

replacement of the talc by another substance outweighed the tremendous cost.

## BAYER-MONSANTO GLYPHOSATE

To defend what they perceive as in their best interests, some corporations not only pressure governmental agencies, they fight them. Samet (p. 976) describes how Monsanto has moved extremely aggressively against the science, the unpaid expert volunteers, and institutions such as the International Agency for Research on Cancer (IARC), which tried to share the result of their independent assessment of glyphosate (Roundup) as a possible carcinogen. These actions imperil the existence of the peer review processes but maybe the survival of Bayer (which bought Monsanto) too.

As in the case of Johnson & Johnson's talc, the dramatic consequences of neglecting the independent risk assessment of

glyphosate are unfolding. As I write, Bayer lost a third trial against a French farmer, Paul François, who suffers from neurologic problems that the courts have causally linked to glyphosate, and a California jury awarded \$2.055 billion to a couple for cancers caused by the weedkiller. There are 11 200 more plaintiffs lined up. Bayer's stocks have lost 40% since 2018 and keep going down, and the image most people have of Bayer, as the company that produces the wonder drug aspirin, may be forever stained. This may have been avoided had Monsanto informed the public that independent science established that glyphosate was "genotoxic" and "probably" caused cancers in humans.

## PUBLIC HEALTH CONSCIENCE

The independent assessment of risk associated with industrial products is, as Vineis (p. 978) reminds us, part of the checks and balances that are indispensable in a

democratic society. The industry cannot be expected to impartially assess the potential toxicity of its own products. Independent risk assessment requires specific procedures and skills for the conclusions arising from reviewing and summarizing a large body of evidence to be transparent and useful for policy decisions. IARC monographs are an ingenious way to do exactly that. The conclusions of their unpaid expert volunteers cannot be replaced by reviews from scientists paid by the industry.

Independent risk assessment has a cost. To play their role as independent checks, governmental and international agencies need resources. Michaels (p. 975), former assistant secretary of labor for the Occupational Safety and Health Administration, stresses that lack of resources handcuffs many public health agencies. In the case of the asbestos-related risk from talc, the FDA's lack of money and manpower may explain why it could not challenge the industry's obviously inadequate risk assessment procedures by generating its own,

polarized microscopy asbestos screening test. The underresourced Federal Aviation Administration's missed assessment of the safety of the Boeing 737 MAX is another case in point.

Some corporations do not hesitate to undermine the legitimacy and credibility of the institutions, such as the FDA, the surgeon general, the Environmental Protection Agency, the Centers for Disease Control and Prevention, or the IARC, whose missions are to produce or summarize the science to protect all of us from harmful, toxic products, behaviors, or policies. But the cases of talc and glyphosate speak for themselves: it was in Johnson & Johnson's and Monsanto's best interest to support and respect the independent, conscientious scientific risk assessment. The converse is not true: the public could not rely on the corporate industry's scientists or on the industry itself to have a public health conscience. **AJPH**

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# Drilling Deeper on the Impact of the Affordable Care Act on Disability-Related Health Care Access Disparities

 See also Kaye, p. 1015.

H. Stephen Kaye's (p. 1015) demonstration of disability-related disparities in health care access makes a significant contribution to our knowledge about disabilities, health, and health care access. People with disabilities are a sizable segment of the population: 13% to 17% of the US population are identified

with serious difficulties in one or more areas of functioning. By contrast to the earlier, diagnosis-based view, the current view of disability is defined by significant limitations in one or more functional domains. The World Health Organization advanced a functional view of disability in 2001 in its International

Classification of Functioning, Disability and Health,<sup>1</sup> and the US Department of Health and Human Services (DHHS) codified this view in its guidelines for

standard disability identification as called for by the Patient Protection and Affordable Care Act (ACA).<sup>2</sup> These identifiers include difficulties in hearing, seeing, cognition, mobility, self-care (e.g., bathing, dressing), and independent living (e.g., shopping, visiting doctor).<sup>2</sup>

This shift from a diagnostic to a functional definition allows disability to be disentangled conceptually from poor health and supports a view that people

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can have a disability and be healthy. Furthermore, it allows observed differences in health status to be examined as potential health disparities and allows health disparities to be seen as stemming from disparities in access to health care. Researchers are coming to understand the complex relationship between disability, health status, and health care utilization. Although people with disabilities are more likely to experience chronic conditions and therefore be high users of care, most people with chronic conditions do not report disability.<sup>3</sup>

## SELECTION OF OUTCOME VARIABLES

Kaye examined three variables of health care access: (1) “uninsurance” indicates whether a third party will pay for health care expenditures, (2) “usual source of care” is an accepted indicator of quality health care with a known provider, and (3) “foregone or delayed health care” documents unmet need. The third is an especially important measure for people with disabilities. By contrast with utilization of care, foregone or delayed care accommodates varying levels of need for care and provides a closer measure of equity in health care access.

## DISAGGREGATING BY DISABILITY SUBGROUPS

To make the case for considering people with disabilities as a health disparity population, researchers, including Krahn et al.,<sup>4</sup> have aggregated all people with disabilities into a single group and compared them with people without disabilities. People with disabilities, however, are a highly

heterogeneous group with diverse health status and health care needs. Effective interventions require precise information about which persons need which services. Kaye begins to do this, as he examines subgroupings of people with disabilities, while including the known correlates of age, gender, race/ethnicity, and family income in his analyses. By disaggregating people with disabilities into four groups, he is able to demonstrate the differential effect of the ACA on subgroups that differ in nature and severity of disability. These groups include people (1) who need help with activities of daily living, (2) whose disability prevents them from working, (3) with other mental health disability, and (4) with other physical or cognitive disability. Kaye’s analyses identify important differences among subgroups before versus after the ACA and gains among people with versus those without disabilities that are attributable to the ACA. His findings demonstrate the value of differentiation among disability subtypes.

## MENTAL HEALTH DISABILITY

Kaye brings much needed attention to the health care access of people whose primary limitation is mental health. The standard disability question set established by DHHS and used in the American Community Survey and other surveys and the slightly different disability identification question set used in the National Health Interview Survey (NHIS; Washington Group questions) use a general question on cognition that is presumed to identify persons with a range of disorders, such as intellectual disability,

dementia, brain injury, and mental difficulties. The use of the K6 question set in NHIS allows inclusion of people with serious limitations because of mental distress who would otherwise not have been identified by the standard identifier questions.

Mental and emotional difficulties are variable and dynamic, and their relationship with other disabilities is beginning to be understood with greater precision.<sup>5</sup> Within a framework of primary disabilities and secondary conditions, mental disorders can be both primary and secondary conditions, when secondary conditions are defined as conditions with an increased likelihood of occurring related to having a primary disability. An example would be a mobility disability that leads to social isolation and cessation of activities that in turn leads to depression as a secondary condition. Understanding the interplay of mental health has been challenging for disability researchers using cross-sectional survey data. Bipolar disorder or psychosis are more likely to be considered primary disabilities, whereas depression can be a primary or secondary condition.

Kaye has navigated this concern by requiring that respondents (1) report significant limitations in functioning on the K6 questions and (2) not report needing activities of daily living assistance or having a disability that prevents work. This allows the study to identify people with other mental disability in addition to those whose mental health needs result in the need for activities of daily living support or work limitations. This other mental health disability group experiences the most severe access barriers among all disability subtypes. This important finding has significant implications for public health programs and policies.

## IMPACT OF IMPLEMENTATION

Several ACA policies were premised on the notion that having health insurance and a usual source of care are critical components of health care access and parity. Kaye’s study reinforces the findings of others on the positive impact of the ACA on working age adults with disabilities.<sup>6</sup> It also extends findings by providing greater specificity on which subgroups of people with disabilities benefit on which access indicators. Further, it documents the ongoing disparities in access after implementation of the ACA. Because Kaye dug deeper into disability subgroups and the nature of access disparity, his findings provide direction for ways to reduce health care access disparities and, potentially, health disparities. Because he used multiple indicators of outcomes, he was able to demonstrate that access to health insurance and a usual source of care are important but not sufficient for ensuring that people with diverse disabilities experience a reduction in unmet health care needs and that disability-related health care disparities are reduced.

Kaye notes as a limitation of his study that “newly acquired health coverage might have moved some population members out of the disability population before the interview” (p. 1020). Although potentially attenuating the measured impact of the ACA, this would truly be a positive effect of the ACA for people with disabilities. As noted by others,<sup>7</sup> an intended benefit of the ACA and its expansion in some states was to allow people with disabilities to work to their potential by eliminating the need to remain eligible for public health care funding. In

Kaye's study, this effect might have resulted in shifting among subgroups of persons with disabilities. Research demonstrates the value of the ACA for persons with disabilities and identifies directions to reduce the disparities in access to care that persist even after ACA implementation. A next wave of research is needed that begins to disaggregate disability into conceptually meaningful and statistically justifiable subcategories, examines variables of access that are specifically meaningful, and

documents improved health outcomes and reductions in health disparities. *AJPH*

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#### CONFLICTS OF INTEREST

The author declares no conflict of interests.

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## Strong Community–Public Health Partnerships May Help Us Move Closer to Tuberculosis Elimination

 See also Collins et al., p. 1028.

Persons experiencing homelessness face substantial barriers to care. Food and financial insecurities, limited transportation, and multiple comorbidities are major challenges. These barriers, combined with sleeping in crowded homeless shelters, create a perfect storm for tuberculosis (TB). Despite today's historically low TB rates, persons experiencing homelessness have an unacceptably 10-fold higher rate of TB than in the US population and are overrepresented in TB outbreaks. An estimated 1.42 million persons (0.4% of the national population) experienced homelessness in 2017, but more than a third of 21 TB outbreaks investigated by the Centers for Disease Control and Prevention from 2009 to 2015 involved overnight homeless shelters. Persons experiencing homelessness accounted for 45% of 457

persons identified with TB in these outbreaks.<sup>1</sup>

From 2008 to 2015, persons experiencing homelessness in Fulton County, Georgia, were heavily affected by an outbreak, with 110 cases of isoniazid-resistant TB.<sup>2,3</sup> Fulton County began a mandatory targeted testing program for persons experiencing homelessness as well as community outreach to improve access to TB prevention services.<sup>3</sup>

#### DEFINING THE CARE CONTINUUM AND TESTING GAPS

In this issue of *AJPH*, Collins et al. (p. 1028) describe the cascade of care for TB prevention by treatment of latent TB infection in persons experiencing homelessness in Fulton County from May 2015 through April 2017. The authors compare the

effect of two different screening strategies on downstream losses in the care continuum. After identifying patients at risk, the next step in the continuum is offering testing to those who are at risk for infection. If this step falters, it will create a ripple effect downstream in the continuum of care.<sup>4</sup> In summary, if patients do not have access to testing that they are able to fully use, they will never have the opportunity to complete treatment. Thus, testing is one of the most critical steps in the continuum of care.

To ensure that persons experiencing homelessness have access to TB prevention services, public health programs must ensure a patient-centered approach to testing for TB. The biggest limitation

of tuberculin skin testing is that it requires patients to have an initial encounter to place the test and a follow-up to have it read, potentially doubling the barriers to care. Even when the test is performed on-site, with the health care worker performing testing and reading at the same location, returning for the reading at a specific time still may be challenging.

The TB screening of persons experiencing homelessness in Fulton County began both at the health department and within community shelters; tuberculin skin test (TST) was used for the first two years. Thereafter, screening took place with an interferon- $\gamma$  release assay, QuantiFERON-TB Gold In-Tube (QFT; QIAGEN Inc, Germantown, MD). Use of QFT allowed for TB testing in one visit, with patients receiving their results at their convenience. Fulton County tested an impressive number of individuals with both TST and QFT and

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