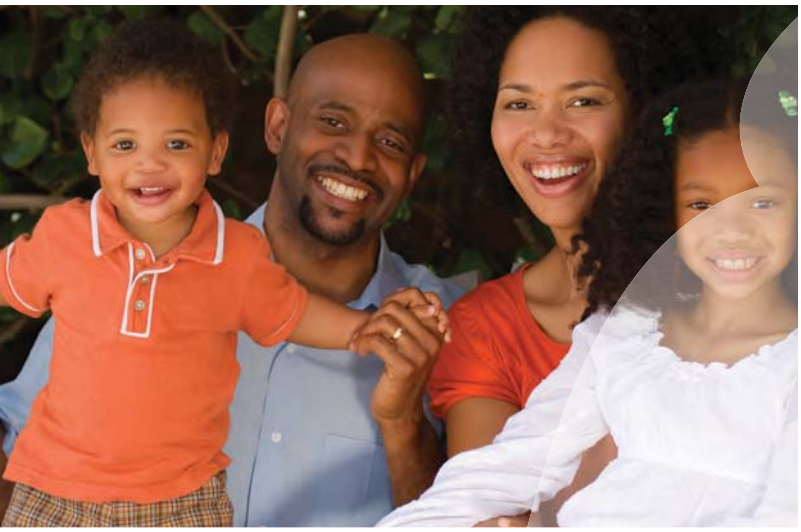
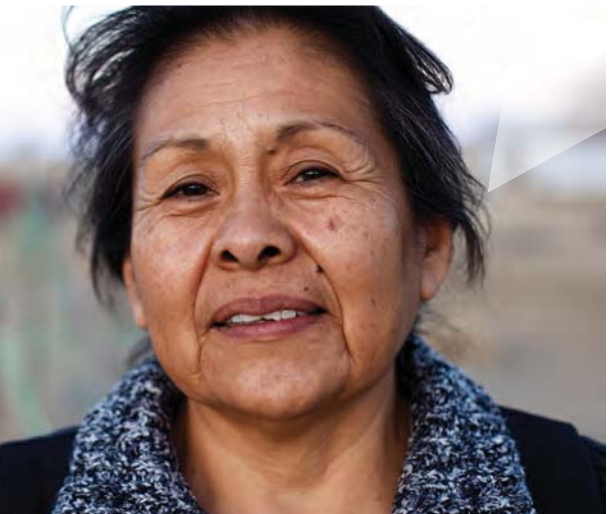
JOINT CENTER FOR POLITICAL AND ECONOMIC STUDIES

THE ECONOMIC BURDEN OF HEALTH INEQUALITIES IN THE UNITED STATES





The Joint Center Health Policy Institute is generously supported by a grant from the W.K. Kellogg Foundation.

THE ECONOMIC BURDEN OF HEALTH INEQUALITIES IN THE UNITED STATES

Thomas A. LaVeist, Ph.D.
Darrell J. Gaskin, Ph.D.
Patrick Richard, Ph.D.

September 2009

FOREWARD

Not everyone in the United States enjoys the same health opportunities. Studies show that minority Americans experience poorer than average health outcomes from cradle to the grave. They are much more likely to die as infants, have higher rates of diseases and disabilities, and have shorter life spans.

As the U.S. Congress and the Obama Administration work toward enactment of legislation to reform America's health care system, a central focus of the debate has been the projected cost of ensuring accessible and affordable health care to every citizen. While some have struggled with the premise that health care reform can actually reduce health-related spending, the experience of racial and ethnic minorities under our current health care system is a strong indication that improving opportunities for good health – and minimizing inequities in health care access and outcomes – may well be good for the nation's fiscal health, as well.

This study, commissioned by the Joint Center for Political and Economic Studies and carried out by leading researchers from Johns Hopkins University and the University of Maryland, provides important insight into how much of a financial burden racial disparities are putting on our health care system and society at large. The researchers examined the direct costs associated with the provision of care to a sicker and more disadvantaged population, as well as the indirect costs of health inequities such as lost productivity, lost wages, absenteeism, family leave, and premature death.

What they found was striking. More than 30 percent of direct medical costs faced by African Americans, Hispanics, and Asian Americans were excess costs due to health inequities – more than $230 billion over a four year period. And when you add the indirect costs of these inequities over the same period, the tab comes to $1.24 trillion.

As legislators look for ways to make health reform pay for itself, it appears that eliminating health inequities can provide an important source of savings. In addition, given the Census Bureau's estimate that by 2042 half of the people living in the United States will be people of color, it is imperative that we be prepared to address the health needs of an increasingly diverse population. There is no time like the present to begin focusing on the goal of health equity – a goal that is not only consistent with the American promise of opportunity, but in our long-term economic interest, as well.

Ralph B. Everett, Esq.
President and CEO
Joint Center for Political and Economic Studies

EXECUTIVE SUMMARY

We estimated the economic burden of health disparities in the United States using three measures: (1) direct medical costs of health inequalities, (2) indirect costs of health inequalities, and (3) costs of premature death. Our analysis found:

- Between 2003 and 2006 the combined costs of health inequalities and premature death in the United States were $1.24 trillion.
- Eliminating health disparities for minorities would have reduced direct medical care expenditures by $229.4 billion for the years 2003-2006.
- Between 2003 and 2006, 30.6% of direct medical care expenditures for African Americans, Asians, and Hispanics were excess costs due to health inequalities.
- Eliminating health inequalities for minorities would have reduced indirect costs associated with illness and premature death by more than one trillion dollars between 2003 and 2006.

INTRODUCTION

On the basis of a compelling social justice argument, government and philanthropy have devoted significant resources to develop research and interventions for addressing inequalities in health status and health care. The moral imperative of addressing health and health care inequalities was brought to the forefront of the public consciousness by the release of the Institute of Medicine's 2002 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* However, while there is a convincing social justice argument for confronting racial and ethnic health inequalities, there are also economic consequences associated with having a large segment of society suffer higher rates of illness and premature death and face inadequate access to quality health care.

Racial and ethnic disparities in health and health care impose costs on many parts of society, including individuals, families, communities, health care organizations, employers, health plans, and government agencies, including, of course, Medicare and Medicaid. These costs include direct expenses associated with the provision of care to a sicker and more disadvantaged population as well as indirect costs such as lost productivity, lost wages, absenteeism, family leave to deal with avoidable illnesses, and lower quality of life. Premature death imposes significant costs on society in the form of lower wages, lost tax revenues, additional services and benefits for families of the deceased, and lower quality of life for survivors. The direct and indirect costs of health inequalities to the economy have not been quantified, but are likely to be substantial.

Annually, the United States spends over $2.2 trillion, or 16% of gross domestic product, on health care (Borger et al. 2006; Poisal et al. 2007). How much should society pay to eliminate health inequalities? The answer to this question depends on two factors: (1) what value does society place on equity, and (2) what cost does society bear by having health inequalities?

In this report we employ econometric analysis to estimate the direct medical costs and indirect costs to the economy of health inequalities. By doing so, we estimate the potential financial benefit that would accrue to the economy if every racial/ethnic group in the United States had similar health outcomes.

STUDY METHODS

We conducted three sets of analysis: direct medical costs of inequalities, indirect costs of health inequalities, and costs of premature death. See Appendix A for a more detailed description of the research methods.

Direct medical costs – We used data from the Medical Expenditure Panel Survey (MEPS) (Cohen et al. 1996/97) for the years 2002-2006 to estimate the potential cost savings of eliminating health disparities for racial and ethnic minorities. We first divided the sample into 14 cohorts based on gender and seven age groups: 18-24, 25-34, 35-44, 45-54, 55-64, 65-74, and 75 and over. We then determined which racial/ethnic group had the best health outcomes within each age/gender group. In most cases it was whites or Asians, but in a few cases Hispanics had the best health profile within a given age/gender group. We developed a model to estimate health care expenditures for each racial/ethnic group (African American, Asian, Hispanic, and white) using each racial/ethnic group's actual health status as recorded in MEPS. Then we re-estimated the model assuming that each racial/ethnic group had health status equal to that of the racial/ethnic group with the best health status in its age/gender group. The difference in the two models represents the potential direct medical cost savings if every racial/ethnic group had health outcomes equal to the racial/ethnic group with the best health outcomes.

Total expenditures in the MEPS include both out-of-pocket and third-party payments to health care providers but do not include health insurance premiums. Expenditures for hospital-based services include those for both facility and separately billed physician services. Total expenditures include inpatient, emergency room, outpatient (hospital, clinic, and office-based visits), prescription drugs, and other (e.g., home health services, vision care services, dental care, ambulance services, and medical equipment). Prescription drug expenditures do not include over-the-counter purchases.

Indirect costs of health inequalities – We used data from the MEPS for the years 2002-2006 to estimate productivity loss associated with health inequalities for racial/ethnic minorities. First, we used data from the 2002 MEPS to develop a two-part model to estimate days of work lost by adults due to a disability or illness. We predicted disability days using demographic, socioeconomic, location, and health status measures. We used the model to estimate the number of lost workdays due to an illness or disability during 2003-2006. Then we estimated the number of disability days for 2003-2006 with health inequalities eliminated. We compared this prediction of the number of disability days for 2003 to 2006 with an estimate that assumed each racial/ethnic group had health status equal to that of the racial/ethnic group with the best health profile within each age/gender group (there were seven age/gender groups: 18-24, 25-34, 35-44, 45-54, 55-64, 65-74, and 75 and over).

Costs of premature death – We used data from the National Vital Statistics Reports (Heron et al. 2009) to obtain the number of deaths and crude death rates by age and race for 2003 to 2006 (the data included seven age groups: 18-24, 25-34, 35-44, 45-54, 55-64, 65-74, and 75 and over). We then estimated the number of deaths that would have occurred for each racial/ethnic group if every group's death rate were equal to that of the racial/ethnic group with the lowest death rate within the age/gender category. The difference between the actual number of deaths and the estimated deaths represents "excess deaths." We computed number of years of life loss in each racial/ethnic groups by assuming that all persons would have lived to age 75 had they not died prematurely. We valued each year of life loss at $50,000 (Hirth et al. 2000). This figure is based on the standard value used in cost-effectiveness analysis for medical intervention. Given that recent studies have valued a quality-adjusted life year at $95,000 to $264,000 (Braithwaite et al. 2008), $50,000 is a conservative estimate.

To obtain total indirect costs, we summed the costs associated with illness with the costs of premature death. We computed the cost savings in current dollars and constant 2008 dollars using conversion factors published by the Bureau of Labor Statistics.

STUDY FINDINGS

Estimating direct medical costs of health inequalities – Eliminating health disparities for minorities would have reduced direct medical care expenditures by $229.4 billion for the years 2003-2006 (see Table 1). More than 59% of these excess expenditures were attributable to African Americans, who have the worst health profile among the racial/ethnic groups. Health inequalities among African Americans led to $135.9 billion in excess direct medical costs between 2003 and 2006. The potential direct medical cost savings for Hispanics was $82.0 billion over the same time period, representing 35.7% of the total direct medical costs of health inequalities. Asians accounted for $11.4 billion, about 5% of excess direct medical expenditures.

Table 1
Estimated excess direct medical care expenditures due to health inequalities, 2003 to 2006, constant 2008 dollars (billions)†

	African Americans	Asians	Hispanics	Total
2003	35.2	3.6	17.6	**56.3**
2004	32.0	2.7	18.2	**53.8**
2005	32.8	2.9	22.4	**58.2**
2006	34.9	2.2	23.9	**61.1**
Total	135.9	11.4	82.0	**229.4**

† All expenditures are standardized to 2008 dollars.
Source: Based on calculations using the Medical Expenditure Panel Survey 2003-2006.

In Table 2 we present estimates for total direct medical care expenditures incurred by African Americans, Asians, and Hispanics combined for 2003 through 2006 and compute the percentage of the medical care expenditures incurred for racial/ethnic minorities that can be attributed to the excess costs of health inequalities. Between 2003 and 2006, 30.6% of direct medical care expenditures were excess costs due to health inequalities.

Table 2
Estimated excess direct medical care expenditures due to health inequalities as a percent of the total expenditures for racial/ethnic minorities, 2003 to 2006, constant 2008 dollars (billions)†

Year	Total expenditures for minorities	Excess expenditures	Percent that is excess
2003	201.1	56.3	28.0%
2004	168.9	53.8	31.8%
2005	187.6	58.2	31.0%
2006	191.4	61.1	31.9%
Total	749.0	229.4	30.6%

† All expenditures are standardized to 2008 dollars.
Source: Based on calculations using the Medical Expenditure Panel Survey 2003-2006.

Estimating indirect costs of health inequalities – Eliminating health inequalities for minorities would have reduced indirect costs associated with illness and premature death by more than one trillion dollars between 2003 and 2006. Health disparities impose two types of indirect costs on society: (1) lower worker productivity, and (2) losses from premature death. We estimated the potential reduction in indirect costs if racial health inequalities did not exist (see Table 3).

Table 3
Estimated excess indirect costs to the economy due to health inequalities, 2003-2006, constant 2008 dollars (billions)†

	African Americans	Asians	Hispanics	Total
2003				
Illness	9.1	0.6	3.7	13.3
Premature death	185.6	0	50.6	236.1
Total	194.6	0.6	54.2	249.4
2004				
Illness	7.9	0.1	3.7	11.7
Premature death	185.6	0	51.4	237.0
Total	193.5	0.1	55.1	248.7
2005				
Illness	10.0	-0.3	3.6	13.2
Premature death	186.9	0	54.3	241.1
Total	196.9	-0.3	57.9	254.5
2006				
Illness	9.6	-0.3	2.7	12.0
Premature death	188.2	0	55.0	243.1
Total	197.8	-0.3	57.7	255.1
Four-year total				
Illness	36.6	0.1	13.7	50.3
Premature death	746.2	0.0	211.3	957.5
Total	782.8	0.1	225.0	1,007.9

† All expenditures are standardized to 2008 dollars.
Sources: Based on calculations using the Medical Expenditure Panel Survey 2003-2006.

About 95% of the indirect costs of health inequalities ($957.5 billion) were due to the costs of premature deaths, while the remaining $50.3 billion resulted from illness. African Americans accounted for $782.8 billion, or more than 77% of all indirect costs attributable to health inequalities. Hispanics and Asians accounted for 22.3% and 0.03%, respectively, of indirect costs. As for the indirect costs of illness, nearly 73% were incurred among African Americans, compared to 27.2% for Hispanics.

COMMENT

Between 2003 and 2006 the combined direct and indirect cost of health inequalities in the United States was $1.24 trillion (in 2008 inflation-adjusted dollars). This is more than the gross domestic product of India, the world's 12th-largest economy in 2008 (World Bank 2008), and equates to $309.3 billion annually lost to the economy.

Sometimes the tremendous human suffering of health inequalities can be obscured by analysis such as was conducted for this report. However, it is not our intent that the utilitarian argument replace moral deliberation or the application of social justice. We should address health disparities because such inequities are inconsistent with the values of our society. Addressing them is the right thing to do. However, what our analysis shows is that social justice can be cost effective.

The large number of premature deaths represents a substantial loss of human potential, a loss of talent and productivity that might otherwise have contributed to the betterment of society. By exacting a substantial burden on the economy, health inequalities visit further suffering on society.

Usually we think of change as coming with costs, that doing something will cost more than doing what we are accustomed to doing. But in the case of health inequalities, doing nothing has a cost we should not continue to bear.

REFERENCES

Agency for Healthcare Research and Quality. 2006. *National Healthcare Disparities Report.* Rockville, MD: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. AHRQ Pub. No. 07-0012.

Borger C, Smith S, Truffer C, Keehan S, Sisko A, Poisal J, Clemens MK. 2006. "Health Spending Projections Through 2015: Changes on the Horizon." *Health Affairs* 25: w61–w73.

Braithwaite RS, Meltzer DO, King JT, Leslie D, Roberts MS. 2008. "What Does the Value of Modern Medicine Say About the $50,000 per Quality-Adjusted Life-Year Decision Rule?" Medical Care 46: 349–356.

Buntin MB, Zaslavsky AM. 2004. "Too Much Ado About Two-Part Models and Transformation? Comparing Methods of Modeling Medicare Expenditures." *Journal of Health Economics* 23: 525–542.

Cameron AC, Trivedi PK. 2008. *Microeconometrics Methods and Applications.* New York, NY: Cambridge University Press.

Cohen JW, Monheit AC, Beauregard KM, et al. 1996/1997. "The Medical Expenditure Panel Survey: A National Health Information Resource." *Inquiry* 33: 373–389.

Duan N. 1983. "Smearing Estimate: A Nonparametric Retransformation Method." *Journal of the American Statistical Association* 78:605–610.

Duan N, Manning WG, Morris N, Newhouse JP. 1983. "A Comparison of Alternative Models for Demand for Medical Care." *Journal of Business and Economic Statistics* 1: 115–126.

Greene WH. 2005. *Econometric Analysis.* Upper Saddle River: NJ: Prentice Hall.

Heron MP, Hoyert DL, Murphy SL, Xu JQ, Kochanek KD, Tejada-Vera B. 2009. "Deaths: Final Data for 2006." National Vital Statistics Reports 57(14). Hyattsville, MD: National Center for Health Statistics.

Hirth RA, Chernew ME, Miller E, et al. 2000. "Willingness to Pay for a Quality-Adjusted Life Year: In Search of a Standard." *Medical Decision Making* 20: 332–342.

Humphreys JM. 2008. "The Multicultural Economy: 2008." Selig Center for Economic Growth, Terry College of Business, University of Georgia.

Manning WG, Mullahy J. 2001. "Estimating Log Models: To Transform or Not to Transform?" *Journal of Health Economics* 20(4): 461–494.

Poisal JA, Truffer C, Smith S, Sisko A, Cowan C, Keehan S, Dickensheets B, and the National Health Expenditure Accounts Projections Team. 2007. "Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact." *Health Affairs* 26(2): w242–w253.

Smedley BD, Stith AY, Nelson AR, eds. 2002. "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care." Washington DC: National Academy Press.

World Bank. 2009. "The World Bank: World Development Indicators Database, 1 July 2009, Gross Domestic Product (2008)." http://siteresources.worldbank.org/DATASTATISTICS/Resources/GDP.pdf (retrieved 2 September 2009).

APPENDIX 1 DETAILED STUDY METHODOLOGY

ESTIMATING THE DIRECT MEDICAL COSTS OF HEALTH INEQUALITIES

We used data from the Medical Expenditure Panel Survey (MEPS) for the years 2002-2006 to estimate the potential cost savings of eliminating health disparities for racial and ethnic minorities. The MEPS, a longitudinal survey that covers the United States civilian noninstitutionalized population, is fielded by the Agency for Healthcare Research and Quality based on a sampling frame of the National Health Interview Survey. The survey is widely used as an authoritative source of information on the nation's health care use, and AHRQ uses it to monitor the nation's progress on health care disparities (AHRQ 2006). More information about the MEPS is available at the website www.meps.ahrq.gov/mepsweb.

We developed our model of health care expenditures using the 2002 MEPS data and then used this model to estimate potential reductions in health care expenditures when health disparities are eliminated in the 2003-2006 MEPS data. To compute these costs, we conducted the following analysis. We used data from the 2002 MEPS to develop a model to predict health care expenditures for adults. We predicted health care spending using demographic, socioeconomic, location, and health status measures. The demographic factors were age, race/ethnicity, and gender. The socioeconomic factors were education, income, and health insurance status. The location factors were census region and urban-rural residence. The health status measures were:

- Self-reported general health status (ranging from excellent to poor)
- Self-reported mental health status (ranging from excellent to poor)
- Presence of a functional limitation
- Number of instrumental activities of daily living (IADL)
- Number of activities of daily living (ADL)
- Body mass index (BMI)/obesity measure
- Presence of chronic conditions (diabetes, asthma, asthma attack, high blood pressure, heart attack, angina, other heart disease, stroke, emphysema, joint pain, or arthritis.

We estimated a standard two-part model on the 2002 MEPS data (Buntin and Zaslavsky 2004). First, we estimated the probability of having nonzero health care expenditures during the year. Second, we estimated a log linear regression model where the dependent variable was the log of expenditures for those adults who had nonzero health care expenditures. We used a log model to address the skewness in the expenditure data. We eliminated outliers, i.e., observations with expenditures greater than $62,000. We restricted the sample to adults, i.e., persons over the age of 17. The 2002 model was estimated on a sample of 26,312. We estimated the models using the survey regression procedure in STATA 10, which appropriately incorporates the design factors and sample weights. We applied specification and diagnostic tests of heteroskedasticity (the variance of the error term is not constant) as recommended by Manning and Mullahy (2001). We then applied this model to MEPS data from 2003-2006 to predict health care expenditures.

For each year from 2003 to 2006, we prepared two estimates of health care expenditures. The first predicted health care expenditures based on each respondent's actual health status. The second simulated health care expenditures when health disparities by race and ethnicity were eliminated. To eliminate health disparities we assigned each race and ethnic group the health profile for the race/ethnic group with the best health profile (in most cases Asians). To identify the best health profile, we pooled the 2003 through 2006 MEPS and divided the sample into 14 age-gender cohorts. There were seven age groups: 18-24, 25-34, 35-44, 45-54, 55-64, 65-74, and 75 and over. For each cohort we computed the average health profile of whites, blacks, Hispanics, and Asians. To create the best health profile, we took the best value for each health status/condition measure.

We assigned persons the best health profile values for the health status/condition variables for their cohort and took their values for the other independent variables along with the coefficients from the regression model to compute simulated health care expenditures. We used age-gender cohort-specific smearing factors to retransform the predicted log expenditures and the simulated log expenditures (Duan 1983; Duan et al. 1983). We subtracted the simulated results from the predicted results to compute the cost of health disparities. Using conversion factors published by the Bureau of Labor Statistics, we computed the cost savings in current dollars and constant 2008 dollars.

In addition, we computed similar cost estimates by applying the health status profile of the white population to each racial/ethnic group. The estimated cost savings are lower, $43.8 billion in 2006 and $173.8 billion over the four-year period. In this scenario, cost savings for Asians and Hispanics fall because some Asian/Hispanic cohorts were healthier than their white counterparts.

ESTIMATING THE INDIRECT SOCIETAL COSTS OF HEALTH DISPARITIES

Estimating the Indirect Costs of Illness

We used MEPS data for the years 2002-2006 to estimate productivity loss associated with health disparities for racial and ethnic minorities. To compute these costs, we conducted the following analysis. We used data from the 2002 MEPS to develop a model of days of work lost for adults due to disability or illness. We predicted disability days using demographic, socioeconomic, location, and health status measures. The demographic factors were age, race/ethnicity, and gender. The socioeconomic factors were education, income, and health insurance status. The location factors were census region and urban-rural residence. The health status measures were:

- Self-reported general health status (ranging from excellent to poor)
- Self-reported mental health status (ranging from excellent to poor)
- Presence of a functional limitation
- Number of IADL
- Number of ADL
- BMI/obesity measure
- Presence of chronic conditions (diabetes, asthma, asthma attack, high blood pressure, heart attack, angina, other heart disease, stroke, emphysema, joint pain, or arthritis.)

We used a Heckman two-step estimator to develop a labor supply model using the 2002 MEPS data (Greene 2005; Cameron and Trivedi 2008). First, we estimated the probability of missing a work day due to an illness or disability during the year. Second, we estimated a log linear regression model where the dependent variable was the log of number of disability days for those adults who had positive disability days. We used a log model to address the skewness in the expenditure data. We restricted the sample to adults, i.e., persons over the age of 17. The 2002 model was estimated on a sample of 26,312. We estimated the models using the survey regression procedure in STATA 10, which appropriately incorporates the design factors and sample weights. We then applied this model to MEPS data from the years 2003-2006 to predict the number of disability days.

For each year from 2003 to 2006 we prepared two estimates of disability days. The first predicted disability days based on each respondent's actual health status. The second simulated disability days by eliminating health disparities by race and ethnicity. To eliminate health disparities we assigned each race and ethnic group the best health profile. To identify the best health profile, we pooled the 2003 through 2006 MEPS and divided the sample into 14 age-gender cohorts. There were seven age groups: 18-24,

25-34, 35-44, 45-54, 55-64, 65-74, and 75 and over. For each cohort we computed the average health profile of whites, blacks, Hispanics, and Asians. To create the best health profile, we took the best value for each health status/condition measure.

We assigned persons the best health profile values for the health status/condition variables for their cohort and took their values for the other independent variables along with the coefficients from the regression model to compute the simulated health care expenditures. We used age-gender cohort-specific smearing factors to retransform the predicted log disability days and the simulated log disability days. We subtracted the simulated result from the predicted result and multiplied the difference by the estimated wage for the individual to compute costs.

Because health status affects the number of hours a person works and his or her wage, we developed a standard labor supply model, estimating labor force participation, hours, and wages, using the 2002 MEPS data. We then estimated labor force participation, hours worked for part-time workers, and wages for the 2003-2006 MEPS samples. We compared predictions for the actual sample to those for a simulated sample in which health disparities were eliminated. We valued the change in hours due to the elimination of health disparities at the predicted wage. We also computed the difference in wages due to improvements in health status.

Estimating the Costs of Premature Death

We used data from the National Vital Statistics Reports to obtain the number of deaths and crude death rates by age and race. We estimated the number of excess deaths due to disparities in death rates for each age group. We compared the actual deaths to the predicted number of deaths if the death rate equaled the lowest death rate for the racial/ethnic group within the age cohort. Typically this was the crude death rate for Asians. We computed number of years of life loss in each cohort by multiplying 75 minus the mean age of the cohort by the number of excess deaths (i.e., we assume that all members of the cohort would have lived to age 75 had they not died prematurely). We valued each year of life loss at $50,000. This figure is based on the standard value used to evaluate the cost effectiveness of medical intervention. Fifty thousand dollars is a conservative estimate given that recent studies have valued a quality-adjusted life year at $95,000 to $264,000 (Braithwaite et al. 2008).

To obtain a total indirect cost, we summed the costs associated with illness and the costs of premature deaths. We computed the cost savings in current dollars and constant 2008 dollars using conversion factors published by the Bureau of Labor Statistics.

ABOUT THE JOINT CENTER AND ITS HEALTH POLICY INSTITUTE

The Joint Center for Political and Economic Studies is one of the nation's leading research and public policy institutions and the only one whose work focuses primarily on issues of concern to African Americans and other people of color. For nearly 40 years, our research and policy analysis have informed and influenced public opinion and national policy, while contributing to a wider understanding of the role of black civic and political participation in making America a better place for all its citizens.

The Joint Center Health Policy Institute, one of its four "centers of excellence," plays a leadership role in reframing policy debates on health and focusing attention on existing health disparities. Our ongoing research and analysis are helping to generate policy recommendations and solutions for longstanding health equity concerns. The Institute strives to identify the complex underlying causes of health disparities and to develop strategies to address them, with the understanding that targeting the social determinants of health can lead to positive changes in patterns of health and well-being.

Ralph B. Everett, Esq. is President and CEO of the Joint Center for Political and Economic Studies, widely acknowledged as the nation's leading think tank for policy analysis and research on issues of concern to African Americans and other people of color. A native of Orangeburg, South Carolina, he has a 30 year track record of pioneering leadership in the nation's capital, having served in the 1980s as Staff Director and Chief Counsel of the U.S. Senate Committee on Commerce, Science and Transportation, and subsequently for more than 17 years as a partner at the international law firm of Paul, Hastings, Janofsky & Walker. A Phi Beta Kappa graduate of Morehouse College, Mr. Everett earned his J.D. from Duke University Law School.

Brian D. Smedley, Ph.D. is Vice President and Director of the Health Policy Institute of the Joint Center for Political and Economic Studies in Washington, DC. Formerly, Smedley was Research Director and co-founder of a communications, research and policy organization, The Opportunity Agenda. Prior to helping launch The Opportunity Agenda, Smedley was a Senior Program Officer in the Division of Health Sciences Policy of the Institute of Medicine (IOM), where he served as Study Director for the IOM reports, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce* and *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* among other reports on diversity in the health professions and minority health research policy.

ABOUT THE AUTHORS

Thomas A. LaVeist, Ph.D. – William C. & Nancy F. Richardson Professor in Health Policy, Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health; Director, Hopkins Center for Health Disparities Solutions, Johns Hopkins Bloomberg School of Public Health.

Darrell J. Gaskin, Ph.D. – Associate Professor of Health Economics, Department of African American Studies, University of Maryland; Adjunct Associate Professor of Health Policy and Management, Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health; Faculty Associate, Hopkins Center for Health Disparities Solutions, Johns Hopkins Bloomberg School of Public Health.

Patrick Richard, Ph.D. – Assistant Research Professor of Health Economics, Department of Health Policy, The George Washington University School of Public Health and Health Services.

JOINT CENTER FOR POLITICAL AND ECONOMIC STUDIES
BOARD OF GOVERNORS

Joint Center for Political and Economic Studies
1090 Vermont Avenue, NW, Suite 1100
Washington, DC 20005
www.jointcenter.org

50

Joint Center HEALTH POLICY INSTITUTE

Hopkins Center for Health Disparities Solutions

This product is printed on paper that is 50% recycled, 25% post consumer, Elemental Chlorine Free (ECF), and acid free.

PRINTED WITH SOY INK