American College of Physicians
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September 29, 2022

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National Academies of Sciences, Engineering, and Medicine
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Re: Review of Federal Policies that Contribute to Racial and Ethnic Health Inequities

Dear Co-Chairs Burke and Polsky,

On behalf of the American College of Physicians (ACP), I am pleased to share our comments in response to the National Academies of Sciences, Engineering, and Medicine's (National Academies) call for input on federal policies that contribute to racial and ethnic health inequities and potential solutions. **As an organization representing frontline physicians who observe the social and health inequities our patients of color experience on a daily basis, the College appreciates the urgency of this work and applauds the National Academies for undertaking efforts to begin to systematically understand and address this evergreen issue.**

ACP is the largest medical specialty organization and the second largest physician membership society in the United States. ACP members include 160,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness. Internal medicine specialists treat many of the patients at greatest risk from COVID-19, including the elderly and patients with pre-existing conditions such as diabetes, heart disease and asthma.

Many interacting factors, including social determinants of health, racism and discrimination, economic and educational disadvantages, health care access and quality, individual behavior,

and biology, affect a person's health.[1] Research has shown that Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other persons in the United States experience disparities in health and health care associated with their race. These disparities have been particularly illuminated by our nation's experience with the COVID-19 pandemic. Although the reasons for such disparities are multifaceted, discrimination and biases, both explicit and implicit, are major contributors to lower rates of health care access and coverage,[2,3] higher rates of mortality and morbidity,[4,5] and poorer health outcomes and health care quality.[6]

In light of this, ACP strongly believes that recommendations that speak directly to the challenges and realities faced by marginalized populations are necessary as part of a comprehensive and interconnected approach to eliminating disparities in health and health care. With population trends diversifying, there is an urgent need for policymakers and clinicians to adapt and reenvision the way health care is structured to reduce racial and ethnic health care gaps and meet the needs of racial and ethnic minorities. **The National Academies' initiative to begin to identify federal policies that contribute to racial and ethnic health inequities is a welcomed first step**.

ACP has long expressed concern over the state of racial and ethnic disparities in health and health care[7,8] and has remained committed to elevating and supporting evidence-based public policy solutions to alleviate them. In our review of the issue, we noticed that many policy approaches focused primarily on downstream symptoms of health inequities. However, ACP believes that to effectively understand, address, and end disparities, one must recognize and confront the fact that many upstream elements of U.S. society, some of which are intertwined and compounding, contribute to poorer health outcomes. If we accept that no one element of society is solely responsible for creating disparities, then any strategy to eliminate disparities that addresses any element independently of the others will fail to accomplish its goal.

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[1] Hooper, Monica Webb, Anna María Nápoles, and Eliseo J. Pérez-Stable. "COVID-19 and racial/ethnic disparities." *Jama* 323, no. 24 (2020): 2466-2467.

[2] Artiga S, Orgera K, Damico A. Changes in health coverage by race and ethnicity since the ACA, 2010-2018. Kaiser Family Foundation. 5 March 2020. Accessed at www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018

[3] Gaskin, Darrell J., Gniesha Y. Dinwiddie, Kitty S. Chan, and Rachael R. McCleary. "Residential segregation and the availability of primary care physicians." *Health services research* 47, no. 6 (2012): 2353-2376.

[4] Agency for Healthcare Research and Quality. 2018 National Healthcare Quality and Disparities Report. Accessed at www.ahrq.gov/research/findings/nhqrdr/nhqdr18/index.html

[5] Richardson, Lisa C., S. Jane Henley, Jacqueline W. Miller, Greta Massetti, and Cheryll C. Thomas. "Patterns and trends in age-specific black-white differences in breast cancer incidence and mortality–United States, 1999–2014." *Morbidity and Mortality Weekly Report* 65, no. 40 (2016): 1093-1098.

[6] Agency for Healthcare Research and Quality. 2018 National Healthcare Quality and Disparities Report. Accessed at www.ahrq.gov/research/findings/nhqrdr/nhqdr18/index.html

[7] Crowley R, Neubauer R, and Fleming D. Racial and Ethnic Disparities in Health Care, Updated 2010. American College of Physicians; 2010. Accessed at https://www.acponline.org/acp_policy/policies/racial_ethnic_disparities_2010.pdf.

[8] Lightner S, Francis C, and Turton D. Racial and Ethnic Disparities in Health Care. American College of Physicians; 2003. Accessed at https://www.acponline.org/acp_policy/policies/racial_ethnic_disparities_healthcare_2003.pdf.

With this in mind, ACP recently developed a series of policy papers and recommendations to provide a comprehensive and interconnected framework[9] that is best suited to achieve our goal of goal of good health care for all, poor health care for none. In addition to the overarching framework, the College published several related companion papers. In "Understanding and Addressing Disparities and Discrimination in Education and in the Physician Workforce," ACP offers recommendations to create safe, inclusive, and supportive educational and workplace environments; promote diverse medical school bodies and workforces; and support, fund, and strengthen education at all levels.[10] In "Understanding and Addressing Disparities and Discrimination Affecting the Health and Health Care of Persons and Populations at Highest Risk," ACP makes recommendations to address disparities in coverage, access, and quality of care, and other issues that disproportionately affect racial and ethnic minorities.[11] In "Understanding and Addressing Disparities and Discrimination in Law Enforcement and Criminal Justice Affecting the Health of At-Risk Persons and Populations," ACP calls for changes to criminal justice and law enforcement policies and practices that result in racial and ethnic disparities in interactions, sentencing, and incarceration as well as disproportionate harm to these communities.[12] These papers build upon ACP's earlier policy work on "Racism and Health in the United States," which provides recommendations to address some of the sources of institutional racism and harm that negatively impacts the health of people of color.[13] Most recently, the College proposed specific policy recommendations on reforming payment programs, including those designed to treat underserved patient populations, to better address value in health care and achieve greater equity in "Reforming Physician Payments to Achieve Greater Equity and Value in Health Care."[14] Taken together, ACP believes these papers provide

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[9] Serchen J, Doherty R, Atiq O, Hilden D; Health and Public Policy Committee of the American College of Physicians. A Comprehensive Policy Framework to Understand and Address Disparities and Discrimination in Health and Health Care: A Policy Paper From the American College of Physicians. Ann Intern Med. 2021 Apr;174(4):529-532. [PMID: 33428444] doi: 10.7326/M20-7219.

[10] Serchen J, Doherty R, Hewett-Abbott G, et al. Understanding and addressing disparities and discrimination in education and in the physician workforce: a policy paper from the American College of Physicians. American College of Physicians; 2021. Accessed at www.acponline.org/acp_policy/policies/understanding_discrimination_in_education_physician_workforce_2021.pdf.

[11] Serchen J, Doherty R, Hewett-Abbott G, et al. Understanding and addressing disparities and discrimination affecting the health and health care of persons and populations at highest risk: a policy paper from the American College of Physicians. American College of Physicians; 2021. Accessed at www.acponline.org/acp_policy/policies/understanding_discrimination_affecting_health_and_health_care_persons_populations_highest_risk_2021.pdf.

[12] Serchen J, Doherty R, Atiq O, et al. Understanding and addressing disparities and discrimination in law enforcement and criminal justice affecting persons and populations at highest risk: a policy paper from the American College of Physicians. American College of Physicians; 2021. Accessed at www.acponline.org/acp_policy/policies/understanding_discrimination_law_enforcement_criminal_justice_affecting_health_at-risk_persons_populations_2021.pdf.

[13] Serchen J, Doherty R, Atiq O, et al. Racism and health in the United States: a policy statement from the American College of Physicians. Ann Intern Med. 2020;173:556-557. [PMID: 32559145] doi: 10.7326/M20-4195.

[14] Outland, Brian E., Shari Erickson, Robert Doherty, et al. "Reforming Physician Payments to Achieve Greater Equity and Value in Health Care: A Position Paper of the American College of Physicians." *Annals of Internal Medicine* 175, no. 7 (2022): 1019-1021.

a comprehensive and interconnected set of policies to address some of the most pressing issues throughout society that contribute to racial health disparities.

In the process of developing these policy papers, the College has identified the following areas that contribute to racial and ethnic disparities in health and health care that may be of interest for the National Academies' consideration:

Coverage and Medicaid Expansion

Racial and ethnic minorities have the lowest rates of coverage in the country: 21.8% of American Indian and Alaska Native individuals, 19% of Hispanic individuals, 11.5% of Black individuals, and 9.3% of Native Hawaiian and other Pacific Islander individuals were uninsured in 2018.[15] Ensuring adequate health coverage for all is essential in addressing and eliminating health disparities as coverage is closely associated with one's access to care and well-being. Compared to those who are insured, uninsured individuals are three times less likely to visit a doctor or health professional regarding their health.[16] Uninsured individuals are less likely to have a regular source of care; more likely to forgo care or prescription drug treatment due to cost; less likely to receive preventive services; and more likely to forgo follow-up care for a chronic condition than those with public or private coverage.[17,18]

While the *Patient Protection and Affordable Care Act* (ACA) greatly decreased the coverage gap, additional measures are needed to achieve universal coverage and eliminate persistent disparities in coverage. As the overall population has seen a decrease in the uninsured rate since the ACA was implemented, racial and ethnic minorities have experienced some of the largest gains but still have higher uninsured rates compared to White persons.[19] However, coverage gains from the ACA have stalled in recent years and uninsured rates have even slightly

[15] Artiga S, Orgera K, Damico A. Changes in health coverage by race and ethnicity since the ACA, 2010-2018. Kaiser Family Foundation. 5 March 2020. Accessed at www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018

[16] Garfield R, Orgera K. The Uninsured and the ACA: A Primer – Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act - How does lack of insurance affect access to care? KFF. 2019. Available from: https://www.kff.org/reportsection/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsuredamidst-changes-to-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-care/

[17] Broadwater-Hollifield, Camille, Troy E. Madsen, Christina A. Porucznik, David N. Sundwall, Scott T. Youngquist, Kajsa Vlasic, and Lisa H. Gren. "Predictors of patient adherence to follow-up recommendations after an ED visit." *The American Journal of Emergency Medicine* 33, no. 10 (2015): 1368-1373.

[18] Hadley, Jack. "Insurance coverage, medical care use, and short-term health changes following an unintentional injury or the onset of a chronic condition." *Jama* 297, no. 10 (2007): 1073-1084.

[19] Artiga S, Orgera K, Damico A. Changes in health coverage by race and ethnicity since the ACA, 2010-2018. Kaiser Family Foundation. 5 March 2020. Accessed at www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018

increased since 2016,[20] suggesting that further action beyond those taken in the ACA is required to achieve full coverage and eliminate coverage disparities.

One mechanism to reducing the uninsured gap, particularly for those with lower incomes, is through public programs like Medicaid. Under the ACA, states are provided the opportunity to expand Medicaid eligibility to those making under 138% of the federal poverty level (FPL) and receive additional federal funding to offset most of the costs. To date, 38 states and the District of Columbia have expanded Medicaid eligibility under the ACA. Expansion states have had greater success in reducing racial and ethnic disparities in coverage and Black persons in expansion states are more likely to be insured than White persons in non-expansion states.[21,22] As 46% of all Black persons and 36% of all Hispanic persons in the U.S. live in non-expansion states, expanding Medicaid eligibility in the remaining holdout states could have a meaningful impact on coverage for racial and ethnic minorities. [23]

Another population neglected by efforts to expand access to coverage are undocumented immigrants, a population that is primarily made up of racial and ethnic minorities. Nearly a quarter of those uninsured in the U.S. are noncitizens[24] and Hispanic persons and Asian American persons are less likely than White persons to be eligible for coverage as they comprise a larger share of those who are noncitizens. [25] Migrant workers, many of whom may be undocumented, tend to work more dangerous jobs with fewer workplace protections, placing them at particular health risk.[26] Undocumented immigrants are ineligible to receive federally funded health care or purchase insurance through the ACA exchange. As a result, nearly 45% of undocumented immigrants.[27] Those with Deferred Action for Childhood Arrivals (DACA) status are ineligible for federal health programs but are able to access employer-

[20] Baumgartner JC, Collins SR, Radley DC, Hayes SL. How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care. Commonwealth Fund. 2020. https://www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowedracial-ethnic-disparities-access

[21] Baumgartner JC, Collins SR, Radley DC, Hayes SL. How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care. Commonwealth Fund. 2020. https://www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowedracial-ethnic-disparities-access

[22] Clark, Cheryl R., Mark J. Ommerborn, Brent Coull, Do Quyen Pham, and Jennifer S. Haas. "Income inequities and Medicaid expansion are related to racial and ethnic disparities in delayed or forgone care due to cost." *Medical care* 54, no. 6 (2016): 555.

[23] Baumgartner JC, Collins SR, Radley DC, Hayes SL. How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care. Commonwealth Fund. 2020. https://www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowedracial-ethnic-disparities-access

[24] Tolbert J, Orgera K, Singer N, Damico A. Key Facts about the Uninsured Population. KFF. 2020. Available from: https://www.kff.org/uninsured/issue-brief/key-facts-about-theuninsured-population

[25] Artiga S, Orgera K, Damico A. Changes in health coverage by race and ethnicity since the ACA, 2010-2018. Kaiser Family Foundation. 5 March 2020. Accessed at www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018

[26] Moyce, Sally C., and Marc Schenker. "Migrant workers and their occupational health and safety." *Annu Rev Public Health* 39, no. 1 (2018): 351-365.

[27] Tolbert J, Orgera K, Singer N, Damico A. Key Facts about the Uninsured Population. KFF. 2020. Available from: https://www.kff.org/uninsured/issue-brief/key-facts-about-theuninsured-population

sponsored insurance or some state programs.[28] Further, research has found that fears around immigration enforcement has resulted in a reduction in the utilization of health and nutrition programs and services for qualified US-born children who are citizens.[29] Expansion of public charge rules, which considers use of public non-cash benefits programs as a negative factor in permanent residency or temporary visa applications, resulted in 14% of immigrants not utilizing public programs, including 42% that reported avoiding participating in Medicaid/Children's Health Insurance Program (CHIP).[30] A lack of policy to provide coverage to undocumented immigrants remains one of the biggest obstacles in achieving the goal of universal coverage.

ACP strongly believes that public policy must strive to make improvements to coverage, quality, and access to care for everyone, while addressing the disproportionate impact on racial and ethnic minorities. Medicaid eligibility must be expanded in all states and approaches should be explored to improve access to coverage for undocumented immigrants. The College further emphasizes that universal health coverage, either through a single-payer or public choice model, is fundamental in addressing the underlying racial and ethnic disparities in comorbidities that increase risk of negative health outcomes.

Language Services

The U.S. Census Bureau estimates that roughly 25.6 million U.S. residents have limited English proficiency (LEP).[31] Those with LEP often receive lower-quality care as a result of communication barriers, cultural differences, and structural barriers and biases.[32] Patients facing linguistic barriers may also misunderstand diagnosis and treatment options, improperly follow treatment instructions, and have poor comprehension of care plans.[33] A meta-analysis of admissions data found that patients with LEP stayed in the hospital 6% longer than English-speaking patients and had longer average hospital stays for various illnesses and procedures.[34]

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[28] Lopez V, Mackey TK. The Health Of Dreamers. Health Affairs Blog. 2018. https://www.healthaffairs.org/doi/10.1377/hblog20180209.367466/full/

[29] Artiga S, Lyons B. Family Consequences of Detention/Deportation: Effects on Finances, Health, and Well-Being. KFF. 2018. Available from: https://www.kff.org/racial-equity-andhealth-policy/issue-brief/family-consequences-of-detention-deportation-effects-on-finances-healthand-well-being/

[30] Bernstein H, Gonzalez D, Karpman M, Zuckerman S. Urban Wire: Immigrants and Immigration. Urban Wire. Urban Institute; 2019. Available from: https://www.urban.org/urban-wire/public-charge-rule-looming-one-seven-adults-immigrant-families-reported-avoidingpublic-benefit-programs-2018

[31] "B16001 Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over 2019: ACS 5-Year Estimates Detailed Tables." American Community Survey. U.S. Census Bureau. Accessed September 1, 2022. https://data.census.gov/cedsci/table?q=ACSDT5Y2019.B16001&tid=ACSDT5Y2019.B16001.

[32] Green, Alexander R., and Chijioke Nze. "Language-based inequity in health care: who is the "poor historian"?." *AMA journal of ethics* 19, no. 3 (2017): 263-271.

[33] Coren, Joshua S., Frank A. Filipetto, and Lucia Beck Weiss. "Eliminating barriers for patients with limited English proficiency." *Journal of Osteopathic Medicine* 109, no. 12 (2009): 634-640.

[34] John-Baptiste, Ava, Gary Naglie, George Tomlinson, Shabbir MH Alibhai, Edward Etchells, Angela Cheung, Moira Kapral et al. "The effect of English language proficiency on length of stay and in-hospital mortality." *Journal of general internal medicine* 19, no. 3 (2004): 221-228.

Providing adequate and accessible translation services is an effective tool for improving care for patients with LEP. Access to trained professional interpreters is associated with improved patient satisfaction, quality of care, and outcomes.[35] Use of interpreter services is also associated with receiving more preventive services, more office visits, and the filling of more prescriptions.[36]

Title VI of the 1964 Civil Rights Act and Section 1557 of the ACA require covered health care entities who receive federal funds to provide meaningful access to services for those with LEP, including by ensuring access to care in one's preferred language through interpretation and translation services. However, interpretation services are often unavailable and compliance with existing law is not always enforced.[37] One study found that roughly 40% of patients with LEP received language interpretation services upon admission and discharge.[38] Another study found that only 57% of patients with LEP had an interpreter present with the physician upon admission and 60% during the hospitalization; these numbers drop to 17% and 14% when limited to professional interpreters.[39]

While an important tool in ensuring quality care for patients, providing interpreter services can be costly, particularly for smaller physician practices. Some estimates place the cost at around $45-$150 per hour for in-person services, $1.25-$3.00 per minute for telephone services, and $1.95-$3.49 per minute for video services.[40] Medicaid and CHIP in 14 states and the District of Columbia will cover the use of interpreter services for beneficiaries, while several others require contracted managed care organizations to offer interpretation services free of charge.

Given the linguistic diversity in the U.S., and the negative health risks for patients with LEP, ACP strongly believes that federal policymakers must make it a priority to support the cultural, informational, and linguistic needs of patients. It is essential that health care communications be made in a language the patient understands. Clinicians must be reimbursed by public and private payers for translation services needed in providing care for those with LEP or who are deaf.

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[35] Flores, Glenn. "The impact of medical interpreter services on the quality of health care: a systematic review." *Medical care research and review* 62, no. 3 (2005): 255-299.

[36] Jacobs, Elizabeth A., Donald S. Shepard, Jose A. Suaya, and Esta-Lee Stone. "Overcoming language barriers in health care: costs and benefits of interpreter services." *American journal of public health* 94, no. 5 (2004): 866-869.

[37] Green AR, Nze C. Language-Based Inequity in Health Care: Who Is the "Poor Historian"?. Journal of Ethics | American Medical Association. American Medical Association; 2017. Available from: https://journalofethics.ama-assn.org/article/language-based-inequity-health-carewho-poor-historian/2017-03

[38] Lindholm, Mary, J. Lee Hargraves, Warren J. Ferguson, and George Reed. "Professional language interpretation and inpatient length of stay and readmission rates." *Journal of general internal medicine* 27, no. 10 (2012): 1294-1299.

[39] Schenker, Yael, Eliseo J. Pérez-Stable, Dana Nickleach, and Leah S. Karliner. "Patterns of interpreter use for hospitalized patients with limited English proficiency." *Journal of general internal medicine* 26, no. 7 (2011): 712-717.

[40] Jacobs, Barb, Anne M. Ryan, Katherine S. Henrichs, and Barry D. Weiss. "Medical interpreters in outpatient practice." *The Annals of Family Medicine* 16, no. 1 (2018): 70-76.

Maternal Mortality

As worldwide maternal mortality rates have dropped in recent years, the U.S. has seen a significant increase in pregnancy-related deaths. Women in the U.S. have the highest risk of dying as a result of pregnancy complications among eleven industrialized nations,[41] and three in five of these pregnancy-related deaths could be prevented.[42] Racial and ethnic minority women are much more likely to die due to pregnancy-related complications or health problems, and Black and American Indian and Alaska Native women are at three times the risk of death than White women.[43]

Racial and ethnic minority women have been found to have higher prevalence of chronic diseases, including chronic hypertension, asthma, placental disorders, gestational diabetes, preexisting diabetes, and blood disorders, that in turn result in increased risk for pregnancy-related mortality.[44,45] Black women have fatality rates 2.4-3.3 times higher for pregnancy complications, including preeclampsia, eclampsia, abruptio placentae, placenta previa, and postpartum hemorrhage.[46] Data suggest the number of prenatal visits is inversely associated with maternal mortality and severe morbidity rates. However, Black, American Indian and Alaska Native, and Native Hawaiian and Pacific Islander women access prenatal care at lower rates than White women within the first trimester.[47]

In addition to health factors, data suggest the quality of the American health system is also failing minority mothers. One national study found that a quarter of hospitals were the site of three quarters of all African American deliveries in the United States, and those hospitals had higher risk-adjusted severe maternal morbidity rates for mothers of all races and ethnicities.[48] Hospitals that had more than 50% of their deliveries be of Black mothers performed worse on

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[41] Gunja MZ, Tikkanen R, Seervai S, Colliins SR. What Is the Status of Women's Health and Health Care in the U.S. Compared to Ten Other Countries? The Commonwealth Fund. 2018. Available from: https://www.commonwealthfund.org/sites/default/files/2018-12/Gunja_status_womens_health_sb.pdf

[42] Petersen, Emily E., Nicole L. Davis, David Goodman, Shanna Cox, Nikki Mayes, Emily Johnston, Carla Syverson et al. "Vital signs: pregnancy-related deaths, United States, 2011–2015, and strategies for prevention, 13 states, 2013–2017." *Morbidity and Mortality Weekly Report* 68, no. 18 (2019): 423.

[43] Howell, Elizabeth A. "Reducing disparities in severe maternal morbidity and mortality." *Clinical obstetrics and gynecology* 61, no. 2 (2018): 387.

[44] Fryar, Cheryl D., Yechiam Ostchega, Craig M. Hales, Guangyu Zhang, and Deanna Kruszon-Moran. "Hypertension prevalence and control among adults: United States, 2015-2016." (2017).

[45] Howell, Elizabeth A., Natalia Egorova, Amy Balbierz, Jennifer Zeitlin, and Paul L. Hebert. "Black-white differences in severe maternal morbidity and site of care." *American journal of obstetrics and gynecology* 214, no. 1 (2016): 122-e1.

[46] Tucker, Myra J., Cynthia J. Berg, William M. Callaghan, and Jason Hsia. "The Black–White disparity in pregnancy-related mortality from 5 conditions: differences in prevalence and case-fatality rates." *American journal of public health* 97, no. 2 (2007): 247-251.

[47] Antony, Kathleen M., and Gary A. Dildy III. "Postpartum hemorrhage: The role of the Maternal–Fetal Medicine specialist in enhancing quality and patient safety." In *Seminars in perinatology*, vol. 37, no. 4, pp. 246-256. WB Saunders, 2013.

[48] Howell, Elizabeth A., Natalia Egorova, Amy Balbierz, Jennifer Zeitlin, and Paul L. Hebert. "Black-white differences in severe maternal morbidity and site of care." *American journal of obstetrics and gynecology* 214, no. 1 (2016): 122-e1.

12 of 15 delivery-related indicators, including maternal mortality and complicated vaginal and caesarian delivery, compared to hospitals serving more White patients.[49]

ACP believes that federal policies must be implemented to address and eliminate disparities in maternal mortality rates among Black, Indigenous, and other women who are at greatest risk. All people must have access to affordable, comprehensive, and nondiscriminatory public or private health care coverage that includes evidence-based care over the course of a woman's lifespan, including high-quality and patient-centered preconception, antenatal, delivery, postpartum, and other care and appropriate specialists and subspecialists. Federal policymakers should incentivize health care institutions to undertake safety and quality improvement activities that are shown to be effective in improving maternal and other health. ACP supports ongoing research, evaluation, and coverage of effective services, such as doulas and patient navigators. Federal policymakers must also support maternal mortality review committees (MMRCs) and other state or local programs to collect pertinent data, identify causes of maternal death, and develop and implement strategies with the goals of preventing pregnancy-related death and improving maternal outcomes.

Health Care for Indigenous Populations

Indigenous peoples have experienced historical structural inequalities including land seizure, forced relocation, and other forms of discrimination that have contributed to disparities in access to health care, poorer health outcomes, increased morbidities and mortality, and higher rates of poverty and incarceration compared to the rest of the country.[50] In recent years, Indigenous communities have experienced high rates of chronic diseases, higher mortality rates for almost every measured cause of death, high rates of infant mortality, and have a 5.5 year lower life expectancy than the national average.[51,52,53]

These disparities have arisen in-part from the historical trauma associated with decades of racism, discrimination, and violence; subsequent poor social drivers of health; the degradation of Indigenous traditions, culture, and society; and inadequate access to and insufficient funding of health care services for Indigenous populations. Given the geographic and ethnic diversity of

[49] Creanga, Andreea A., Brian T. Bateman, Jill M. Mhyre, Elena Kuklina, Alexander Shilkrut, and William M. Callaghan. "Performance of racial and ethnic minority-serving hospitals on delivery-related indicators." *American journal of obstetrics and gynecology* 211, no. 6 (2014): 647-e1.

[50] Solomon, Teshia G. Arambula, Rachel Rose Bobelu Starks, Agnes Attakai, Fatima Molina, Felina Cordova-Marks, Michelle Kahn-John, Chester L. Antone, Miguel Flores Jr, and Francisco Garcia. "The Generational Impact Of Racism On Health: Voices From American Indian Communities: Study examines the generational impact of racism on the health of American Indian communities and people." *Health Affairs* 41, no. 2 (2022): 281-288.

[51] Frizzell LB, Spencer K. American Indian and Alaska Native Policy Paper – NRHA – 2/3/2016. Accessed at www.health.umn.edu/sites/health.umn.edu/files/frizzell_nrha_paper_long_version.pdf.

[52] Sequist, Thomas D., Theresa Cullen, and Kelly J. Acton. "Indian Health Service innovations have helped reduce health disparities affecting American Indian and Alaska Native people." *Health Affairs* 30, no. 10 (2011): 1965-1973.

[53] United States Government Accountability Office, Indian Health Service. Agency faces ongoing challenges filling provider vacancies. Accessed at www.gao.gov/assets/700/693940.pdf.

Indigenous Peoples, their unique legal standing, their violent history at the hands of European settlers and the American state, and their experience of discrimination within American society, it is essential that appropriate and needed federal policy focus is given to these communities to address their distinct health and social challenges.

Historically, the federal government engaged with Indigenous tribes as sovereign nations, before eventually incorporating them into the American legal system with unique legal status as domestic, dependent tribes. As part of this process, transfers of tribal lands created treaty obligations requiring the federal government to provide for the well-being of tribes. This has resulted in a legally binding trust responsibility to provide health care services to Indigenous individuals, either directly through the Indian Health Service (IHS) or through federally funded, tribally managed programs, including Urban and Tribal programs. While these programs have made great strides in improving Indigenous health in some cases, their effectiveness have been limited due in part to insufficient funding by Congress. Despite providing care for a population that has experienced historical trauma and subsequent high rates of health problems, IHS only spends $4,078 per capita, compared to $8,109 by Medicaid, $10,692 by the Veterans Health Administration, and $13,185 by Medicare.[54] Services not directly provided by IHS are contracted out to private providers through the Purchased/Referred Care (PRC) program. Given IHS's limited and fixed funding, not all PRC requests are approved. In FY 2019, nearly $616 million in services, or roughly 156,000 cases, were deferred or denied.[55] Absent additional coverage, Indigenous patients must pay out of pocket when PRC requests are denied.

Access to care is further challenged by geographic isolation and health care workforce vacancies. IHS facilities face high vacancy rates for positions across the clinical care team, ranging from 13% to 31% by location.[56] Additionally, IHS turnover rate is 46%, which negatively impacts quality of and access to care, ability of the health system to build trust with the community, and morale.[57] Retention is challenging due to the rural location of many facilities, insufficient housing near facilities, and low salaries.

The quality of care at some IHS facilities, as well as outdated technology and equipment, is also of concern. While the average age of U.S. hospitals is 10 years, within IHS it is 37.5 years.[58] Long

[54] U.S. Government Accountability Office. Indian Health Service: spending levels and characteristics of IHS and three other federal health care programs. Accessed at www.gao.gov/assets/700/695871.pdf.
[55] U.S. Department of Health and Human Services. Fiscal year 2021. Indian Health Service. Justification of estimates for appropriations committees. Accessed at www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY_2021_Final_CJ-IHS.pdf
[56] United States Government Accountability Office, Indian Health Service. Agency faces ongoing challenges filling provider vacancies. Accessed at www.gao.gov/assets/700/693940.pdf.
[57] Frizzell LB, Spencer K. American Indian and Alaska Native Policy Paper – NRHA – 2/3/2016. Accessed at www.health.umn.edu/sites/health.umn.edu/files/frizzell_nrha_paper_long_version.pdf.
[58] Torres A, Joseph V, Abrahamson G. Reclaiming tribal health: a national budget plan to rise above failed policies and fulfill trust obligations to tribal nations. The National Tribal Budget Formulation Workgroup's

patient wait times have been reported at IHS facilities due to resource and staffing constraints.[59] Years of neglect have left IHS' electronic health record system (EHR) insufficient for latest standards, resulting in limited interoperability and a system that could be completely unsupportable in ten years.[60]

Indigenous households face high rates of negative social, environmental, and nutritional determinants of health. Approximately 48% of households on tribal lands do not have access to clean drinking water, sewage, or solid waste disposal,[61] and lack things like flush toilets, running water, bathing facilities, and kitchen sinks. Many with running water may rely on public water systems that do not meet EPA requirements. Inadequate plumbing and access to clean water has adverse implications for the health, education, and economy of Indigenous communities. One study concluded that for every dollar IHS spends on sanitation facilities there is at least a twentyfold return in health benefits.[62]

The federal government provides direct food assistance via the Food Distribution Program on Indian Reservations (FDPIR). FDPIR has faced criticism for providing recipients with unhealthy foods like lard, canned meats, white flour, salt, peanut butter, powdered milk, corn syrup, and sugar.[63,64] Some have called on the U.S. Department of Agriculture (USDA) to integrate more traditional foods, which are often lean and low in sugar, into FDPIR.[65,66]

Access to high-speed broadband internet continues to be limited for many Indigenous communities, particularly those in rural and remote areas, which has negative implications on access to telehealth services. While federal programs such as the Connect America Fund and

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recommendations on the Indian Health Service fiscal year 2022 budget. Accessed at www.nihb.org/docs/05042020/FINAL_FY22%20IHS%20Budget%20Book.pdf

[59] U.S. Government Accountability Office. Indian Health Service: actions needed to improve oversight of patient wait times. Accessed at www.gao.gov/assets/gao-16-333.pdf

[60] Cullen T, Demaree MA, Effler S. Closing the health disparity gap for American Indians and Alaska Natives through health IT modernization. Health Affairs Forefront. 27 January 2020. Accessed at www.healthaffairs.org/do/10.1377/forefront.20200122.299286/full/

[61] Democratic staff of the House Committee on Natural Resources. Water delayed is water denied: how Congress has blocked access to water for Native families. Accessed at https://naturalresources.house.gov/imo/media/doc/House%20Water%20Report_FINAL.pdf

[62] Indian Health Service. Safe water and waste disposal facilities. Accessed at www.ihs.gov/newsroom/factsheets/safewater/

[63] Warne, Donald, and Siobhan Wescott. "Social determinants of American Indian nutritional health." *Current developments in nutrition* 3, no. Supplement_2 (2019): 12-18.

[64] Warne, Donald, and Denise Lajimodiere. "American Indian health disparities: Psychosocial influences." *Social and Personality Psychology Compass* 9, no. 10 (2015): 567-579.

[65] Echo Hawk Consulting. Feeding ourselves: food access, health disparities, and the pathways to healthy Native American communities. 2015. Accessed at https://nebula.wsimg.com/891e74d1afe847b92abe87b2a1df7c63?AccessKeyId=2EF8ECC329760AC5A98D&disposition=0&alloworigin=1

[66] Sowerwine J, Mucioki M, Hillman L, et al. Restoring access to native foods can reduce tribal food insecurity: findings from a case study of food (in)security among the Karuk, Yurok, Hoopa and Klamath tribes in the Klamath River Basin of California and Oregon. Accessed at https://nature.berkeley.edu/karuk-collaborative/wp-content/uploads/2019/06/Native-Food-Insecurity-Policy-Brief_June-2019.pdf

the Rural Digital Opportunity Fund incentivize rural broadband, roughly 21% of individuals residing on tribal lands still lack broadband access.[67]

ACP believes community-driven public policy, developed under the leadership of Indigenous leaders and built upon existing resilience, is necessary to remedy the injustices, disparities, and inequities experienced by Indigenous individuals and communities. Federal policy must acknowledge the long history of racism, discrimination, abuse, forced relocation, destruction of elements of social structure, and other injustices experienced by Indigenous people. Health and wellness promotion, chronic disease prevention, and other public health interventions addressing morbidities with high incidence in Indigenous communities should be prioritized by federal policymakers. These interventions must be developed by or in collaboration with Indigenous Peoples and medical experts; evidence-based and evidence-informed; culture optimizing; and respectful of traditional values, beliefs, and practices. Federal policymakers, in partnership and collaboration with Indigenous Peoples and appropriate medical experts, should bolster and adequately invest in the health infrastructure that serves Indigenous individuals to ensure equitable access to high-quality, modern, and state-of-the-art health care. Federal policymakers must also team with Indigenous leaders to address the full range of underlying social drivers of health impacting Indigenous communities.

Underrepresentation in Medical Education and Workforce

After an initial increase in underrepresented in medicine (URM) medical school applicants and matriculants beginning in 2009, these increases have slowed down in recent years and in some cases become stagnant.[68,69] Data show during the 2018-2019 school year, over half (54.6%) of medical school graduates identified as White, almost one quarter (21.6%) identified as Asian American, and 8.0% identified as multiple races/ethnicities. Only 6.2% identified as Black or African American; compared to 5.3% as Hispanic, Latino, or of Spanish origin; 0.2% as American Indian or Alaska Native; and only nine graduates (0.1%) as Native Hawaiian or Pacific Islander.[70]

Numerous barriers have contributed to disproportionately low rates of URM individuals attending and graduating from medical school, including hostile and unwelcoming environments. Racial and ethnic minority students are more likely to report adverse medical school experiences as a result of their race due to discrimination, prejudice, feelings of

[67] 143 Federal Communications Commission. Fourteenth Broadband Deployment Report. Accessed at www.fcc.gov/reports-research/reports/broadband-progress-reports/fourteenth-broadband-deployment-report

[68] Boatright, Dowin H., Elizabeth A. Samuels, Laura Cramer, Jeremiah Cross, Mayur Desai, Darin Latimore, and Cary P. Gross. "Association between the Liaison Committee on Medical Education's diversity standards and changes in percentage of medical student sex, race, and ethnicity." *Jama* 320, no. 21 (2018): 2267-2269.

[69] Lett, Elle, H. Moses Murdock, Whitney U. Orji, Jaya Aysola, and Ronnie Sebro. "Trends in racial/ethnic representation among US medical students." *JAMA Network Open* 2, no. 9 (2019): e1910490-e1910490.

[70] AAMC Data Warehouse. Figure 13. Percentage of U.S. medical school graduates by race/ ethnicity (alone), academic year 2018-2019. AAMC. 2019. Available from: https://www.aamc.org/data-reports/workforce/interactive-data/figure-13-percentage-usmedical-school-graduates-race/ethnicity-alone-academic-year-2018-2019

isolation, and different cultural experiences and these students were more likely to report burnout, depressive symptoms, and low mental quality of life.[71] Additionally, some research suggests that medical school admissions committees display unconscious White preference, creating additional institutional barriers for URM students.[72] Several potential approaches to ameliorate racial disparities in medical school enrollment have been identified, including pathway programs to support URM students in the local community, additional financial aid, guaranteed admission mechanisms for local URM students, increased recruitment efforts at historically black colleges and universities, and additional support and resources for URMs on campus.[73]

In addition to the modest increases in the diversity of medical school student bodies, there has also been a small increase in the diversity of medical school faculty. Between 1966 and 2015, the proportion of URMs in assistance professorships, associate professorships, and professorships doubled, with more diversity for lower- than higher-ranked faculty. However, this increase is not keeping pace with U.S. population diversification nor with medical school student body diversification.[74,75] Higher rates of racial and ethnic minority faculty have been linked to improved cultural competence in graduates, more inclusive campus environments, more comprehensive research agendas, and improved patient care and can be an institutional driver of excellence.[76] Minority faculty also serve an important role as mentors and role models for URM medical students.[77]

Disproportionately low rates of URM students have unsurprisingly translated to an inadequately diverse health care workforce. In 2018, over half (56.2%) of practicing physicians identified as White, 17.1% as Asian American, 5.8% as Hispanic, and 5.0% as Black or African American, and 13.7% were unknown. Only 0.3% identified as American Indian or Alaska Native and 0.1% as Native Hawaiian or Pacific Islander.[78] Many barriers exist that make working in medicine a difficult—and sometimes threatening—environment for racial and ethnic minorities.

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[71] Dyrbye, Liselotte N., Matthew R. Thomas, Anne Eacker, William Harper, F. Stanford Massie, David V. Power, Mashele Huschka, Paul J. Novotny, Jeff A. Sloan, and Tait D. Shanafelt. "Race, ethnicity, and medical student well-being in the United States." *Archives of internal medicine* 167, no. 19 (2007): 2103-2109.

[72] Capers IV, Quinn, Daniel Clinchot, Leon McDougle, and Anthony G. Greenwald. "Implicit racial bias in medical school admissions." *Academic Medicine* 92, no. 3 (2017): 365-369.

[73] Racial Justice Report Card. White Coats 4 Black Lives. 2019. Available from: https://whitecoats4blacklives.org/wp-content/uploads/2019/08/RJRC-2019-Full-ReportFinal-8.28.19.pdf

[74] Xierali IM, Fair MA, Nivet MA. Faculty Diversity in U.S. Medical Schools: Progress and Gaps Coexist. AAMC. 2016Dec;16(6).

[75] Guevara, James P., Emem Adanga, Elorm Avakame, and Margo Brooks Carthon. "Minority faculty development programs and underrepresented minority faculty representation at US medical schools." *Jama* 310, no. 21 (2013): 2297-2304.

[76] Xierali IM, Fair MA, Nivet MA. Faculty Diversity in U.S. Medical Schools: Progress and Gaps Coexist. AAMC. 2016Dec;16(6).

[77] Hassouneh, Dena, Kristin F. Lutz, Ann K. Beckett, Edward P. Junkins Jr, and LaShawn L. Horton. "The experiences of underrepresented minority faculty in schools of medicine." *Medical education online* 19, no. 1 (2014): 24768.

[78] Figure 18. Percentage of all active physicians by race/ethnicity, 2018. AAMC. 2019. Available from: https://www.aamc.org/data-reports/workforce/interactive-data/figure18-percentage-all-active-physicians-race/ethnicity-2018

As many as 35% of residents in one survey reported being discriminated against in the workplace on the basis of race, culture, or gender.[79] Workplace discrimination can have negative mental health implications for health care professionals.[80]

The lack of medical school and workforce diversity has direct implications on patient care and health outcomes. URM physicians are more likely than White physicians to see patients in underserved communities, provide care to low-income patients and to those on Medicaid, and treat more racial and ethnic minority patients.[81,82] Additionally, racial and ethnic minority patients report higher quality care and higher care satisfaction when treated by a physician of the same racial or ethnic background. One study found that Black men who saw Black male doctors were more likely to opt for preventive screening tests, particularly those more invasive, and were more likely to discuss other health problems than those with White male doctors.[83] Another study found that newborn-physician racial concordance was associated with improvements in mortality for Black newborns.[84]

ACP strongly believes that a diverse, equitable, and inclusive physician workforce is crucial to promote equity and understanding among clinicians and patients and to facilitate quality care, and urges federal policymakers to undertake and support actions to achieve such diversity, equity, and inclusion. Federal policy should support the maintenance, reinstatement, and expansion of programs that provide outreach to encourage racial and ethnic minority enrollment in medical and other health professional schools, including diversity/minority affairs offices, scholarships, and other financial aid programs. To further increase access to medical education for those of all backgrounds, the federal government should develop or expand programs that provide scholarships and loan forgiveness to physicians linked to a reasonable service obligation in the field. Additional measures are needed to improve publicity about and the ease of the application process for scholarships, loan-forgiveness programs, and low-interest loan programs that require service in return for financial aid.

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[79] Crutcher, Rodney A., Olga Szafran, Wayne Woloschuk, Fatima Chatur, and Chantal Hansen. "Family medicine graduates' perceptions of intimidation, harassment, and discrimination during residency training." *BMC medical education* 11, no. 1 (2011): 1-7.

[80] Yuce, Tarik K., Patricia L. Turner, Charity Glass, David B. Hoyt, Thomas Nasca, Karl Y. Bilimoria, and Yue-Yung Hu. "National evaluation of racial/ethnic discrimination in US surgical residency programs." *JAMA surgery* 155, no. 6 (2020): 526-528.

[81] Walker, Kara Odom, Gerardo Moreno, and Kevin Grumbach. "The association among specialty, race, ethnicity, and practice location among California physicians in diverse specialties." *Journal of the National Medical Association* 104, no. 1-2 (2012): 46-52.

[82] Marrast, Lyndonna M., Leah Zallman, Steffie Woolhandler, David H. Bor, and Danny McCormick. "Minority physicians' role in the care of underserved patients: diversifying the physician workforce may be key in addressing health disparities." *JAMA internal medicine* 174, no. 2 (2014): 289-291.

[83] Alsan, Marcella, Owen Garrick, and Grant Graziani. "Does diversity matter for health? Experimental evidence from Oakland." *American Economic Review* 109, no. 12 (2019): 4071-4111.

[84] Greenwood, Brad N., Rachel R. Hardeman, Laura Huang, and Aaron Sojourner. "Physician–patient racial concordance and disparities in birthing mortality for newborns." *Proceedings of the National Academy of Sciences* 117, no. 35 (2020): 21194-21200.

Data Collection

Having access to racial level data is essential to identifying health trends among certain populations and offering targeted interventions and treatments in order to alleviate racial and ethnic health disparities. However, there are many challenges and shortcomings to current data collection practices and national standards that pose barriers to effectively using it for these purposes. Given that race and ethnicity are social rather than scientific constructs that lack a uniform understanding, and that an individual can identify with more than one race or ethnicity, definitional challenges exist that make them difficult to measure and meaningfully compare in research. Individuals may face limited race or ethnicity choices they do not identify with and inadequate sample sizes prohibit reliable estimates of smaller populations.

At the national level, the U.S. Office of Management and Budget (OMB) has standards on race and ethnicity categorization that the U.S. Census is required to use and is used in research funded by the National Institutes of Health.[85] OMB utilizes a two-part question format: respondents can self-identify with five racial categories, including American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, and White, as well as Hispanic or Latino ethnicity categories. Since 2000, the U.S. Census has allowed respondents to self-identify with more than one race and write in racial identities and in 2020, those who identify as White are requested to also write in their origins. There has been some criticism over the use of such broad racial and ethnicity categories. For example, the Asian category encompasses a vast region of peoples with varying religious and medical beliefs, diets, languages, and traditions and homogenizes a heterogeneous population.[86]

The U.S. Census Bureau's classification of people with roots in the Middle East or North Africa (MENA) as White has made it difficult for researchers to study the nuanced issues specific to that community, including health disparities that may be linked to concerns of discrimination and differing cultural beliefs.[87] Historically, those who wrote in MENA identities have been recoded as White by the federal government. However, Arab Americans have higher rates of LEP, poverty, housing instability, state surveillance, and discrimination than the general public.[88] Hence, the undercounting of MENA individuals has ramifications on the funding of and ability to target social services to address disparities specific to these communities.

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[85] Hayes-Bautista, David E., Mara Bryant, Michael Yudell, Teodocia Maria Hayes-Bautista, Keosha Partlow, Alice Beecher Popejoy, Esteban Burchard, and Paul Hsu. "Office of Management and Budget Racial/Ethnic Categories in Mortality Research: A framework for including the voices of racialized communities." *American journal of public health* 111, no. S2 (2021): S133-S140.

[86] Hasnain-Wynia, Romana, and David W. Baker. "Obtaining data on patient race, ethnicity, and primary language in health care organizations: current challenges and proposed solutions." *Health services research* 41, no. 4p1 (2006): 1501-1518.

[87] IOM (Institute of Medicine). 2009. Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement. Washington, DC: The National Academies Press

[88] Will You Count? Middle Eastern and North African Americans (MENA) in the 2020 Census. The Leadership Conference Education Fund. 2018. Available from: http://civilrightsdocs.info/pdf/census/2020/Fact-Sheet-MENA-HTC.pdf

Without adequate data for marginalized communities, it is impossible to know the full extent of the various social, economic, and health issues they face. **ACP believes federal policymakers must support additional research and data collection related to racial and ethnic health disparities in order to empower stakeholders to better understand and address disparities. Collected data must be granular and inclusive of all personal identities to more accurately identify socioeconomic trends and patterns.**

Structuring Payment Models to Ensure Equitable Access to Care

Socioeconomic factors remain one of the most clinically significant contributors to health outcomes in this country, yet the current fee-for-service (FFS) payment structure incentivizes volume and does not address such factors. As work continues to build on a flawed system based on FFS and relative value units, a more promising approach is to prospectively pay physicians and their clinical care teams a predetermined amount per patient per month (that is, prospected population-based payments or capitation). Another promising approach is to move to hybrid-type models that adjust for elements that affect the resources needed to achieve the best possible outcomes, including health status, risk, and the cost of caring for patients disproportionately affected by health disparities and social drivers of health that exacerbate those disparities.

Under any such payment model, it is essential that payment amounts be sufficient and appropriately adjusted to ensure access to needed care and address the unique health needs of racial and ethnic minority populations. Payments that are set at appropriate and sufficient amounts aid in ensuring access to care. Appropriate payments allow social drivers of health to be addressed by paying enough for primary care, specialist, and subspecialist practices to recruit and retain primary care physicians and clinicians and hire or partner with case managers, behavioral health clinicians, and others who can interface with community services and public health. Prospective payments must value primary and comprehensive care appropriately and be sufficient to cover the costs of treating patients, recognizing and supporting the additional resources involved in providing care to underserved patients and advancing health equity.

ACP believes that federal policymakers must support the adoption by public and private payers of population-based, prospective payment models for primary and comprehensive care that are structured and sufficient to ensure access to needed care and address the needs of racial and ethnic minorities experiencing health care disparities and inequities and/or are disproportionately impacted by social drivers of health. All payers should prioritize the inclusion of underserved patient populations and those who are disadvantaged by health care disparities and inequities and/or are disproportionately impacted by social drivers of health in all value-based payment models, including population-based prospective payment approaches. Hybrid models that combine FFS with prospective payment should be made available and should prioritize the needs of such individuals. Total compensation, FFS, and prospective payment combined should prioritize improving the total valuation of primary and comprehensive care.

Utilizing Telehealth to Increase Access to Care

The national emergency of the COVID-19 pandemic has demonstrated the need for a fundamental change in the way we think about how health care is delivered. Federal and state-level policies must be expanded to provide broader patient access to telehealth. Restrictions on where the patient or physician is located must be permanently removed. The way should be opened for telehealth services to be performed in a recipient's home or delivered remotely from a physician's home, ensuring that patient privacy is protected. Many of the most vulnerable patients benefit from telehealth services. All types of telemedicine, including telephone visits, play a critical role in preventing and stabilizing patients' primary care needs. Providing flexibility that allows health care clinicians participating in both Medicare and Medicaid to respond to their patients' needs is an essential step in caring for their broader patient population.

ACP believes that delivery and payment systems must fully support physicians, other clinicians, and health care facilities in offering all patients the ability to receive care when and where they need it in the most appropriate manner possible, whether that be via in-person visits, telehealth, audio only, or other means, particularly for those who are experiencing health care disparities and inequities and/or are disproportionately impacted by social drivers of health. Access to all care modalities for all patient populations should be supported via adequate payment levels, policies, and investments to improve how health care is organized. Such improvements should include prioritizing population health in communities that are experiencing health care disparities and inequities and/or are disproportionately impacted by social drivers of health.

Education

Disparities exist at all levels of education. At the primary and secondary education levels, disparities in resources can impact educational quality, opportunities, and outcomes. Education is an important social determinant of health[89] as it can determine access to safer neighborhoods, financial resources, employment opportunities (and in turn insurance coverage), and the skills and reasoning necessary for producing health.[90,91] More education has

[89] Hahn, Robert A., and Benedict I. Truman. "Education improves public health and promotes health equity." *International journal of health services* 45, no. 4 (2015): 657-678.
[90] Zajacova, Anna, and Elizabeth M. Lawrence. "The relationship between education and health: reducing disparities through a contextual approach." *Annual review of public health* (2018).
[91] Zimmerman E, Woolf SH. Understanding the Relationship Between Education and Health. Institute of Medicine of the National Academies. 2014. Available from: https://nam.edu/wp-content/uploads/2015/06/BPH-UnderstandingTheRelationship1.pdf

been associated with longer life expectancy,[92,93] lower mortality rates,[94] and lower rates of risk factors. Research suggests that the development of these forms of human capital that positively impact social drivers of health begin as soon as early childhood.[95] The effect of these primary and secondary education disparities have the potential to manifest into medical school disparities.

The American education system is rife with other racial disparities ranging from opportunities and access to discipline and outcomes. Schools in high- poverty areas, which are 80% Black or Hispanic, offered less access to college prep courses and fewer math and science courses expected by colleges. Fewer Black students were found to take advanced courses and dual-credit programs or have access to advanced tracked programs compared to White, and in some cases Asian American students.[96] Hispanic, Black, and American Indian and Alaska Native students had lower high school graduation rates as well as 6-year college graduation rates compared to White students,[97,98] while Black and Hispanic students had large achievement gaps in mathematics and reading compared to White students.[99] Black students are overrepresented among suspended public school students, while Black and Hispanic boys are transferred to alternative public schools for disciplinary reasons at rates higher than any other racial group comprise a larger proportion at alternative schools than regular public schools.[100,101]

Education funding in the U.S. comes from a combination of federal, state, and local sources. Federal spending accounts for about 10% of all education funding, with state and local governments nearly equally providing the remaining funds. At the local level, this is primarily

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[92] Sasson, Isaac, and Mark D. Hayward. "Association between educational attainment and causes of death among white and black US adults, 2010-2017." *Jama* 322, no. 8 (2019): 756-763.

[93] Why Education Matters to Health: Exploring the Causes. Center on Society and Health. Virginia Commonwealth University; 2015. Available from: https://societyhealth.vcu.edu/work/the-projects/why-education-matters-to-health-exploring-the-causes.html

[94] Hummer, Robert A., and Elaine M. Hernandez. "The effect of educational attainment on adult mortality in the United States." *Population bulletin* 68, no. 1 (2013): 1.

[95] Williams, David R., and Lisa A. Cooper. "Reducing racial inequities in health: using what we already know to take action." *International journal of environmental research and public health* 16, no. 4 (2019): 606.

[96] K-12 Education: Public High Schools with More Students in Poverty and Smaller Schools Provide Fewer Academic Offerings to Prepare for College. U.S. Government Accountability Office (U.S. GAO). 2018. Available from: https://www.gao.gov/products/GAO-19-8

[97] Public High School Graduation Rates. The Condition of Education - Preprimary, Elementary, and Secondary Education - High School Completion - Public High School Graduation Rates - Indicator May (2020). NCES; 2020. Available from: https://nces.ed.gov/programs/coe/indicator_coi.asp

[98] Indicator 23: Postsecondary Graduation Rates. Status and Trends in the Education of Racial and Ethnic Groups. NCES; 2019. Available from: https://nces.ed.gov/programs/ raceindicators/indicator_red.asp

[99] de Brey, Cristobal, Lauren Musu, Joel McFarland, Sidney Wilkinson-Flicker, Melissa Diliberti, Anlan Zhang, Claire Branstetter, and Xiaolei Wang. "Status and Trends in the Education of Racial and Ethnic Groups 2018. NCES 2019-038." *National Center for Education Statistics* (2019).

[100] K-12 Education: Discipline Disparities for Black Students, Boys, and Students with Disabilities. U.S. Government Accountability Office (U.S. GAO). 2018. Available from: https://www.gao.gov/products/GAO-18-258

[101] K-12 Education: Certain Groups of Students Attend Alternative Schools in Greater Proportions Than They Do Other Schools. U.S. Government Accountability Office (U.S. GAO). 2019. Available from: https://www.gao.gov/products/GAO-19-373

through property taxes.[102,103] Slavery and its aftermath, as well as discrimination and racist policies like redlining, have resulted in high degrees of racial segregation throughout the country and racial economic disparities. At their intersection, racial and ethnic minority communities have less wealth in their neighborhoods and a smaller tax base to draw from in funding local schools. Local property taxes are a biased funding mechanism that systematically perpetuate inequities.

While education reform is a broad and complex issue requiring a multifaceted approach, ACP believes that education must be strengthened at all levels to improve health, health literacy, and diversity in medical education and in the physician workforce and must prioritize policies to address the disproportionate adverse effect of discrimination and inequitable financing in education on racial and ethnic minority communities. Federal public policy must support the implementation of new and innovative funding mechanisms at the federal, state, and local level to address biases in resource allocation that contribute to education disparities. Schools should be sufficiently funded and evidence-based practices shown to be effective in strengthening educational quality and results for all students should be supported. All students should have equitable access to experienced and qualified teachers, a rigorous evidence-based curriculum, extracurricular activities, and educational materials and opportunities. Instruction should be culturally and linguistically competent for the population served.

Criminal Justice

There are wide-ranging racial and ethnic disparities throughout the criminal justice system, from law enforcement interactions to courtrooms and prisons. Those who are Black, Indigenous, and Latinx are stopped, searched, and arrested at disproportionately high rates.[104] Unconscious associations between Blackness, criminality, and guilt have been found among the general public,[105] potentially contributing to higher rates of incarceration and other sentencing disparities in the courtroom.[106,107] Further, racial and ethnic minorities are disproportionately represented in capital punishment sentences.[108] Of these cases, roughly one third of the cases

[102] How do school funding formulas work? Urban Institute. 2017. https://apps.urban.org/features/funding-formulas/

[103] Educational Finance Branch. Public Education Finances: 2015. Washington, DC: U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau; 2017

[104] The Stanford Open Policing Project: Findings. The Stanford Open Policing Project. Available from: https://openpolicing.stanford.edu/findings/

[105] Eberhardt, Jennifer L., Phillip Atiba Goff, Valerie J. Purdie, and Paul G. Davies. "Seeing black: race, crime, and visual processing." *Journal of personality and social psychology* 87, no. 6 (2004): 876.

[106] Mauer M. Addressing Racial Disparities in Incarceration. The Sentencing Project. 2011. Available from: https://www.sentencingproject.org/publications/addressing-racialdisparities-in-incarceration/

[107] Nellis A. The Color of Justice: Racial and Ethnic Disparity in State Prisons. The Sentencing Project. 2019. Available from: https://www.sentencingproject.org/publications/color-ofjustice-racial-and-ethnic-disparity-in-state-prisons/

[108] Segura L, Smith J. By Any Measure, Capital Punishment Is a Failed Policy. Counting the Condemned. The Intercept; 2019. Available from: https://theintercept.com/2019/12/03/death-penalty-capital-punishment-data/

were resentenced due to flawed prosecutions, resulting in the release of at least 333 people and exoneration of 132.

The impact of incarceration and other interactions with the criminal justice system on health is well documented. Public health researchers have identified five intersecting avenues in which violence by law enforcement impacts health: "fatal injuries that increase population-specific mortality rates; adverse physiological responses that increase morbidity; racist public reactions that cause stress; arrests, incarcerations, and legal, medical, and funeral bills that cause financial strain; and integrated oppressive structures that cause systematic disempowerment."[109] Data suggest that African American and American Indian/Alaska Native women and men are killed by law enforcement at higher rates than White women and men, and Latinx men are killed at higher rates than White men. African American men are 2.5 times more likely to be killed by law enforcement than White men.[110]

Short of direct loss of life, law enforcement encounters can cause other negative health effects. Residents disproportionately affected by stop-and-frisk in New York City have been found to have worse health indicators, such as high blood pressure, diabetes, self-reported health status, and asthma.[111] Discrimination, perceived and experienced, has been associated with risk for hypertension and cardiovascular disease[112] and unhealthy behaviors.[113] Law enforcement violence and racial discrimination also has mental health implications[114] and can induce psychological distress[115,116] and depression.[117,118] In a study of young men in New York City, the frequency and intrusiveness of police interactions was positively associated with trauma and

[109] Alang, Sirry, Donna McAlpine, Ellen McCreedy, and Rachel Hardeman. "Police brutality and black health: Setting the agenda for public health scholars." *American journal of public health* 107, no. 5 (2017): 662-665.
[110] Edwards, Frank, Hedwig Lee, and Michael Esposito. "Risk of being killed by police use of force in the United States by age, race–ethnicity, and sex." *Proceedings of the National Academy of Sciences* 116, no. 34 (2019): 16793-16798.
[111] Sewell, Abigail A., and Kevin A. Jefferson. "Collateral damage: the health effects of invasive police encounters in New York City." *Journal of Urban Health* 93, no. 1 (2016): 42-67.
[112] Krieger, Nancy, and Stephen Sidney. "Racial discrimination and blood pressure: the CARDIA Study of young black and white adults." *American journal of public health* 86, no. 10 (1996): 1370-1378.
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anxiety symptoms.[119] Another study of African American residents in Baltimore found associations of police actions with significant stress and worry that threatened social cohesion and health.[120]

In addition to law enforcement officer encounters, incarceration and interaction with the criminal justice system can function as a social determinant of health and impact health at the personal, familial, and community levels.[121] Incarceration is associated with high rates of numerous health conditions, mortality, and morbidity.[122,123] Correctional health resources can be limited; food is often of low nutrition; and physical facility conditions, such as overcrowding or solitary confinement, may worsen chronic and mental health conditions.[124] Evidence suggests those with mental illness[125] and substance use disorders[126] experience better outcomes when treated in a community rather than a correctional setting. At the familial level, nearly 2.7 million children in the U.S. have an incarcerated parent,[127] an adverse childhood event that is associated with poorer mental and physical health later in adulthood.[128]

Various federal policies contribute to the negative health impacts criminal justice and law enforcement can disproportionately pose on racial and ethnic minorities. Vague, weak, and inadequate use-of-force policies create situations that unnecessarily increase the risk for

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civilian death during police encounters.[129,130] Through weakening of the *Posse Comitatus Act*, enactment of *the National Defense Authorization Act*, and the 1033 program, local police departments have been able to obtain surplus military equipment.[131] The availability of this equipment has been associated with disproportionate use of force and extrajudicial murders by officers in marginalized communities.[132,133] Militarization of police has not increased police officer safety or reduced violent crime, but it has resulted in the erosion of public opinion toward police,[134] although some research suggests it has reduced certain street-level crimes.[135]

Cash bail policies can also unnecessarily expose individuals to the criminal justice system, and subsequent negative health effects. Due to cash bail policies, 65% of the jail population in the U.S. is made up of unconvicted defendants awaiting trial, or nearly 500,000 people per day,[136] 43% of whom are Black and 20% Hispanic. Further, 65% of those held in pretrial detention were held on nonviolent charges and 20% were held on minor public-order offenses.[137] Cash bail criminalizes poverty by jailing those who cannot afford to pay and disproportionately impacts racial and ethnic minority communities. Racial disparities in law enforcement practices can result in disproportionate arrest rates, translating to higher rates of pretrial detention given lower access to credit and wealth. Black persons and Latinx persons receive bail amounts that are 35% and 19%, respectively, higher on average and are more likely to be detained than White persons under similar circumstances, and Black persons are less likely to receive alternatives to cash bail.[138,139,140]

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At the same time policymakers uphold flawed criminal justice policies, they fail to adequately invest in community well-being and social factors that underlie crime. As a percentage of GDP, the U.S. spends more on policing and less on social services compared to other nations[141,142] and incarcerates more people total and per capita than any other country in the world.[143] There is an opportunity to reduce the potential for violent law enforcement encounters by funding programs that address the social drivers of health that underlie the propensity to commit a crime. Things like education,[144] employment,[145] housing,[146] and income[147] are all socioeconomic factors that are associated with crime rates. By redirecting investments into communities to mitigate some of the root causes of crime, the origins of potential violent interactions with law enforcement could be eliminated.

ACP believes that federal policymakers must understand, address, and implement evidence-based solutions to systemic racism, discrimination, and violence in criminal justice and law enforcement policies and practices that disproportionately negatively affect the physical health, mental health, and well-being of racial and ethnic minorities. Criminal justice law, policies, and practices should be examined and studied for racial impact and overhauled if they result in unnecessary or disproportionate harm. Federal policymakers should incentivize and require law enforcement authorities to incorporate best practices to eliminate excessive use of force, reevaluate use of force policies, establish parameters around reasonable force, and delineate between acceptable and excessive force. Racial and ethnic disparities in rates of law enforcement interactions, incarceration, and severity in sentencing, including capital offenses, should be tracked and reported at the local, federal, and state levels, and steps must be taken to eliminate them. All persons should have access to high-quality and affordable legal defense and funding should be increased for public defender representation. Priority should be given to reducing the health risks associated with incarceration while ensuring public safety and justice by implementing of alternatives to cash bail, incarceration, and other criminal penalties where appropriate.

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Conclusion

The historically intertwined nature of race, discrimination, and socioeconomic status has translated to numerous disparities in health and health care. Racial and ethnic minorities face their own unique needs and challenges that require federal policymakers to prioritize and support tailored, culturally appropriate, community-supported, and evidence-based interventions. ACP appreciates the National Academies' attention on this crucial issue and its commitment to identifying federal policies that exacerbate and ameliorate racial and ethnic disparities in health and health care. These efforts are a critical step forward, and the College stands ready to work with the National Academies to advocate for federal public policy change to achieve health equity in the United States. Please contact Josh Serchen, Associate, Health Policy at jserchen@acponline.org if you have any questions or need any additional information.

Sincerely,

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