Should healthcare reform be 'color-blind'? Addressing the barriers to improving minority health

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The scandalous disparity between the health indicators for minority and nonminority and poor and nonpoor populations is of such long standing that it has lost the power to shock. The authors review the landmark studies of the past year which document discrimination in the healthcare system. They reiterate the most compelling statistics of mortality, birth, the AIDS epidemic, destructive health habits, and poverty. They trace the impact of healthcare policy on these vulnerable populations and address the myth that malpractice claims are filed more frequently by the poor. They conclude that equality is instrumental to the improvement of the nation's health demographics; the persistence of economic, social, and political discrimination will continue to create barriers even if financial access is assured through a pluralistic approach to healthcare reform. Ultimately, they predict that any healthcare reform that does not address minority issues is doomed to fail if all three areas driving the national "crisis"—access, cost, and quality—do not encompass minority-specific healthcare strategies.

(Key words: Minority health, healthcare reform, minority health policy, barriers to healthcare access, minority mortality, medical malpractice)

Whether race or any specific minority group should be specifically targeted in the agenda for healthcare reform is a nagging question for policymakers. The studies that we reference in this article suggest that greater "financial access" will not necessarily eliminate the dramatic racial differences in healthcare treatment and services, because there are other significant barriers such as racial and socioeconomic discrimination, language and uninformed policy.[1] People of color are frequently absent from policy development resulting in pluralistic strategies for improving health demographics. Policymakers show little sensitivity to specific minority health issues and their significant negative impact on those same demographics.

Free market competition will not automatically offer a solution to the different rates of health service utilization or cure the racial disparities in health status which plague the United States. Whether race-specific policies are needed or not, a commitment to prevention and health promotion is clearly called for in effecting an improvement in the shameful status of minority health in the United States.

One of the most controversial areas being tackled by healthcare reformers, malpractice reform, has special importance in the arena of healthcare for minority and poor populations. The long-held perception among physicians, especially obstetricians, that poor and minority patients are more likely to sue continues to create barriers to access which add to the disparity of care. Whereas it is illegal to discriminate against people on the basis of gender, age, race, ethnicity, religion, and national origin, discrimination based on economic status is not illegal. As the median size of jury verdicts in medical-malpractice cases appears to be growing

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again after a 2-year decline, physicians responding to a survey by the American Academy of Family Practice identify malpractice reform as their first concern.[2,3] This concern is not based on the compromised access or the recognition that poor patients are less likely to sue, but is related to generalized concerns about the cost of care.

The underlying issue, from the perspective of health policy, is whether equality is instrumental to improved health status. The persistence of economic, social, and political inequalities—even when financial access to healthcare is assured—may continue to be injurious to the health of minority Americans.[4]

Documented racial barriers

Landmark studies[5-7] have been published during 1994 documenting the insidious differences between the care provided to black and white populations as well as to poor and nonpoor populations.

Johns Hopkins' researchers published the results of a study in March 1994 that showed blacks who are HIV-positive are much less likely than whites to be given antiretroviral drugs, including medication to prevent pneumonia, a major killer of HIV-infected persons.[5] Fifty-eight percent of eligible black patients received drug therapy compared with 82% of eligible white patients. The researchers studied 838 patients for 2 years and found no differences other than race in the receipt of drug therapy. Factors such as age, sex, mode of HIV transmission, type of insurance, income, education, or place of residence did not relate to the differences in therapeutic regimen.[5]

Such differences do not surprise researchers who have been studying the widespread nature of racial and socioeconomic disparities in healthcare delivery. *JAMA* published two landmark studies[6,7] in the April 1994 issue: They are focused on the outcomes and quality of care in two federal systems—Medicare and the Veterans Health Administration—which were designed to provide equality of access to all eligible Americans.

The Medicare system

In the Medicare study,[6] the sample included 9932 patients 65 years or older who were hospitalized with congestive heart failure, acute myocardial infarction (AMI), pneumonia, or cerebrovascular accident after living at home. The study compared the quality of care received by the patients who were black or poor with that of those who were neither. Forty-four rural hospitals, 147 urban nonteaching hospitals, and 106 urban teaching hospitals treated the patients in the study, with 1610 of the patients being black or poor. The authors conclude that even among insured patients, those who are black or from poor neighborhoods received worse care. They called for an evaluation of the extent to which discrimination exists in the hospital setting.[6]

Veterans Health Administration

The goal of the second study[7] was to examine whether blacks with AMI admitted to Veterans Affairs Medical Centers were less likely than whites to undergo cardiac catheterization and revascularization procedures. Previous studies support the conclusion that invasive diagnostic and therapeutic technologies have not been used equally across all segments of the population. This study was also designed to examine the impact of these variations on subsequent patient survival. In this healthcare system designed to provide equivalent availability of care to all eligible patients, blacks received substantially fewer cardiac procedures after AMI than whites. Despite the differences in treatment, blacks had better short-term and similar intermediate survival rates as whites.

The authors conclude that the differences in this study cannot be explained by differences in insurance or socioeconomic status. Nor were the differences limited to a region or institution. The only documented difference related to race. The authors call for additional research to explain the differences and investigate the relationships between process of care and outcomes. Patients who undergo more procedures do not necessarily have better outcomes.[7]

Minority health

"The poor ranking of America's black population in the indices of good health is a scandal of such long standing that it has lost the power to shock."

Daniel S. Greenberg

(in "News and Comments, Washington Perspective," *The Lancet,* March 31, 1990[8])

The mortality scandal

Black Americans can expect to die 5 years earlier than white Americans. Native Americans

and Alaskan Natives also have shorter life expectancies than the US white population, although the differences for these groups narrowed sharply between 1940 and 1980. Because persons of Hispanic origin may be of any race, comparisons are more difficult. However, they show unique socioeconomic and cultural problems that compromise their health status, one significant barrier being language. The Department of Health and Human Services (DHHS) Secretary's Task Force on Black and Minority Health first documented the health status of minority populations in 1985. Even with incomplete date, their findings were grim: approximately 60,000 excess deaths occur among black people each year. One and a half times the total number of battlefield casualties sustained in Vietnam die each year unnecessarily! Sixty thousand men, women, and children die each year who would not have died if the death rates were equal to nonminority rates.

In an *International Journal of Epidemiology* study published in Great Britain in 1990, Schwartz and colleagues[9] examined an average of 17,366 deaths preventable by medical intervention over each of 6 years in the United States, and compared mortality rates for blacks with those for whites. Their analysis revealed a 4.5-fold overall excess in mortality among blacks compared with whites for 12 selected sentinel conditions reviewed. The authors conclude that the excess mortality rate cannot be fully explained by an increased incidence of disease and probably reflects racial inequities in healthcare access and quality. Their recommendation is that screening and treatment efforts for hypertension, cervical cancer, and tuberculosis among black populations be bolstered.[9]

For the 15 leading causes of death identified in the last Department of Health and Human Services study,[10] black rates are 52% higher than white rates for all causes of death. For four of the 15 causes, black rates were more than twice those of whites: nephritis, septicemia, perinatal conditions, and diabetes mellitus. In our American society that glamorizes and is mesmerized by violence, black Americans die from homicide at a rate six times that of whites.

Native American rates for tuberculosis are more than four times those of the United States overall. Chronic liver disease and cirrhosis rates for Native Americans are three times the overall rates, and their rates for diabetes mellitus are twice as high.[10]

The infant scandal

Higher proportions of Native American, black, and Hispanic mothers compared with white mothers have low-birthweight babies (*Table 1*), have babies at very young ages (*Table 2*), and are unmarried when giving birth.[10] Low birthweight is directly associated with high infant mortality and significant lifelong morbidity and developmental disabilities.

The black infant mortality rate is more than twice that of white infants and pulls the whole country's rate below that of other industrialized nations. Department of Health and Human Services baseline data used to set the Healthy People 2000 agenda show 17.9 deaths per 1000 live births for blacks, 12.5 for Native American/Alaskan Natives, and 12.9 for Puerto Ricans. The national rate was 11 deaths per 1000 live births for all races and 9.3 for whites.

In an era when maternal deaths are preventable, the rate of maternal death for blacks is 3.3 times the white rate. Black maternal deaths account for 43% of the total US maternal deaths.

The AIDS scandal

African Americans, who make up 12% of the population, comprise 26% of the cases of acquired immunodeficiency syndrome (AIDS) reported to date. Hispanics, at 6% of the population, comprise 15%. The risk of AIDS in black and Hispanic men is almost three times as great as that in white men, and black women and black children had 13.2 and 11.6 times the risk of AIDS, respectively. Significantly, minorities surveyed were less aware of the risks and of the specific preventive measures to avoid transmission of HIV.[10]

Fifty-two percent of the 3500 children with AIDS are African American. The AIDS virus, which was not registered among causes of death in 1981, is now the largest killer of African-American women between the ages of 25 and 34 years in New York City. Twenty-one percent of the women contracting AIDS in the past decade are Latino; 53%, African American.[11]

The behavioral scandal

Excess deaths due to cancer, cardiovascular condition, and cirrhosis of the liver annually rob African Americans of thousands of years of life. Many of these conditions reflect health habits such as smoking—32% of all smokers

Table 1
Low-Birthweight* Infants by Race or Origin—1987[10]

Racial/ethnic group	% of Live births
■ All races	6.9
■ White	5.7
■ Black	12.7
■ Native American	6.2
■ Asian or Pacific Islander	
Chinese	5.0
Japanese	6.3
Hawaiian	6.6
Filipino	7.3
■ Hispanic	
Mexican	5.7
Puerto Rican	9.3
Cuban	5.9
Central and South America	5.7

*Birthweight of less than 2500 g.

Table 2
Children Having Children
Live Births per 1000 Women—1987[10]

	Live births per 1000 women by age of mother, yr	
Race of child	**10 to 14**	**15 to 19**
All races	1.3	51.1
White	0.6	41.9
All other	4.0	90.9
Black	4.7	100.3

are African-American men older than 18 years, (25% higher than their white counterparts).[11] Prevention strategies are not targeted for minorities. In fact, tobacco manufacturers have been repeatedly admonished for their advertising campaigns targeted at minority consumers.

The Native American death rate is substantially higher than that for all other races for causes of death where alcohol is believed to play a substantial role, that is, chronic liver disease and cirrhosis, accidents, and suicide. The health impact of alcohol abuse among Native Americans is nowhere more poignant than in the incidence of fetal alcohol syndrome, which affects 29.9% of births, compared with 0.9% for white Americans.[10]

The poverty scandal

Poverty has been repeatedly identified as the major determinant of health status of a population group or region. A disproportionate number of blacks live in low-income households. One third of all black households nationally have incomes below the poverty line, and almost half of all black children live in these families. Moreover, an additional 40% of black households have incomes below 125% of the poverty line. Thus, for black households in or near poverty, affordable healthcare is out of financial reach.[12]

Medical insurance in the United States is linked to employment. This linkage presents a special problem where the unemployment rate for blacks increased steadily through the 1980s. Complicating this situation is the fact that many employed blacks have no medical insurance.[13] In the late 1980s, blacks represented about 18% of the estimated 37 million uninsured individuals in the United States.[13] Economic factors, including lack of health insurance, create barriers to healthcare in at least three ways. The most obvious is a delay in seeking care until forced to do so by the progressive severity of the illness. Second is a reluctance by healthcare providers to provide services to persons without insurance or to those who rely on public programs like Medicaid or General Assistance. Third, treating illnesses at advanced stages is more expensive and complicated than preventive care or early intervention.[14] Thus, poverty and poor health reinforce each other.

To the extent that poverty is the limiting factor to access, the healthcare reform momentum for universal access will address some of the issues in the appalling state of health of US minorities. Thirty-three and a third percent of blacks and 27% of Hispanics live below the poverty level compared with 11% of whites.[15] The result, when combined with the more subtle barriers of undertreatment or denial of services, was described best by McCord and Freeman[16] in their study comparing Harlem's health statistics with those of the Third World countries. It showed that men in this inner-city community were less likely to reach their sixty-fifth birthday than men in Bangladesh.

The failure of health policy in minority health

Federal health policy has been aimed at the general population and has not, for the most part, dealt with the health concerns of minority pop-

ulations specifically. Instead of a comprehensive approach to black health problems, for example, the pluralistic tradition has resulted in a patchwork of federal programs, policies, and guidelines (played out in the states) that have minimal impact in the black community.[12] However, many health policy decisions have been affected by "race politics."[1]

Positive gains following civil rights activism of the 1960s and 1970s were reversed by the racially divisive environment under the Reagan and Bush administrations.[1]

Engagement

David McBride has traced the policy shifts that occurred beginning in the 1960s as they have affected the disadvantaged African Americans. The first phase, which he labels "engagement," saw the development of a community health policy as the national government targeted resources to healthcare programs for needy blacks and the poor. The federal health initiatives were largely the product of antipoverty campaigns of the Kennedy and Johnson administrations. The Health Rights movement galvanized a policy network of public agencies and congressional overseers. The black physicians' organization, the National Medical Association (NMA), was especially active in local and federal political and health-policy-making circles. Federal grants allowed them to rebuild the neighborhood health center model. From 1965 to 1969, the Office of Economic Opportunity sponsored 104 comprehensive health services facilities administered by nonprofit organizations. Community health leaders viewed stepped-up primary healthcare resources as the most important reforms in those years.[17]

Submersion

In the second phase, which McBride labels "submersion," those active in black community healthcare experienced the early stages of alienation and social disorder as well as a public backlash against blacks. Health activists saw the link between traditional general practice physicians and the community hospital weakened by national health policies at the very time it needed strengthening. A decline in the number of traditional general practitioners in the inner city and the higher costs for health technology made urban dwellers increasingly dependent on public hospitals for primary care medical needs. Many urban hospitals were closed. Federal and employment-based medical benefits declined. Twenty-eight percent (239 of 872) of the health centers closed as funding was withdrawn reversing the trend of the 1960s. In fact, an increase in local infant mortality was directly traced to the federal aid reductions in Boston, Mass.[17]

Black communities, unable to reverse the federal retreat from supporting community-level preventive healthcare resources, were increasingly isolated. National health policy concerns shifted to a focus on cost-containment, abandoning the strategies that were designed to address the scandalous health demographics of minorities.

Crisis recognition

By the mid-1980s, the overall disorganization of the healthcare system and the wide disparity in the health of black as well as white Americans reached the current phase "crisis recognition." The *Report of the Secretary's Task Force on Black and Minority Health* was released by DHHS and profiled an alarming failure by the healthcare system to eliminate wide racial differentials in mortality and illness in the nation. Ironically, subsequent to the report the life expectancy of black Americans began to decline for the first time in this century, in 1987 and 1988. It was barely 2 years old when the AIDS epidemic began to spread rapidly into the black population. Health policy, meanwhile, continues to be "color-blind."[17]

The Disadvantaged Minority Health Improvement Act was enacted to address several of the key healthcare needs of minority populations in 1990. It addressed the severe underrepresentation of minorities in the healthcare professions. Blacks, Hispanics, and Native Americans represent approximately 20% of the population of the nation; however, these minorities constitute only 7% of physicians, 4% of dentists, and 6% of nurses practicing in the United States. Grants and scholarships from this source encourage the recruitment of healthcare professionals from the underrepresented groups. Black and minority medical school graduates continue to serve the underserved at high rates, and this strategy is the only clearly identified policy attempt to address the wide disparities in the health of a growing population anticipated to be nearly 1 in 4 Americans.[18] As a strategy, the Disadvantaged Minority Health Improvement Act is a drop in the bucket. To attempt to address the scandalous health demo-

graphics in such a significant portion of the population in this incremental manner is foolhardy and doomed to failure.

As policymakers formulate national healthcare reform, proponents of improved minority health status are divided. On the one hand, it is clear that programs that enjoy universal support and serve the broadest possible constituency offer the best chance of political success. Therefore, including race-specific policies on the healthcare reform agenda could have the negative effect of deflecting broader objectives. On the other hand, financial coverage alone as part of the universal access objective, will not eliminate the racial disparity in health status nor the other barriers to care affecting people of color.[1]

Medical liability

Of all the issues on the healthcare reform agenda, the relationship of medical malpractice to access for the poor and minorities may be the least well-understood.

Physicians and lawyers have been dueling over tort reform for years, and the current healthcare reform climate is intensifying the debate. Malpractice law has assumed gargantuan responsibilities in healthcare—partly by default. Because healthcare has been provided, for the most part, by a loose collaboration among independent and autonomous providers, there is no consistent system of accountability present. The result has been a patchwork, adversarial approach to accountability through the courts. This approach has created an emotional and misinformed provider group who has further limited access for the poor or minority patient.

You strike the final blow to any hope of equitable healthcare when you add the misinformation about malpractice suits to the disparity in insurance coverage, to the racism in healthcare delivery, and to the absence of representation at policy-making tables for minority populations.

The perception among physicians, especially obstetricians, that poor and minority patients are more likely to sue has had a negative impact on access to care for minority patients. The carefully documented study published in *JAMA* in October 1993[19] should herald the ending of a stereotypic perception that has had such a profound impact on human health. By starting with hospital records of patients injured while under hospital care and working back to suits filed, Burstin and coworkers[19] were able to demonstrate that poor and uninsured patients were significantly less likely to file malpractice claims. The risk of claims was lower among Medicaid recipients in the sample, but not significantly, and no significant differences were found by patient race or gender among injured patients. Burstin and associates' very clear conclusion was that gender and race were not independently associated with risk of malpractice claims.[19]

One of the most important conclusions that can be drawn from this study is that proposed legislation to shield physicians who serve the poor from malpractice suits should be reconsidered. Such legislation would probably have the effect of further perpetuating the myth and depriving the poor of the accountability processes afforded to all other Americans.

One factor resulting in fewer malpractice suits filed by the poor is that these cases are less economically attractive to a lawyer than those of wealthy persons. Average payouts for Medicaid plaintiffs were $25,000, compared with $250,000 for the privately insured. In addition, legal services lawyers who serve poor neighborhoods can only take on malpractice cases if two private attorneys have turned them away.

Burstin and colleagues state:

> Our results suggest that rather than suing more frequently, poor and near-poor patients are far less likely to sue, taking into account the fact of injury. Underclaiming by poor patients occurs in the full case-control sample as well as the injured patient group. The effect is very strong, and the relationship between income and claiming is similar to a dose-response effect. Furthermore, we found that the poor were also less likely to file inappropriate malpractice claims when they were not medically injured.[19]

Addressing the barriers

"We live in a society full of preventable disorders, preventable diseases and preventable pain, of harshness and stupid, unpremeditated cruelties."

H. G. Wells

Reform: The minority voice?

The NMA has presented their agenda for reform to the President's task force. It calls for the Administration to develop a healthcare delivery system to replace the fragmented industry we

have. The NMA's key recommendations are

- full participation of African-American physicians;
- establishment of national health boards;
- managed competition and universal access to healthcare;
- quality assurance and cost-containment; and
- medical liability reform.[20]

The NMA position is clearly to avoid race-specific policies and fold the concerns of minorities into the universal issues. There is no assurance, though, that free market competition offers any amelioration of the problems of racial disparities in health status or the differentials in healthcare service utilization. The healthcare reform agenda offers an opportunity to address the formidable problems related to race as the system is restructured for the benefit of all, but whether the opportunity is seized will be decided once again by the politics of race.[1]

Without reform

"Of all the forms of inequality, injustice in health is the most shocking and the most inhuman."

Rev Martin Luther King

(at the Second National Convention of the Medical Committee for Human Rights in Chicago, Ill, March 25, 1966)

Aside from the politics of healthcare reform, the DHHS has voiced a commitment to prevention and a commitment to help remedy the toll ill health exacts from minority people. The 1990 Disadvantaged Minority Health Improvement Act, Public Law 101-527, provided statutory authority to the Office of Minority Health. Between 1988 and 1992, US Public Health Service spending on health programs for minority people rose from $175 million to $600 million. These expenditures do not include the Indian Health Service and Native American tribal governments' expenditures for healthcare[10]: $600 million represents only 0.05% of the total healthcare expenditures in 1993. By any analysis, the scope of the problem overwhelms this budget.

Toward Equality of Well-Being: Strategies for Improving Minority Health, published in 1993 by the Office of Minority Health of the DHHS, was released as an introduction to a strategic planning and coordination process to support individual and collective efforts of states, counties, municipalities, voluntary associations, community groups, and "families."[21]

In an era of healthcare reform where the presence of a perceived "crisis" for all Americans could yield structural changes that promote equity and equality of healthcare for minorities, the Office of Minority Health is missing an opportunity to have an impact on emerging policy. The report does not, in fact, present system strategies, identify resources, or promote a timetable. The report describes goals and objectives like a lion without teeth.

Comment

The issue of minority health cannot be ignored or subsumed in such concepts as the underserved, the uninsured, or the poor (or any combination thereof) for much longer. As we have discussed, a system biased against race and socioeconomic status is a strong "counteractive" to improved access. Moreover, a system biased against race and socioeconomic status presents a barrier to quality care which providers frequently do not recognize their personal role in perpetuating. A reformed healthcare system that does not improve the healthcare of the population group with the worst health status is destined to fail, particularly if that group represents a significant portion of the population. The three major descriptors of the healthcare crisis—access, cost, and quality—function as an iron triangle. The overriding issue driving change is cost. Costs cannot be effectively controlled without establishing a system of universal access, assuring a level of quality and funding prevention strategies that will diminish the overutilization of costly resources as a result of the delay in seeking treatment for preventable disorders.

Because osteopathic physicians treat such large numbers of the vulnerable populations in the United States, they need to be particularly aware of racial and socioeconomic bias and its influence on clinical decision-making. Osteopathic physicians have historically accepted a major role in caring for the vulnerable populations of the United States, and are responsible for 25% of the Medicaid population though they make up fewer than 5% of US physicians (AOA Immediate Past President Laurence E. Bouchard, DO; letter to Health Care Financing Administration administrator Bruce Vladeck, October 5, 1993). The historic commitment of the osteopathic medical profession to underserved, vulnerable populations and the tenets of the osteopathic phi-

losophy which emphasize prevention and health promotion make osteopathic physicians natural advocates for minority populations.

Little professional attention has been paid to the effect of provider biases and behaviors on the health outcomes of patients. "Perhaps it is time to focus public health research on racism and its effects as the potential origin of continuing [health] disparities...."[22] We recognize that patient behaviors have an impact on health status. Emerging evidence points to provider and institutional behaviors as a major contributor to less than optimal minority patient outcomes. Culturally sensitive care requires a medical education system that emphasizes the sociocultural and psychosocial influences on healthcare and requires an examination and recognition of our personal biases. Culturally sensitive care that depends exclusively on the "simplistic" strategy of African American providers for African American patients, Hispanic providers for Hispanic patients, or Native American providers for Native American patients represents an abrogation of the medical profession's responsibility to serve an increasingly diverse society.

As advocates, osteopathic physicians must examine and analyze state and federal reform strategies for their impact on vulnerable populations. *Toward Equality of Well-Being*, in this context, becomes an invaluable guide. Proactive initiatives by the osteopathic medical profession's state and national organizations can have significant influence on emerging policy and would establish a natural posture for the profession. Examination of health data clearly reveals that no population is more vulnerable than minority Americans.

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