

What Will Health-Care Reform Mean for Minority Health Disparities?

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In January 2010, after decades of attempts to reform health-care financing and many months of anticipation, debate, and politics, the U.S. Senate passed the Patient Protection and Affordable Care Act (hereafter, Affordable Care Act).¹ With this dramatic change in the prospects for health-care reform and a law possibly only weeks away, the planning committee for the 16th Annual Summer Public Health Research Institute and Videoconference on Minority Health (hereafter, the Institute) chose the topic “What Will Health-Care Reform Mean for Minority Health Disparities?” for its June 8, 2010, broadcast. Created through a cooperative agreement with the Minority Health Statistics Grants Program of the National Center for Health Statistics, the Institute began in 1995 as a one-week course on minority health research. From 1997 to 2005, the afternoon sessions of the Institute were broadcast across the U.S. by satellite. Since 2006, the Institute/Videoconference has been presented as a one- or two-afternoon broadcast, with a total live audience of about 1,000, including a local audience of about 100 students participating in programs seeking to recruit underrepresented minorities to health careers. The broadcasts are also disseminated as on-demand webcasts by the University of North Carolina Gillings School of Global Public Health and Kaisernetwork.org, as well as on videotapes and DVDs by the Public Health Foundation.

The 16th Annual Videoconference featured three presenters: Mayra Alvarez, MHA, Legislative Assistant to U.S. Senator Richard J. Durbin (Illinois) at the time of the Videoconference and now in the Department of Health and Human Services (HHS), Office of Health Reform; Ralph Forquera, MPH,

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Executive Director of the Seattle Indian Health Board and Clinical Assistant Professor with the School of Public Health, Department of Health Sciences at the University of Washington; and Tony L. Whitehead, PhD, MSHyg, Professor of Medical Anthropology and founding Director of the Cultural Systems Analysis Group, Department of Anthropology, University of Maryland. The Videoconference was moderated by Howard Lee, MSW, Executive Director of the North Carolina Education Cabinet. This article summarizes the Videoconference presentations (available at www.minority.unc.edu/institute/2010) and makes some additional comments.

MAYRA ALVAREZ

Alvarez opened the Videoconference by quoting from President Harry Truman's appeal to a 1945 joint session of Congress to pass national health insurance. Citing a 2008 Agency for Healthcare Research and Quality report,² she noted that disparities continue to exist across all areas of health care, including quality, access, types of care, clinical conditions, and care settings. For black, Asian, and Latino people, at least two-thirds of the measures of quality of care are not improving. Although many factors are responsible for these disparities, lack of insurance is an important contributor. Racial/ethnic minority groups comprise a third of the U.S. population but one-half of the uninsured.³ The Affordable Care Act is expected to bring health insurance to 32 million uninsured Americans.⁴ Through the Medicaid expansion, insurance exchanges, and government subsidies, 81% of uninsured African Americans, 60% of uninsured Latinos, and 60% of uninsured Asian-Pacific Islanders will be able to obtain coverage.

Besides the various provisions that improve and extend the availability of health insurance, the Affordable Care Act provides funding for up to 10,000 new community health centers. The Affordable Care Act quadruples the size of the National Health Service Corps to increase the number of health-care providers serving in those health centers and in underserved areas generally. The Affordable Care Act also emphasizes the role of community health workers (e.g., lay health advisors, or *promotoras*). The need to increase the number of underrepresented minority groups in the health-care workforce is addressed by reauthorizing the Centers of Excellence and the Health Career Opportunity Program, which seek to recruit and retain members of racial/ethnic minority groups to the health professions. The Affordable Care Act reauthorizes the HHS Office of Minority Health and

places it in the Office of the Secretary, and elevates the National Institutes of Health National Center for Minority Health and Health Disparities to an Institute, thereby raising the profile and resources for health disparities research.

A congressional staffer very concerned about health disparities, Alvarez struggled with recommending that the Affordable Care Act have a section on "health care for people of color" or "the elimination of health disparities." In the end, it was made clear that the new law, as a whole, should be dedicated to reducing health disparities by virtue of impacting the issues for which racial/ethnic minority groups are most at risk (e.g., being uninsured, not having a regular source of care, and underrepresentation in the health professions). Alvarez acknowledged that as with other critical pieces of social legislation (e.g., Medicare, Medicaid, the Civil Rights Act, and the Voting Rights Act), improvements occur over time. Thus, racial/ethnic minority groups must play a role in shaping the legislative landscape. Likewise, advocates for public health must continue their efforts to reduce health disparities.

RALPH FORQUERA

Forquera, the second presenter, focused most of his remarks on urban American Indian (AI) health. Most people do not realize that about two-thirds of AI people live in U.S. cities and not on reservations. Urban AIs struggle with a variety of related social and health problems, including the stereotype of AIs living on reservations, where casinos have made everyone rich.

The Indian Health Care Improvement Act, passed in 1976, defines the parameters of health care that the federal government owes to AIs.⁵ That law expired in 2001, which led to a decade-long struggle for reauthorization. The most important thing about the Affordable Care Act from the AI side was the permanent reauthorization of the Indian Health Care Improvement Act, which will give urban AIs a stronger bargaining position for both bureaucratic attention and resources, including health care.

Forquera explained that historically, the federal trust obligation for AI health has been administered by the Indian Health Service (IHS), which was established in 1955 within HHS. The IHS delivers health-care services through its own hospitals and clinics and by contracting with tribal communities. Further, the IHS also negotiates self-governance compacts, where the tribal community gets to decide the types of health care to be delivered, how services will be provided, and how they will be managed. But all these services concern AIs on reservations. The IHS has a small program,

under Title V of the Indian Health Care Improvement Act, that directs resources to about 34 urban contracts around the country in 19 states to provide assistance to communities to gain better access to health care.⁶ The Title V program receives only 1% of the IHS budget, so those providing health services to urban AIs have to obtain most of their resources elsewhere. The Affordable Care Act appropriation for community health centers and the National Health Service Corps will provide a significant opportunity for AI and other community institutions to obtain resources to build capacity to provide health-care services for urban AIs.

According to Forquera, AIs who leave reservations often lose their rights to tribal assistance (e.g., housing and food). In addition, in many cases they lose their tribal voting rights and may actually be removed from tribal rolls. Urban AIs may not be considered AIs by either the federal government or tribes, giving these people an inferior standing within the AI community. Those who work with urban AIs feel that they should be recognized as belonging to a people with a long and distinguished history, regardless of where they currently reside. However, the Justice Department challenged the legitimacy of urban AIs during both the Reagan and Bush administrations. The Bush administration actually eliminated funding for urban AI health programs in its last three budgets, but fortunately, Congress did not agree.

Forquera noted that health disparities are a much more complex matter than health care. Health disparities are an issue of social conditions, cultural differences, economics, and historical factors. Among AIs, historical factors play an enormous role. AIs are aware of the long history of government not following through on promises and legislation, notwithstanding the federal government's trust obligation to the AI community. Although caution may still be appropriate, Forquera regards the Affordable Care Act as a significant accomplishment. AIs should benefit greatly from a number of Affordable Care Act provisions. For example, according to some studies, 26% of AIs have some physical or mental disability that has interfered with their capacity to obtain insurance. The Affordable Care Act will eliminate preexisting conditions as a barrier to insurance. However, AIs will not benefit from some other provisions. For example, elders who have lived in subsistence agriculture are not eligible for Medicare and so will not benefit from the Affordable Care Act improvements in that program.

Forquera reminded the audience that it is a continuing challenge to keep health-care needs visible, as other major issues such as the Gulf of Mexico oil spill disaster arise. Can the changes involved in health-care

reform be sustained? Will the health-care resources be available, including primary care health-care providers? The health-care reform agenda is a critical change, but the work has just begun—not only for the AI community, but for all communities.

TONY WHITEHEAD

Whitehead, an anthropologist, addressed some of the powerful determinants of health disparities that are not necessarily related to health care and, therefore, are unlikely to be affected by health-care reform. The communities in which he works, in the Baltimore-Washington urban corridor, are primarily (90%) black. He terms these communities racialized urban ghettos (RUGs) to underscore the need to address race and racism, with respect to the policies that have created and shaped these communities, as well as the role that race and racism play in the minds of the people who reside in them.⁷

These communities have high population densities and have experienced low male-to-female population ratios, as homicide became a leading killer of young black people, and high rates of incarceration during the past quarter have removed many young men. Low gender ratios then contribute to large proportions of female-headed households, which are at higher risk of poverty. When young men are removed, the pool of potential husbands and fathers is reduced, making it difficult to have strong, healthy families. Without strong families, how can we have healthy communities?

RUGs are further characterized by inadequate employment opportunities, a declining tax base due to the exodus of higher socioeconomic status residents, high rates of concentrated and extreme poverty, lack of transportation to take advantage of employment opportunities elsewhere, high mortality rates from many of these conditions, environmental deterioration, social and cultural isolation, competition with immigrant groups, and displacement of people from their homes and their communities by gentrification processes and "revitalization" programs.

The impact of incarceration is particularly powerful. Reliance on incarceration as a strategy for social control has made prison a primary socializing institution for many young people. Prison is where some of those who were not criminals when they were imprisoned learn to become criminals. Moreover, many of those imprisoned have numerous social deficits (e.g., low literacy and education levels) prior to incarceration and become afflicted with a range of diseases (e.g., tuberculosis, hepatitis C, and human immunodeficiency virus/acquired immunodeficiency syndrome) and other con-

ditions while imprisoned. Thus, young people who have spent time in prison often reenter the community with more health and social needs than when they entered prison, and with few opportunities for addressing such deficits. Communities that were already struggling with many of these issues have the additional burden of the influx of released prisoners.

Whitehead mentioned that in his research during the past 20 years, he has frequently heard calls for comprehensive or multisectoral strategies to adequately address the complexity of issues that are being experienced by the very residents of these communities. He strongly advocated that universities engage in community-based participatory research (CBPR) not only as a tool, but also as an action plan for complementing the efforts of other community sectors. CBPR provides an excellent framework to ensure that the activities academics conduct in communities are part of a process in which needs assessment research data inform the design, implementation, and evaluation of effective intervention activities. Through CBPR, academics can collect data at the neighborhood level that focus on the needs within the community, as well as on its assets and resources. The data can then be organized, continually updated, and fed back to the community, which can use the information to design its own programs. Data are critical for community-based organizations seeking funding, as is evaluation. Without a strong relationship between the community and university, communities see themselves as being used by academicians who benefit from, but do not really help, the community. Institutionalizing university-community health outreach can make university resources and skills available to the community.

Whitehead also advocated for the involvement of anthropologists in CBPR efforts, assisting in the use of ethnography and other qualitative methods in needs assessment research and in the design of formative and outcome evaluations. Anthropologists can also contribute to an enhanced understanding of culture, cultural diversity, language, and other forms of human difference that may emerge as barriers to successful programs. Finally, Whitehead suggested CBPR as an action plan through which university faculty and students can play a crucial role in achieving the goals and objectives envisioned when such policies as health-care reform are envisioned and passed.

THE AFFORDABLE CARE ACT'S IMPACT ON MINORITY HEALTH

As the U.S. continues its progression toward a country in which no single racial/ethnic group will constitute a majority of the population, the Affordable Care Act represents a shift toward integrating and addressing racial/ethnic minority groups as part of the broader American community. In this way, the Affordable Care Act sends a strong signal that as a country we need to change our perspectives and attitudes about minority communities and the issues that impact health care in those communities. Eliminating the health disparities that have plagued racial/ethnic minority groups requires considering the impacts of all economic and political legislation. Regarding these health disparities as central, rather than as an addendum, is at least a good start. Further, by addressing disparities through programs that will benefit most Americans, the Affordable Care Act avoids the politically unpopular situation in which improvements for racial/ethnic minority groups are seen as coming at the expense of the rest of the population. For example, the insurance exchanges being created by the Affordable Care Act should lead to reduced insurance rates and better coverage to all people not eligible for a group insurance plan.

The greatest impact of the Affordable Care Act on racial/ethnic health disparities will presumably come from the general provisions aimed at reducing financial barriers to care, providing access to health insurance for an additional 32 million Americans.⁴ Communities of racial/ethnic minority groups comprise more than 50% of the uninsured.³ Rates of the uninsured among African American, Hispanic, and AI populations are two to five times that of white Americans.⁸ Given that communities comprising racial/ethnic minority groups have higher rates of disease,⁹ these communities will also derive greater benefits from increased access. At present, compared with insured people with a chronic disease, the one-third of uninsured people with a chronic disease are only one-sixth as likely to receive care for a health problem, which helps to explain the Institute of Medicine's estimate that 18,000 lives are prematurely lost in the U.S. each year due to lack of insurance.⁹

Required copayments for medical services are another barrier, particularly for receiving preventive care. The Affordable Care Act requires that all insurance plans cover a set of preventive services with no copayments. Much of the expansion of coverage of low-income people will come from the extension of Medicaid eligibility to all people with household incomes below 133% of the federal poverty level, both

raising the income ceiling and eliminating categorical requirements. An unresolved issue, however, is the large number of providers who do not take Medicaid patients.

Disparities in access to care also arise from the lack of a regular source of appropriate and timely health care, a problem that is more prevalent among racial/ethnic minority groups.⁹ The Affordable Care Act contains specific provisions to promote access to a regular source of adequate and timely health care, such as the expanded funding for community health centers offering comprehensive services in one place, the “medical home” option for Medicaid enrollees with chronic conditions,¹⁰ and the funding to train community health workers to educate their communities on how to protect their health and monitor their chronic diseases.

One access barrier that may be exacerbated by broader insurance coverage is an insufficient number of health-care providers and facilities, or unavailability of specialty services (e.g., physical therapy and dialysis). One area of particular concern is racial/ethnic diversity in public health-care providers; specifically, primary care physicians and health professionals who are themselves African American, AI/Alaska Native, or Latino. The Affordable Care Act includes several provisions aimed at expanding the health-care workforce, increasing its racial/ethnic diversity, and recruiting more primary care physicians. These provisions include quadrupling the size of the National Health Service Corps, expanding scholarships and loan repayment programs, reauthorizing the Centers of Excellence and the Health Career Opportunity Program, and creating additional provisions for promoting diversity and improving the cultural competence of providers.

The Affordable Care Act has also engineered organizational changes that will enhance the visibility, resources, and influence of agencies whose mission is the elimination of health disparities. The director of the HHS Office of Minority Health will now report directly to the Secretary of HHS, and the National Institutes of Health Center for Minority Health and Health Disparities will be given Institute status and additional responsibilities.

Shortly after the Videoconference, the Joint Center for Political and Economic Studies published a detailed analysis of the Affordable Care Act, with particular attention paid to its implications for racial/ethnic minority groups. The report summarizes more than three dozen provisions of the Affordable Care Act that specifically refer to race/ethnicity, language, or cultural competency, and also the many general provi-

sions of the Act that have important implications for minority health.¹⁰

Although the impact of the Affordable Care Act on racial/ethnic health disparities should be positive and powerful, there are many questions about how the future will unfold. The Joint Center report makes clear that many of the Affordable Care Act provisions lack specificity concerning appropriations and time frames for implementation, and other provisions will make significant demands on provider supply and expertise.¹⁰ Of particular concern is a cost-containment provision that may reduce payments made under Medicaid to hospitals that treat a disproportionate share of low-income and uninsured payments. Depending on how reductions are implemented, hospitals that function as safety net providers for populations with special needs and those remaining uninsured (e.g., undocumented people) could be in jeopardy.

The Videoconference highlighted that the Affordable Care Act was not designed to address all of the factors associated with health disparities. Rather, it was created to address one of the primary barriers to health care: access to health insurance. But reversing the decades of disparities experienced by racial/ethnic minority groups will require systematically addressing the issues of racism, education, and gross socioeconomic disparities. As Rudolf Virchow wrote more than a century ago, “If medicine is to fulfill her greatest task, then she must enter the political and social life. . . . Do we not always find diseases of the populace traceable to defects in society?”

The Affordable Care Act is a giant step forward in the long march to eliminate health disparities and should go a long way toward reducing disparities in health-care access and quality. The new law represents the greatest advance in public financing of health care since the start of Medicare and Medicaid in 1965. That the Affordable Care Act will not eliminate health disparities for racial/ethnic minority groups does not at all diminish the importance of its bold and innovative approaches to solving existing problems. Evaluation of the efficacy of these approaches will provide the basis for refinement or replacement. But it is a truism that for the promise of the Affordable Care Act to be realized, public health professionals must be engaged with how its many provisions are implemented.

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