ACCESSIBILITY AND AVAILABILITY TO HEALTH CARE IN THE AFRICAN-AMERICAN COMMUNITY

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Health care is defined as those activities that are undertaken on an individual with the objective of preventing, treating, restoring, preserving, or enhancing the physical and mental well-being of that person. Although access and availability to health-care services should be a fundamental right granted to all US citizens by the federal government, in reality, the delivery of health-care in this country remains fundamentally private. However, since the 1900s, the federal government has provided financial support and developed health-care programs (as defined by law) for the care of special segments of the population, such as mothers and children. Such programs were subsequently extended to members of the armed forces and their dependents, veterans, Native Americans, and Alaskan natives.

In the early 1960s, the federal government continued to expand health-care services to the underserved through its Medicaid and Medicare programs. In the late 1960s and early 1970s, neighborhood and community health center programs and the National Health Service Corps were developed to improve access and availability to health-care services to the underserved. During the 1980s, federal policy began to shift by placing more responsibilities on states in the development and implementation of health-care programs for that segment of society depending on public health-care assistance.

With the expansion of these publicly funded programs, health-care costs escalated to the second largest expense to the nation, second only to the defense budget. The United States ranks first among the world's nations in its expenditures for health care, and this cost continues to escalate. In 1965, national health-care expenditures accounted for 6.1% of the gross national product (GNP). By 1987, national health-care expenditures rose to 11% of the GNP, and by the year 2000, it is expected to exceed 15% of the GNP.

Notwithstanding such vast financial expenditures on health care in this country, a large and growing segment of the population lacks adequate access and availability to health-care services. Needless to say, African Americans and other minority groups are disproportionately represented among those that are underserved and suffering from poor health as a result of the lack of access and availability to health care services. African Americans and other minority groups continue to have disproportionately higher rates of infant mortality, cancer, cardiovascular diseases, diabetes, acquired immunodeficiency syndrome, and other diseases. In 1985, the Heckler Report stated that approximately 60 000 excess deaths among African Americans could have been prevented had they received health care that was accessible and available to most nonminorities. The consequence is that the life span of African Americans continues to decrease, while that of the majority population continues to increase, for an average of 6 to 7 years more than African Americans.

With such a disparity existing between the health status of African Americans and the majority population, equitable access and availability to health care for all is imperative. The major health-care task challenging the federal, state, and local governments in the 1990s is to legitimately recognize the barriers to access and availability to health care for the underserved and to eradicate those barriers through the cooperation of the public sector, health professionals, and private organizations.

BARRIERS TO ACCESS AND AVAILABILITY TO HEALTH-CARE SERVICES IN THE AFRICAN AMERICAN COMMUNITY

Although there are numerous barriers to access and

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availability to health care for African Americans, the rising cost of health care, the insufficient number of minority health-care providers, and the delivery of health care in rural areas seem to have the most impact. The rate of increases in health-care prices has far exceeded the rate of growth of the general economy, and in particular, the percentage of income the average person uses to cover health-care expenses. In 1982, the total national health expenditure was $323.6 billion, increasing by approximately 9% by 1987 to $500.3 billion. During this period, the expenditures for hospital care increased at an average annual rate of 7.6%, from $135.2 billion to $194.7 billion. Expenditures for physician services alone grew at a higher rate than that for hospitals, at a rate of 10.7% during 1982 through 1987, increasing from $61.8 billion in 1982 to $102.7 billion in 1987.

The escalating cost of health-care services directly affects consumers and is the primary barrier to access to health care for most African Americans. Thirty-three percent of African Americans, 50% of whom are children, live below the poverty level. African Americans are more likely to have low-paying jobs that fail to provide insurance benefits. It is estimated that 22% of African Americans are uninsured and are not covered by Medicaid. Lacking the resources to finance preventive or timely health-care services, many African Americans defer treatment until their symptoms are far advanced, requiring emergency room care. Such incidents increase the strain on public expenditures because delays in treatment may lead to more expensive care or hospitalization. Subsequently, many emergency rooms are forced to close their doors, leaving these patients with no access or availability to health-care services, which forces the patients to rely on family or friends to look after them.

A second barrier to access and availability to health care in the African-American community is an insufficient number of African-American health-care providers. Statistics show that African-American physicians are more likely to practice in their own communities, and in underserved areas. However, while African Americans constitute approximately 12% of the population, only 3% of the physicians, dentists, pharmacists, and other health professionals in the United States are African Americans. This is an insufficient number of health-care providers to adequately serve the African-American community, and this shortage directly affects access and availability to health-care services and professionals in these areas. It logically follows that increasing the number of African-American physicians will increase access and availability to health-care services and professionals in the African-American community.

While a large portion of the African-American community still reside in rural areas, particularly in the south, the erosion of health care in rural areas is a third barrier to access and availability to health-care services for African Americans residing in such areas. A failing economy, the persistent shortages of health-care professionals, and the increasing reliance on high-technology devices that may not be available in rural health facilities all contribute to the reduced access and availability to health-care services in rural areas. In addition to these factors, an increasing number of rural hospitals are being forced to close, leaving rural residents isolated from health-care facilities altogether. The lack of health-care providers and facilities are crucial to patients needing prenatal care and emergency services. In a rural area lacking a local physician, health-care facility, or an adequate mode of emergency transportation, the impact of the lack of access and availability to health-care services escalates in a life-or-death situation.

In reviewing some of the barriers to access and availability to health-care services to African-Americans, it is evident that public health-care programs alone cannot eradicate the barriers. The present public health-care programs and financing do not guarantee access and availability to basic health-care services to all of our citizens, and excludes many of those requiring health-care services the most. It is the responsibility of the federal government to develop and implement a health-care agenda that assures each citizen equal access and availability to health-care financing, health-care providers, and access to health services in rural areas.

STRATEGIES TO ERADICATE THE BARRIERS TO ACCESS AND AVAILABILITY OF HEALTH-CARE SERVICES IN THE AFRICAN-AMERICAN COMMUNITY

Although the federal government shifted its policies in the 1980s by placing more of the responsibility for health care on the states, it is hoped that in the 1990s it has seen the error of doing so and will regain full responsibility in assuring equal access and availability to health care to all of its citizens. Recognizing that this task cannot be undertaken by the federal government alone, it is necessary for the government to coordinate its efforts between the public and private sectors of society.

Recommendations to accomplish this task were released in March 1990 by the Pepper Commission. The Pepper Commission consisted of six members of the US House of Representatives and the US Senate, respectively, as well as three presidential appointees. The Commission's responsibility was to develop a proposal to expand access to health-care services and to provide long-term care insurance for uninsured or underinsured Americans. The Commission proposed that universal access to health care be provided to the approximately 50 million Americans who are uninsured or underinsured, and also established a provision for nursing and home care for the disabled and a conversion of the Medicaid program. The proposal pulled the private sector into the act by requiring employers with 100 or more employees to provide health insurance. It is estimated that the Commission's proposals could be implemented over a 5-year period, costing approximately $66 billion.

For these recommendations to become law, Congress must introduce a bill and pass legislation based on the recommendations. Two such bills have been introduced in Congress, one by Senate Majority Leader George J. Mitchell and the second by House Ways and Means Committee Chairman Dan Rostenkowski. Both bills provide for public and private participation in financing health-care services for the underinsured and uninsured by making it mandatory for employers to provide health insurance for their employees or pay a tax to assist the government in providing it. There are also provisions to cover acute and long-term health care for low-income people. If these bills become law, those who are uninsured or not covered by Medicare would be enrolled in a new federally run health insurance program. Those able to pay some fees and premiums would be required to do so; however, health-care services for the poor or nearly poor would be free or subsidized.

In addition to the preceding provisions, Representative Rostenkowski's bill provides for mandatory cost-control measures that will limit the annual increases in total public and private health outlays for services covered by the bill. This increase will equal the percentage of annual growth in the GNP. Furthermore, the bill authorizes the Secretary of Health and Human Services to set mandatory nationwide fees for doctors, hospitals, and other health-care providers at whatever level is needed to keep national health expenditures from exceeding the national cap. The Mitchell bill has been amended and now provides for mandatory fee-setting power by a national health board.

Notwithstanding opposition from the White House and small businesses, the time has come for the private sector to join hands with the federal government in assuring equal access to health-care financing. This country is long overdue in providing universal health-care financing to all of its citizens, irrelevant of race, class, and gender, and particularly in placing African Americans on economic parity with the majority population when it comes to financing health-care services. To complete the picture, the public and private forces must join their efforts in increasing the number of African-American physicians practicing in underserved areas.

In order to increase the number of African-American physicians practicing in African-American communities, a long-term strategy must be implemented to recruit, train, and retain minority health professionals who are willing to provide health services to the underserved. Congress signed the Disadvantaged Minority Health Improvement Act into law on November 6, 1990, highlighting the need to increase the number of minority health professionals serving indigents. Congress also has passed legislation authorizing increased funding to the National Health Service Corps. Reducing physicians' debt burden will allow more African-American physicians to bypass high-paying positions and set up practices in areas that are underserved. In order to steer more minority students into primary care medicine, scholarships, as opposed to loans, should be awarded to those seeking to practice in this area, and the pay scales should be adjusted to adequately compensate those physicians serving in underserved areas.

Private foundations can get involved in the effort to increase the percentage of African-American physicians by funding special programs for minority high school students interested in pursuing a career in the health profession. In addition, private foundations can fund scholarships to medical students, and research grants to minority medical professors. Furthermore, they can make donations in the form of money or equipment to the predominantly black medical schools that train the majority of African-American physicians practicing in underserved areas.

Health care is a service offered in a competitive, free market economy. In reality, African-American physicians respond to economic advantages and disadvantages in a manner similar to physicians in the majority population. With this fact in mind, the African-American community should not place the responsibility of assuring equal access and availability to health-care providers solely on African-American physicians.

If the African-American community seeks equal access and availability to health-care providers, such responsibility must be placed equally on minority and majority health-care professionals alike. This is particularly so in light of the fact that African-American physicians cannot undertake this task alone while representing only a small percentage of the total physician population. In assuring equal access and availability to health-care providers, the question of race should not and must not continue to be a barrier.

In an effort to alleviate the lack of health-care services in rural areas, Congress established the Office of Rural Health Policy in the Department of Health and Human Services in 1987. This office was charged with the responsibility of developing policy recommendations to protect and enhance the rural health-care system. Congress also adjusted the Medicare Prospective Payment system by reducing the difference in payment rates between rural and urban hospitals.

The public and private sector can join hands in providing incentives to attract potential physicians and nurses to practice in rural areas. Financial incentives may be offered in the form of salary/benefit packages and through tax incentives on real estate and business operations. Nonfinancial incentives may be offered through the procurement of high technology equipment available in urban areas, by setting up information management systems allowing rural physicians access to medical information possessed by their urban colleagues, or by donating emergency transportation vehicles. Irrelevant of where a person may reside, there should be legitimate efforts to equalize access and availability to health-care facilities and professionals.

Since the 1980s, the movement to eliminate the barriers to access and availability to health care for minorities and indigents has been growing slowly as more Americans find themselves falling between the cracks in the health-care system. Because neither the public nor private sectors of society can conquer this massive task on its own, it is imperative that these two segments of society work together. Although there is not a current fix-all solution to this problem, the bills introduced in Congress, which provide for public and private participation in revamping health-care services for the uninsured and underinsured, seem to be an adequate start. It is now up to the American people to not let the opportunity to break down the health-care barriers slip away while it is a pressing issue.

CONCLUSION

Other than the Republic of South Africa, the United States is the only industrialized country that fails to provide universal access to health care, regardless of ability to pay. The United States spends more money on health-care services than any other country in the world, and boasts of health-care procedures and technology unmatched by any other country, yet there is a severe health-care crisis for minorities and indigents in this country. As African Americans fight for economic, political, and social parity with the majority population in this country, so too must African Americans fight for parity in the access and availability to health-care services. Just as society is beginning to view high education and economic goals as a prerequisite for national security in the new world order, it also must view a healthy population, with equal access and availability to health-care services, as a prerequisite to holding its status as the protector of this new world order.

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