



FACT SHEET

For Release: April 1, 2010

Health Insurance Only Partial Solution to Racial Health Disparities

The approval of national health care reform is only one step toward narrowing the racial health disparities in our nation. While more non-Whites than Whites are in need of health coverage, and several provisions in the Reconciliation Bill may address some remaining issues, it is important to realize that broader health *coverage* does not automatically mean more equitable health *care* or more equal health *outcomes*. Insurance will not necessarily bring primary care and other medical resources to medically underserved areas, and there are existing racial disparities in the quality of care.

- In 2007, 66 percent of Whites but only 49 percent of African Americans had employer-sponsored health insurance. Meanwhile, 9 percent of Whites and 23.8 percent of African Americans relied on public health insurance; and 10.4 percent of Whites and 19.5 percent of African-Americans were uninsured. (See <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=51>.)
- According to a separate 2007 report, 35.9 percent of Spanish-speaking Latinos had employer health coverage. (See <http://www.rwjf.org/pr/product.jsp?id=24683>.)
- For those with incomes less than four times the poverty level, the majority were without employer health coverage. (See <http://www.statehealthfacts.org/comparebar.jsp?ind=146&cat=3>.)
- Latinos with health insurance reported having problems paying their medical bills (19%), and postponed seeking health care (16%).¹ Almost three in ten Latinos say they have had a problem communicating with health providers, and almost two in ten Latinos say they have had difficulty getting care because of their race or ethnic background.
- Even controlling for access factors including insurance status, non-Whites are more likely to receive a lower quality of care than Whites. Non-Whites were less likely to get lifesaving heart medications, bypass surgery, dialysis, or kidney transplants. They were more likely to have feet and legs amputated for late-stage diabetes treatment.²
- Even for groups of similar socioeconomic standing, racial disparities persist: the infant mortality rate for college educated Black women is higher than for college educated White women (11.5 vs. 4.2 per 1000 live births).³

¹ Pew Hispanic Center. "Health Care Experiences." Survey Brief. 2004. Page 3. Available at <http://pewhispanic.org/factsheets/factsheet.php?FactsheetID=14>

² Smedley, Brian et. al. "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care." Institute of Medicine. 2003. Page 1.

³ The Henry J Kaiser Family Foundation. "Eliminating Racial/Ethnic Disparities in Health Care: What Are the Options?" Brief. October 2008. Available at http://www.kff.org/minorityhealth/h08_7830.cfm

- A March 2010 article cites statistics from the American Cancer Society⁴
 - Late-stage breast cancer diagnosis is twice as high for Black women as for White women.
 - Early diagnosis of cancer is less likely for minority, low-income, uninsured and Medicaid patients.
 - Uninsured and Medicaid patients face more than twice the rate of late-stage breast cancer diagnosis as privately insured persons.
 - Appropriate treatments for breast cancer like chemotherapy and breast conserving surgery are less likely to be received by minority and low-income patients – 50 percent less likely for African-Americans and 70 percent less likely for American Indians.
 - African American men face a 50 percent higher prostate cancer diagnosis rate and a 200 percent higher prostate cancer death rate than White men. Although White women face a higher breast cancer diagnosis rate, African American women face a 30 percent higher breast cancer mortality rate.

Increased insurance coverage and higher demand for health care services is unlikely to translate quickly into increased availability of care in underserved communities. Racial disparities in the quality of care, which exist regardless of insurance status, also are likely to persist. Lack of access to convenient primary care may still lead some people of color to rely on Emergency Rooms for their care, rather than on doctors' offices which offer greater continuity of care and more patient-centered care.

- In 2006, Blacks and Latinos were twice as likely to rely on hospital outpatient departments as Whites, who are more likely to rely on doctors' offices as a source of regular care.⁵ In 2007, 43% of Latinos and 21% of Blacks reported having no access to a regular doctor or source of care, compared to 15% of Whites.⁶

Even more important, national health care does nothing to address the critical social determinants of health that most account for racial disparities in health outcomes – poverty, food quality, working conditions, neighborhood environment, exposure to chronic stress, and more.

- A recent study references specific health risks of segregated neighborhoods including: elevated risks of cause-specific and overall adult mortality, infant mortality and tuberculosis; elevated exposure to noxious pollutants and allergens; a lack of recreational facilities; higher cost, poorer quality groceries; and limited access to high quality medical care.⁷
- “Moving to Opportunity” (MTO) was an experimental housing program that moved poor families to lower-poverty neighborhoods in cities across the U.S. for five years in the 1990s. In an interim report published in 2003, researchers reported positive outcomes across a number of measures, including

⁴ Michaels, Samantha. “The color barrier to health care: Panel discusses racial disparities in cancer detection and treatment.” March 5, 2010. Available at <http://news.medill.northwestern.edu/390/news.aspx?id=159705>

⁵ *Id.* citing The Commonwealth Fund Health Quality Survey, Chart 4-2, 2006

⁶ Beal, Anne C. et. al. “Closing the Divide: How Medical Homes Promote Equity in Health Care.” The Commonwealth Fund. June 2007. Page ix. Available at

http://www.commonwealthfund.org/~media/Files/Surveys/2006/The%20Commonwealth%20Fund%202006%20%20Health%20Care%20Quality%20Survey/Closing_divide%20pdf.pdf, p. ix

⁷ D. R. Williams and C. Collins, “Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health,” 116 *Public Health Reports* 404, 405 (Sept.-Oct. 2001).

reductions in obesity, positive increases in mental health, and improved housing conditions, neighborhoods, and safety.⁸

- The uneven geography of opportunity is especially acute for children. A study of the 100 largest metro areas found that not only do more Black and Latino children live in high poverty neighborhoods than White children, but that they are also more likely to live in more disadvantaged families (“double jeopardy”), a phenomenon White children rarely experience.⁹
 - 76% of Black children and 69% of Latino children live in neighborhoods with higher poverty rates than the 25% “worst off” White children.¹⁰
 - 16.8% of Black children and 20.5% of Latino children experience double jeopardy, compared to 1.4% of White children.¹¹

Several provisions in the Reconciliation Bill potentially could address some of these concerns:¹²

- **\$11 Billion for Health Center Program Expansion.** This funding is estimated to double¹³ the number of centers and allow existing health centers to expand their operational capacity to serve nearly 39 million¹⁴ new patients and to enhance their medical, oral, and behavioral health services.
- **Investment in nation’s health care workforce.** An estimated 16,500 practitioners are needed to address the needs of under-served areas. This bill provides incentives for primary care providers to locate in underserved communities. Specifically, the bill invests in scholarship and student loan repayment programs through the National Health Services Corps to expand the workforce.
- **Medicaid Expansion to 133% of the Federal Poverty Level in Fiscal Year 2014.** This provision is expected to insure 16 million Americans.
- **Investment of \$2.55 billion in Historically Black Colleges and Minority-Serving Institutions through 2019¹⁵ and Provision of \$500 million a year for fiscal years 2010 through 2014 for community colleges to develop and improve educational or career training programs.¹⁶**

⁸ Orr, Feins, Jacob, and Beecroft (Abt Associates Inc.) and Sanbonmatsu, Katz, Liebman and Kling (NBER), U.S. Department of Housing and Urban Development Office of Policy Development and Research, *Moving To Opportunity Interim Impacts Evaluation* (September 2003).

⁹ *Id.* at 324

¹⁰ *Id.* at 325

¹¹ *Id.* at 327

¹² National Association of Health Centers, “Community Health Centers and Health Reform: Summary of Key Health Center Provisions.” Available at <http://www.nachc.com/client/Summary%20of%20Final%20Health%20Reform%20Package.pdf>

¹³ Lee Bowman. “It will take years to build the new health care system.” Scripps Howard News Service. March 25, 2010.

Accessed April 1, 2010 at <http://www.scrippsnews.com/node/52494>

¹⁴ *Id.*

¹⁵ According to politico.com, the funds will be distributed in the following manner: \$100 million to Hispanic Serving Institutions, \$85 million to Historically Black Colleges and Universities, \$15 million to Predominantly Black Institutions, \$30 million to Tribal Colleges and Universities, \$15 million to Alaska, Hawaiian Native Institutions, \$5 million to Asian American and Pacific Islander Institutions, and \$5 million to Native American non-tribal serving institutions. Chris Frates. “BREAKING—Reconciliation Bill Posted.” Live Pulse. Posted March 18, 2010. Accessed April 1, 2010 at

http://www.politico.com/livepulse/0310/BREAKING_Reconciliation_bill_posted.html

¹⁶ The Health Care and Education Reconciliation Act. Accessed April 1, 2010 at

http://docs.house.gov/rules/hr4872/111_hr4872_amndsub.pdf