et al., *Selection, Training and Utilization of Health Counselors in the Management of High Blood Pressure*, 12 URBAN HEALTH 52, 53 (1983) (establishing the efficacy of health counselors in the management of high blood pressure).

138. Natural helpers are part of an informal support network found in many rural communities. Lowell Jenkins & Alicia S. Cook, *The Rural Hospice: Integrating Formal and Informal Helping Systems*, 26 SOC. WORK 414, 415 (1981) (“[natural helpers] operate out of concern for and familiarity with the people or families needing help.”).

139. See Ronald L. Braithwaite et al., *Ethnographic Approach to Community Organization and Health Empowerment*, 21 HEALTH EDUC. Q. 407, 414 (1994); Earp et al., *supra* note 137, at 440; Eugenia Eng & Rebecca Young, *Lay Health Advisors As Community Change Agents*, 15 FAM. & CMTY.

employing these strategies tended to be general health promotion or disease prevention projects.

Other investigators have focused the activities of CHWs on specific diseases or problems, such as HIV/AIDS and breast and cervical cancer.¹⁴⁰ Training for these programs was also very varied and, unfortunately, not always reported. Most of these programs trained CHWs in basic pathophysiology of the particular disease and primary prevention and screening strategies. Accordingly, these programs stressed outreach, patient education, case finding, and screening.¹⁴¹ Most of these studies failed to adequately characterize the specific training content, duration, and evaluation methodologies used to equip the CHWs.¹⁴²

A few researchers have narrowed the work of the CHW to primarily the hospital setting. In this capacity, CHWs are used as facilitators of appropriate utilization of health care services. As such, they have been called “patient navigators.”¹⁴³ While the activities and outcomes of this type of CHW have been described in several studies, the specific training given to these CHWs has not been characterized.¹⁴⁴

HEALTH 24, 37 (1992); Eugenia Eng et al., *Lay Health Advisor Intervention Strategies: A Continuum From Natural Helping to Paraprofessional Helping*, 24 HEALTH EDUC. & BEHAVIOR 413, 414 (1997); see also I.N. Ramos et al., *Environmental Health Training of Promotoras in Colonias Along the Texas-Mexico Border*, 91 AM. J. OF PUB. HEALTH 568, 569 (2001); Lee Ann Roman et al., *Community Health Workers: Examining the Helper Therapy Principle*, 16 PUB. HEALTH NURSING 87, 94 (1999); Amy J. Schulz et al., “It’s a 24-hour Thing, a Living for Each Other Concept”: Identity, Networks, and Community in an Urban Village Health Worker Project, 24 HEALTH EDUC. & BEHAVIOR 465, 470-71 (1997); Amy J. Schulz et al., *The East Side Village Health Worker Partnership: Integrating Research with Action to Reduce Health Disparities*, 116 PUB. HEALTH REP. 458, 550 (2001).

140. See, e.g., Barbara Curbow et al., *Community-Based Cancer Screening Programs in Older Populations: Making Progress But Can We Do Better?*, 38 PREVENTIVE MED. 676, 684-85 (2004) (reviewing the various specialized areas in which health workers are specializing).

141. *Id.* at 678-83.

142. See Joyce Adair Bird et al., *Opening Pathways to Cancer Screening for Vietnamese-American Women: Lay Health Workers Hold a Key*, 27 PREVENTIVE MED. 821, 822 (1998); Rebecca Cabral et al., *Paraprofessional Delivery of a Theory Based HIV Prevention Counseling Intervention for Women*, 111 PUB. HEALTH REP. 75, 77 (1996); Robert A. Hiatt et al., *Community-Based Cancer Screening for Underserved Women: Design and Baseline Findings from the Breast and Cervical Cancer Intervention Study*, 33 PREVENTIVE MED. 190, 192-93 (2001). But see, e.g., Eugenia Eng, *The Save Our Sisters Project: A Social Network Strategy for Reaching Rural Black Women*, 72 CANCER 1071, 1074 (1993) (detailing topics covered in training program consisting of 5 sessions).

143. Patient Navigator Outreach and Chronic Disease Prevention Act of 2005, Pub. L. No. 109-18, 119 Stat. 340. In hospital settings, nurses may also act as patient navigators. In that capacity, they may “provide newly diagnosed patients with a roadmap of the direction their care will take and coordinate the care where they live.” Donalee Moulton, “Patient Navigators:” *Newest members of NS Health Care Team*, 167 CANADIAN MED. ASS’N J. 295 (2002).

144. See, e.g., Soji F. Oluwole et al., *Impact of a Cancer Screening Program on Breast Cancer Stage at Diagnosis in a Medically Underserved Urban Community*, 196 J. AM. COLL. SURGEONS 180, 181 (2003); Laura Liberman et al., *Carcinoma Detection at the Breast Examination Center of Harlem*, 95 CANCER 9 (2002).

Nittoli and Giloth found that in general, most CHWs receive about forty hours worth of training from social workers or nurses prior to beginning their jobs.¹⁴⁵ This initial training is then usually followed by regular on-the-job training every two-to-four months covering topics such as communication skills, community resources, and general disease prevention.¹⁴⁶

Finally, reports from the University of Arizona and the California Endowment have surveyed CHWs working across the United States to ascertain their perceptions of requisite skills and education needed to adequately perform their tasks. The University of Arizona surveyed approximately 300 CHWs and found that communications skills, knowledge about health issues or the health care system, and documentation/writing skills were the most important skills for which training was important.¹⁴⁷ This study also cited skills in communications, interpersonal relations, medical knowledge, health care service coordination, capacity-building, advocacy, teaching, and organizational development as “core” skills needed by CHWs working in the United States.¹⁴⁸ Similarly, a report from the California Endowment, which outlined progress and lessons learned from thirty different CHW programs it has funded, found that ongoing training is needed that focuses on skill-building in the areas of communications, health and documentation.¹⁴⁹

D. CHW Training and Certification – Promising Future Research

Recently, researchers have begun to explore the utility and feasibility of utilizing a U.S. Department of Labor training program as a framework for a national training and certification system for CHWs and Patient Navigators. In addition, they are studying how to seamlessly integrate the CHW model into the current health care delivery system.

The U.S. Department of Labor currently recognizes several types of social and human services support occupations as sub-classifications of the federally recognized occupational category of “Social and Human Service Assistants” (recently renamed as “Direct Support Professionals” (DSPs)).¹⁵⁰ Social and human

145. Nittoli & Giloth, *supra* note 112, at 48-49.

146. *Id.* at 49.

147. NATIONAL COMMUNITY HEALTH ADVISER, UNIV. OF ARIZ., A SUMMARY OF THE NATIONAL COMMUNITY HEALTH ADVISOR STUDY 8-10 (1998).

148. *Id.* at 11-12.

149. THE CALIFORNIA ENDOWMENT, HIGHLIGHTS FROM PROMOTORES/COMMUNITY HEALTH WORKERS GRANTEE CONVENING 8 (2000), http://www.calendow.org/reference/publications/pdf/cultural/TCE0607-2000_Highlights_Fro.pdf.

150. BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, OCCUPATIONAL OUTLOOK HANDBOOK, *Social and Human Service Assistants* (2004-05), available at <http://www.stats.bls.gov/ocos059.htm#top>; EMPLOYMENT AND TRAINING ADMIN., OFFICE OF APPRENTICESHIP TRAINING EMPLOYER AND LABOR SERV., HUMAN SERVICES DIRECT SUPPORT PROFESSIONAL APPRENTICESHIP

service assistant is a generic name for people with many job titles, including community support worker and community outreach worker.¹⁵¹ These individuals usually are supervised by physicians, nurses, psychologists, rehabilitative or physical therapists, and sometimes social workers.¹⁵² Social and human service assistants have different degrees of authority and supervision. They provide direct and indirect services to ensure that individuals reach their maximum level of functioning, by assessing clients' needs, conducting eligibility assessments for programs including food stamps, Medicaid and Medicare while helping eligible clients to enroll.¹⁵³ They may coordinate transportation, provide emotional comfort, track and store clients' case records, and notify supervisors and case managers of improvement.¹⁵⁴

In the community DSPs play a variety of roles.¹⁵⁵ They organize and lead group activities, assist clients in need of counseling or crisis intervention, help with daily living skills, review clients' records, ensure that they take correct doses of medication, and confer with medical personnel.¹⁵⁶ In addition, DSPs provide emotional comfort and help clients take care of themselves by working to help clients communicate more effectively with health care personnel and others.¹⁵⁷ They help their clients' treatment by providing individual or group counseling or occupational therapy.¹⁵⁸

According to the Department of Labor, the future job opportunities outlook for DSPs is excellent. It predicts that from 2002-2012, DSP occupation will be one of the fastest growing in the nation.¹⁵⁹ Job opportunities will arise from the need to support an increasingly aged U.S. populace and to replace workers who advance into new positions, retire, or leave the workforce for other reasons. Competition will be greater in urban areas, but qualified applicants should have little difficulty

PROGRAM STANDARDS OF APPRENTICESHIP BULLETIN 2002-02 (2001). The federal O-Net Code for both Direct Support Specialists and Social and Human Service Assistants is 21-1093. This indicates that in the eyes of the federal government these categorizations are identical.

151. *Id.*

152. *Id.*

153. *Id.* Typical programs that DSPs help clients enroll in are Food Stamp Programs, Welfare, and Medicaid. *Id.*

154. *Id.*

155. Amy Hewitt et al., *Issues in the Direct Support Workforce and their Connections to the Growth, Sustainability and Quality of Community Supports*, RESEARCH AND TRAINING CTR. ON CMTY. LIVING, UNIV. OF MINN. 4 (2001), available at <http://www.nadsp.org/pdf/hcfa.pdf> ("Today, in addition to meeting peoples' basic health, safety and care needs, DSPs have responsibilities to support people to develop and achieve their own personal goals, to balance risks with choices, to connect with peers, friends and family members, and to be full and active citizens in their communities. They carry out these expanded responsibilities with less supervision and, increasingly, while working alone.").

156. BUREAU OF LABOR STATISTICS, *supra* note 150.

157. *Id.*

158. *Id.*

159. *Id.*

finding employment. Because of increasing need and demand for services, employers are increasingly relying upon DSPs to deliver these services to clients.¹⁶⁰ Because the Department of Labor maintains standards of training and certification for many occupations,¹⁶¹ the potential and infrastructure for developing and implementing a national certification and training program for CHWs and Patient Navigators, through this mechanism, is significant.

E. CHW Impact

The National Institutes of Health, the Centers for Disease Control and Prevention, the Institute of Medicine, and many private foundations and federally funded research studies demonstrate the value of a community health worker mediated-care delivery model.¹⁶² For example, the Pew Health Professions Commission commented that CHWs can increase access to care and facilitate appropriate use of health resources by providing outreach and cultural linkages between communities and delivery systems; reducing costs by providing health education screening, detection, and basic emergency care; and improving the quality of services by contributing to patient-provider communication, continuity of care, and consumer protection.¹⁶³

Community Health Workers have been studied in many racial and ethnic populations, in a variety of health care settings, testing many types of CHW intervention models, and investigating a large variety of health outcomes. While relatively few large-scale studies have been done, several recent reviews and meta-analyses, along with a preponderance of the smaller experimental and observational studies, suggest that the weight of scientific evidence supports the efficacy of a well-designed and managed CHW intervention model.¹⁶⁴ Several large scale state and national demonstration projects, supported by the National Institutes of Health, the Center for Medicare and Medicaid Services and the Centers for Disease Control and Prevention are currently underway and will, in the future, provide further insight regarding the efficacy of this model.¹⁶⁵

160. *Id.*

161. *See, e.g., id.* For instance, a National Accrediting Commission is in place for barbers, cosmetologists, and other personal appearance workers. *Id.*

162. *See, e.g.,* SCHNEIDER INST. FOR HEALTH POL'Y, BRANDEIS UNIVERSITY, CANCER PREVENTION AND TREATMENT DEMONSTRATION FOR RACIAL AND ETHNIC MINORITIES (2003); Nittoli & Giloth, *supra* note 112; NAT'L CTR. FOR CHRONIC DISEASE PREVENTION & HEALTH PROMOTION, *supra* note 116.

163. Witmer et al., *supra* note 122, at 1056-57.

164. *E.g.,* Hewitt et al., *supra* note 155; BUREAU OF LABOR STATISTICS, *supra* note 150; THE CALIFORNIA ENDOWMENT, *supra* note 149.

165. Two ongoing studies include, for example, CMS's Cancer Prevention and Treatment Demonstration for Racial and Ethnic Minority Medicare Beneficiaries and the National Cancer Institute's Patient Navigator Research program.

Given the plethora of studies and the heterogeneity of outcomes that have been evaluated, an exhaustive explication of the literature is beyond the scope of this paper. Rather, a brief illustrative summary of the select studies and outcomes will be provided. Further details can be obtained from several excellent reviews of the field.¹⁶⁶

With regard to racial and ethnic populations, the CHW model has been proven effective among African-Americans,¹⁶⁷ Hispanics,¹⁶⁸ American Indians,¹⁶⁹ Asians/Pacific Islanders,¹⁷⁰ and North American Vietnamese¹⁷¹ populations. Across these populations, researchers have demonstrated beneficial effects of CHW interventions to address diabetes,¹⁷² hypertension/cardiovascular disease,¹⁷³ cancer,¹⁷⁴ HIV/AIDS,¹⁷⁵ asthma,¹⁷⁶ chronic disease self-management,¹⁷⁷

166. Simon A. Lewin et al., *Lay Health Workers in Primary and Community Health Care (Review)*, 1 THE COCHRANE LIBR. 1 (2005); Marguerite J. Ro et al., NAT'L CTR. FOR PRIMARY CARE, CMTY. HEALTH WORKERS AND CMTY. VOICES: PROMOTING GOOD HEALTH 1, 1-14, (2003); Susan M. Swider, *Outcome Effectiveness of Community Health Workers: An Integrative Literature Review*, 19 PUB. HEALTH NURSING 11 (2002); University of Arizona, A SUMMARY OF THE NATIONAL COMMUNITY HEALTH ADVISOR STUDY (1998); Ann Zuvekas et al., *Impact of Community Health Workers on Access, Use of Services, and Patient Knowledge and Behavior*, 22 J. AMBULATORY CARE MGMT. 33 (1999).

167. E.g., Jo Anne Earp et al., *Increasing Use of Mammography Among Older, Rural African American Women: Results From a Community Trial*, 92 AM. J. PUB. HEALTH 650 (2002); Martha N. Hill et al., *Hypertension Care and Control in Underserved Urban African American Men: Behavioral and Physiologic Outcomes at 36 Months*, 16 AM. J. HYPERTENSION 906, 910-11 (2003); Lisa R. Yanek et al., *Project Joy: Faith-Based Cardiovascular Health Promotion for African American Women*, 116 PUB. HEALTH REP. 68, 76-78 (2001).

168. E.g., Jennifer B. Hunter et al., *The Impact of a Promotora on Increasing Routine Chronic Disease Prevention Among Women Aged 40 and Older at the U.S.-Mexico Border*, 31 HEALTH EDUC. & BEHAV. 1S, 18S (Aug. Supp. 2004); Ana M. Navarro et al., *Por La Vida Model Intervention Enhances Use of Cancer Screening Tests Among Latinas*, 15 AM. J. PREVENTIVE MED. 32, 38 (1998).

169. E.g., Mark Dignan et al., *Effectiveness of Health Education to Increase Screening for Cervical Cancer Among Eastern-Band Cherokee Indian Women in North Carolina*, 88 J. NAT'L CANCER INST. 1670, 1674 (1996); Mark B. Dignan et al., *Health Education to Increase Screening for Cervical Cancer Among Lumbee Indian Women in North Carolina*, 13 HEALTH EDUC. RES. 545, 554 (1998).

170. E.g., Carolyn Cook Gotay et al., *Impact of a Culturally Appropriate Intervention on Breast and Cervical Screening Among Native Hawaiian Women*, 31 PREVENTIVE MED. 529, 535 (2000); Victoria M. Taylor et al., *A Randomized Controlled Trial of Interventions to Promote Cervical Cancer Screening Among Chinese Women in North America*, 94 J. NAT'L CANCER INST. 670, 677 (2002).

171. E.g., Bird et al., *supra* note 142, at 827; Tram K. Lam et al., *Encouraging Vietnamese-American Women to Obtain Pap Tests Through Lay Health Worker Outreach and Media Education*, 18 J. GEN. INTERNAL MED. 516, 521 (2003).

172. E.g., Tiffany L. Gary et al., *Randomized Controlled Trial of the Effects of Nurse Case Manager and Community Health Worker Interventions on Risk Factors for Diabetes-Related Complications in Urban African Americans*, 37 PREVENTIVE MED. 23, 29-30 (2003); Mary Jo Vetter et al., *A Model for Home Care Clinician and Home Health Aide Collaboration: Diabetes Care by Nurse Case Managers and Community Health Workers*, 22 HOME HEALTHCARE NURSE 645, 646-47 (2004).

173. E.g., Hill et al., *supra* note 167; Yanek et al., *supra* note 167.

174. E.g., Liberman et al., *supra* note 144, at 11-13; Oluwole et al., *supra* note 144.

175. E.g., Richard C. Birkel et al., *Findings From the Horizontes Acquired Immune Deficiency Syndrome Education Project: The Impact of Indigenous Outreach Workers as Change Agents for Injection Drug Users*, 20 HEALTH EDUC. Q. 523, 532 (1993); Carl A. Latkin et al., *HIV Prevention*

smoking,¹⁷⁸ infant and newborn outcomes,¹⁷⁹ and diet.¹⁸⁰ In terms of health care services utilization and health care access, CHWs can be very effective in improving community-based outreach and case finding,¹⁸¹ health education,¹⁸² childhood immunization rates,¹⁸³ and emergency room utilization patterns.¹⁸⁴ Appropriately trained CHWs may also serve as translators and interpreters for patients with limited English proficiency.¹⁸⁵

Limited evidence suggests that patient navigators may achieve significant efficacy among impoverished patients with a diagnosis of breast cancer. Studies among poor African-American and Hispanic women in Harlem, N.Y., suggest that patient navigators were able to significantly reduce the proportion of late-stage (and thus poor prognosis) diagnoses from approximately 50% to 20%.¹⁸⁶ At the same time, the number of early-stage (stage 0 or 1) diagnoses went from 6% to over 40% of patients screened.¹⁸⁷ In addition, patient navigators were credited with observed changes in mean five-year survival rates among these women.¹⁸⁸ These improvements were accomplished without evidence of any significant change in personal or neighborhood socioeconomic or insurance status.¹⁸⁹

Among Drug Users: Outcome of a Network-Oriented Peer Outreach Intervention, 22 HEALTH PSYCHOL. 332, 337 (2003).

176. E.g., Arlene M. Butz et al., *Use of Community Health Workers with Inner-City Children Who Have Asthma*, 33 CLINICAL PEDIATRICS 135, 139 (1994); James W. Krieger et al., *The Seattle-King County Healthy Homes Project: A Randomized, Controlled Trial of a Community Health Worker Intervention to Decrease Exposure to Indoor Asthma Triggers*, 95 AM. J. PUB. HEALTH 652, 658 (2005).

177. E.g., Hunter et al., *supra* note 168, at 24S.

178. E.g., Frances A. Stillman et al., *Heart, Body, and Soul: A Church-Based Smoking-Cessation Program for Urban African Americans*, 22 PREVENTIVE MED. 335, 345 (1993).

179. E.g., Cynthia Barnes-Boyd et al., *Promoting Infant Health Through Home Visiting By a Nurse-Managed Community Worker Team*, 18 PUB. HEALTH NURSING 225, 234 (2001); Kathleen F. Norr et al., *Maternal and Infant Outcomes at One Year for a Nurse-Health Advocate Home Visiting Program Serving African Americans and Mexican Americans*, 20 PUB. HEALTH NURSING 190, 200 (2003).

180. E.g., Lisa K. Staten et al., *Provider Counseling, Health Education, and Community Health Workers: The Arizona WISEWOMAN Project*, 13 J. WOMEN'S HEALTH 547, 552-555 (2004).

181. E.g., Martha N. Hill et al., *supra* note 114, at 225-26.

182. E.g., Theodore J. Colombo et al., *The Effect of Outreach Workers' Educational Efforts on Disadvantaged Preschool Children's Use of Preventive Services*, 69 AM. J. PUB. HEALTH 465, 466 (1979); Zuvekas et al., *supra* note 166, at 40-41.

183. E.g., Colombo, *supra* note 182, at 467-68.

184. E.g., Lee R. Bone et al., *Emergency Department Detection and Follow-Up of High Blood Pressure: Use and Effectiveness of Community Health Workers*, 7 AM. J. EMERGENCY MED. 16, 18 (1989).

185. E.g., Eileen Corkery et al., *Effect of a Bicultural Community Health Worker on Completion of Diabetes Education in a Hispanic Population*, 20 DIABETES CARE 254, 255-56 (1997).

186. Oluwole, *supra* note 144, at 183.

187. *Id.*

188. *Id.* at 186.

189. Liberman, *supra* note 144; Oluwole, *supra* note 144.

Attempting to understand how such a relatively “low tech” intervention could be effective at addressing such an amazingly diverse array of problems and populations in both clinical and community based settings is a challenge, especially if one looks for similarities across diseases, states, populations, interventions, neighborhoods, genes, socioeconomic factors, health systems factors, or other societal forces. The answer, however, may lie not so much on the external determinants as it does on the heuristics of health behaviorism that individuals and thus populations exhibit. Several theories of health behaviorism have been developed and evaluated.¹⁹⁰ While several theories (Transtheoretical,¹⁹¹ Health Beliefs¹⁹²) have been widely used, most are less appropriate for use among minority populations.¹⁹³ The Theory of Reasoned Action¹⁹⁴ is less widely used, but best approximates the realities of health behaviorism among many minority groups living in the United States. Briefly, this model posits that individuals are inherently socially oriented creatures and that this social orientation may profoundly affect health behaviorism.¹⁹⁵ The model depicts a given health choice as occurring due to the relative balance between what the individual thinks the “health expert or professional” would have him/her do and what the local “community expert” would have them do about a given health problem.¹⁹⁶ Thus, while community members may go to the hospital to seek care from a provider, they will likely balance that action against what their pastor or community elder thinks they should do. In the end, it is the relative balance of these choices that determines the final decision.¹⁹⁷

It is widely recognized that African-Americans, Hispanics, Asian, and American-Indian populations are significantly more community and family

190. HEALTH BEHAVIOR AND HEALTH EDUCATION 37-147 (Karen Glanz et al. eds., 2d ed. 1997); Kristi J. Ferguson, *Health Behavior*, in PUB. HEALTH & PREVENTIVE MED. 811, 812-13 (John M. Last ed., 14th ed. 1998).

191. The Transtheoretical (or “Stages of Change”) model of health behavior posits that an individual’s willingness to change is a five-step process, and the rate of progress through those steps is largely dependent on the individual’s perception of the pros and cons of behavior change. Ferguson, *supra* note 190, at 812.

192. The Health Belief model of health behavior describes a person’s health-related behavior as dependent on that individual’s perception of: (1) the severity of an illness; (2) their own susceptibility to that illness; (3) the benefits of preventive measures; and (4) the barriers to obtaining those preventive measures. *Id.*

193. See Rena J. Pasick, *Socioeconomic and Cultural Factors in the Development and Use of Theory*, in HEALTH BEHAVIOR AND HEALTH EDUCATION 425-26 (Karen Glanz et al. eds., 2d ed. 1997).

194. See Ferguson, *supra* note 190, at 812; James O. Prochaska et al., *The Transtheoretical Model and Stages of Change*, in HEALTH BEHAVIOR AND HEALTH EDUCATION 60, 60-84 (Karen Glanz et al. eds., 2d ed. 1997).

195. See Ferguson, *supra* note 190, at 812.

196. See, e.g., Prochaska, *supra* note 194, at 86-90.

197. *Id.*; Ferguson, *supra* note 190, at 813-14.

oriented than many Caucasian/European subpopulations.¹⁹⁸ Thus, those from the community that are held in high regard often have significant influence over the behaviors of other members of the group on this basis. This recognized but undervalued cultural observation may play a major role in the success or failure of an intervention by influencing the way people perceive and respond to the message or strategy.¹⁹⁹ The CHW model builds on this notion and attempts to make these relationships and realities advantageous to health behaviorism, personal choices and health outcomes.

F. Department of Health and Human Services (DHHS) Interest

Federal agencies including the National Cancer Institute, Center for Medicare & Medicaid Services (CMS), and the Health Resources and Services Administration (HRSA) are exploring the utility of employing CHWs widely in Medicare, Medicaid, and other at-risk populations. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) was enacted in 2000 as a way of implementing this strategy.²⁰⁰ Section 122 calls for the “Cancer Prevention and Treatment Demonstrations for Ethnic and Racial Minorities,” which requires CMS to reduce health care disparities among racial and ethnic minority Medicare beneficiaries by developing evidence-based recommendations and exploring new models of health care financing and service delivery.²⁰¹ The recently completed report found that effective strategies need to target *how* minorities are offered access and how they are treated within the health care system and appear to be required to address disparities.²⁰² In particular, the report highlighted the importance of 1) new indigenous workers (such as CHWs or patient navigators); 2) emphasizing the improvement of accessibility and continuity of prevention, detection, and treatment services instead of exclusively patient education and screening; and 3) supporting these workers with new health care system information systems and decision-making supports that facilitate better integration in the health care system.²⁰³

198. See, e.g., Charles Smith, *Racism and Community Planning: Building Equity or Waiting for Explosions*, 8 STAN. L. & POL’Y REV. 61, 64 (1997); Gilbert A. Holmes, *The Extended Family System in the Black Community: A Child-Centered Model for Adoption Policy*, 68 TEMP. L. REV. 1649, 1655 (1995); Joseph Erasto Jaramillo, *The Community-Building Project: Racial Justice Through Class Solidarity Within Communities of Color*, 9 LA RAZA L.J. 195, 210 (1996).

199. Rena J. Pasick, *Socioeconomic and Cultural Factors in the Development and Use of Theory*, in HEALTH BEHAVIOR AND HEALTH EDUCATION 429 (Karen Glanz et al. eds., 2d ed. 1997).

200. 42 U.S.C. § 1305.

201. *Id.* § 122.

202. SCHNEIDER INST. FOR HEALTH POL’Y, *supra* note 162, at xvi.

203. *Id.*

G. Congressional Interest

The U.S. Congress has also become interested in the CHW concept. Members of Congress have introduced several pieces of legislation related to CHWs and patient navigators. For example, the proposed Community Health Workers Act of 2002 would allow states and Indian tribes to apply for federal funding to promote positive health behaviors in minority women living in medically underserved communities.²⁰⁴ Another bill, the Patient Navigator Outreach and Chronic Disease Prevention Act which received significant bipartisan support, was signed into law on June 29, 2005, by President Bush.²⁰⁵ The Act states that the Health Resources and Services Administration (HRSA) may make grants, to eligible entities, for the development and operation of demonstration programs to provide patient navigator services to improve health care outcomes.²⁰⁶ The legislation calls on the Secretary of Health to work with the Indian Health Service (IHS), the National Cancer Institute, and the Office of Rural Health Policy in the design and evaluation of these demonstration programs.²⁰⁷

H. Cost Implications of the CHW Model

Few studies have examined this aspect of the CHW model, but a recent study by Donald Fedder suggests a potential cost-benefit analysis.²⁰⁸ This study assessed the impact of CHWs on health care utilization among African-American Medicaid patients. It documented a 40% reduction in emergency room visits, a 33% reduction in emergency room related admissions to the hospitals, a resultant 27% decline in Medicaid reimbursements, and an average cost savings of \$2,245 per patient per year.²⁰⁹

CONCLUSION

While a significant amount of evidence convincingly documents the existence of racial and ethnic disparities, broad consensus does not yet exist regarding the fundamental causes of these disparities or the best strategies to address the problem. Progress on this issue has been hampered by poorly defined terminology and imprecise dialogue. In addition, presuppositional differences regarding the relationship between the socio-environment, health behaviors, health care, and

204. S. 2139, 107th Cong. § 3 (2002).

205. Patient Navigator Outreach and Chronic Disease Prevention Act, Pub. L. No. 109-18, 119 Stat. 340 (2005).

206. *Id.* at § 340A (a).

207. *Id.*

208. Donald O. Fedder et al., *The Effectiveness of a Community Health Worker Outreach Program on Healthcare Utilization of West Baltimore City Medicaid Patients with Diabetes, With or Without Hypertension*, 13 *ETHNICITY & DISEASE* 22, 25 (2003).

209. *Id.* at 22.

health status serve to confuse and influence the scientific questions being asked and the interpretation of findings. In the face of these challenges, the existence of racial and ethnic disparities, and in some cases the increasing magnitude of these disparities, is forcing debate and action on possible strategies and policy solutions.

One approach that continues to receive significant bipartisan support involves the identification, training, and utilization of individuals indigenous to minority populations as culturally appropriate bridges between minority communities and a fragmented health care system. Community Health Workers, as they are generically called, are also known by over thirty terms, including Patient Navigators, Lay Health Aids, Community Health Advisors, Dumas, and Promotoras. While the idea of the Community Health Worker is not new and its roots can be traced to several health care infrastructure building efforts of the developing world, its domestic origins have their roots in the War on Poverty. As health care costs continue to rise in the face of an increasingly diverse U.S. population, a resurgence of interest in the model has emerged. Scientific evidence suggests that the model can help improve access to health care, enhance communication between providers and patients, and improve health outcomes. In addition, preliminary evidence suggests significant potential cost savings for wider implementation of the model. Ongoing research is elucidating the best approaches for systematic training and integration of CHWs into the current health care system.