



Making
Public Programs
Work for
Communities
of Color

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An Action
Kit for
Community
Leaders

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January 2006

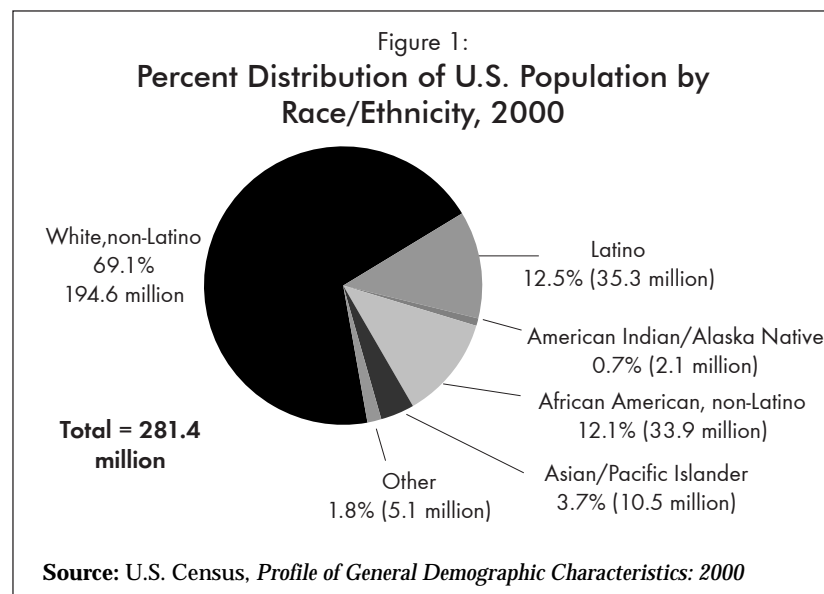
Improve Public Programs, Improve Minority Health

Background

The demographics of the nation are changing. People of color—African Americans, American Indians/Alaska Natives, Asian/Pacific Islanders, and Latinos—make up one-third of the U.S. population, and that proportion is expected to increase to half by 2050.¹ In many of America’s major cities and urban areas, “minorities” now make up the majority.

Racial and Ethnic Health Disparities: An Overview

The problem of racial and ethnic disparities in access, coverage, treatment, and health outcomes has been well documented in recent years. In fact, the magnitude of this problem led the U.S. Department of Health and Human Services (HHS) to make eliminating health disparities by 2010 a national goal and has inspired members of Congress to introduce legislation to help achieve that goal. However, recent threats to public health programs such as Medicaid and SCHIP (the State Children’s Health Insurance Program), changes in the Medicare program, and the growing number of racial and ethnic minorities who don’t have health insurance coverage make reducing and ultimately eliminating these health disparities a challenging task.



The extent and breadth of racial and ethnic health disparities is staggering. People of color are less likely to have health insurance coverage, see a provider on a regular basis, and receive preventive screenings or routine health care services. At the same time, they are more likely to be diagnosed at a later stage of disease and be hospitalized for preventable conditions. For example:

- African-American men are 50 percent more likely to suffer from prostate cancer than white men, and they are more than twice as likely to die as a result of the cancer.²
- One-third of Latinos in fair or poor health had not visited a physician during the preceding year, a considerably higher rate than the rates for whites and African Americans.³
- Compared to the general U.S. population, American Indians are 638 percent more likely to suffer from alcoholism, 400 percent more likely to contract tuberculosis, 291 percent more likely to suffer from diabetes, 67 percent more likely to have pneumonia and influenza, and 20 percent more likely to suffer from heart disease.⁴
- Insurance rates among Asian American and Pacific Islander subgroups vary widely. Because of their likelihood to be self-employed or work in small businesses, one-third of Korean Americans remain uninsured, compared to only 13 percent of Japanese Americans.⁵
- African Americans and Latinos had higher rates of lower extremity amputations than non-Hispanic whites.⁶

Defining Disparities

The term “racial and ethnic health disparities” is an umbrella term that includes disparities in *health* and disparities in *health care*. Although these two terms are often incorrectly used interchangeably, they are two different concepts:

Disparities in health: Disparities in health refer to differences between two or more population groups in health outcomes and in the prevalence, incidence, or burden of disease, disability, injury, or death.

Disparities in health care: Disparities in health care refer to the differences between two or more population groups in health care access, coverage, and quality of care, including differences in preventive, diagnostic, and treatment services.

There is no one solution to eliminating racial and ethnic health disparities, because myriad sources contribute to this gap. These factors include:

- societal factors, such as racism, class differences, and poverty;
- environmental factors, such as hazardous air, unsafe neighborhoods, and lack of green space; and
- structural factors, such as health care delivery systems that may alienate people of color or discourage them from accessing needed care.

While a multi-pronged approach—including efforts from both the private and public sectors—is needed to address this issue, increasing access to coverage is key, and public programs provide the best chance for improving the health of communities of color.

Although the determinants of health disparities are complex and varied, we do not need to unravel every last piece of this puzzle to begin to take action.⁷

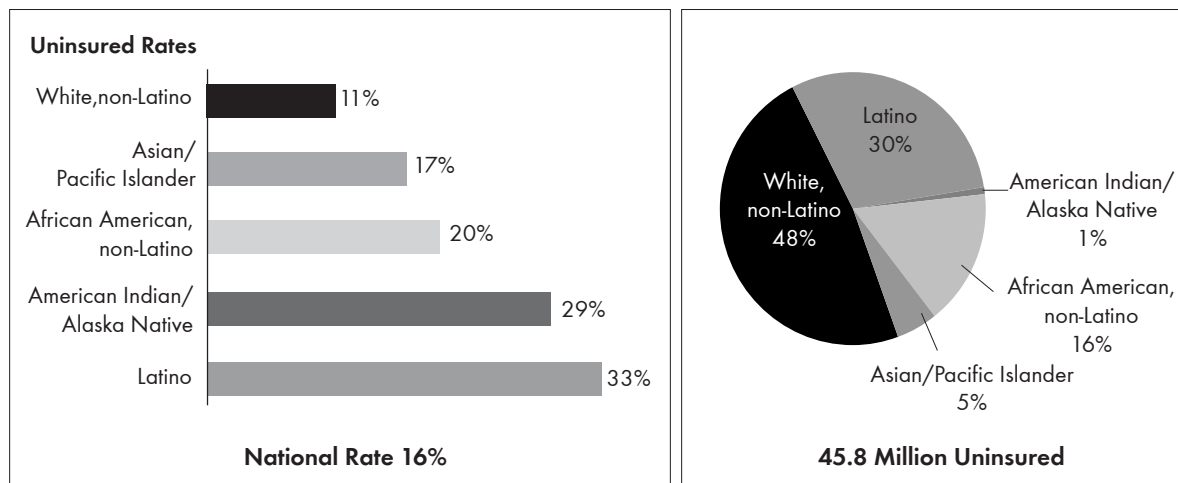
The Role of Coverage in Reducing Disparities

Of all the factors that contribute to health disparities, lack of health care coverage is the single most important factor.⁸ Individuals with affordable and comprehensive health insurance coverage have fewer barriers to health care, are more likely to see a physician on a regular basis, and experience better health outcomes. Insurance coverage also reduces out-of-pocket costs and shields individuals and their families from the economic hardships that an unexpected injury or illness can create.⁹

Unfortunately, racial and ethnic minorities are much more likely to lack health insurance coverage or to be underinsured compared to non-Hispanic whites. While people of color make up just one-third of the U.S. population, they comprise over half of the 45.8 million uninsured. In 2004, 32.7 percent of Latinos (13.7 million) lacked coverage, as did 19.7 percent of African Americans (7.2 million) and 16.8 percent of Asian Americans/ Pacific Islanders (2.1 million), compared with 11.3 percent of non-Hispanic whites (22 million).

Figure 2:

People without Insurance by Race/Ethnicity, 2004



Source: U.S. Census Bureau, "Health Insurance Coverage: 2004," *Current Population Survey 2004*, available online at <http://www.census.gov/hhes/www/hlthins/hlthin04.html>.

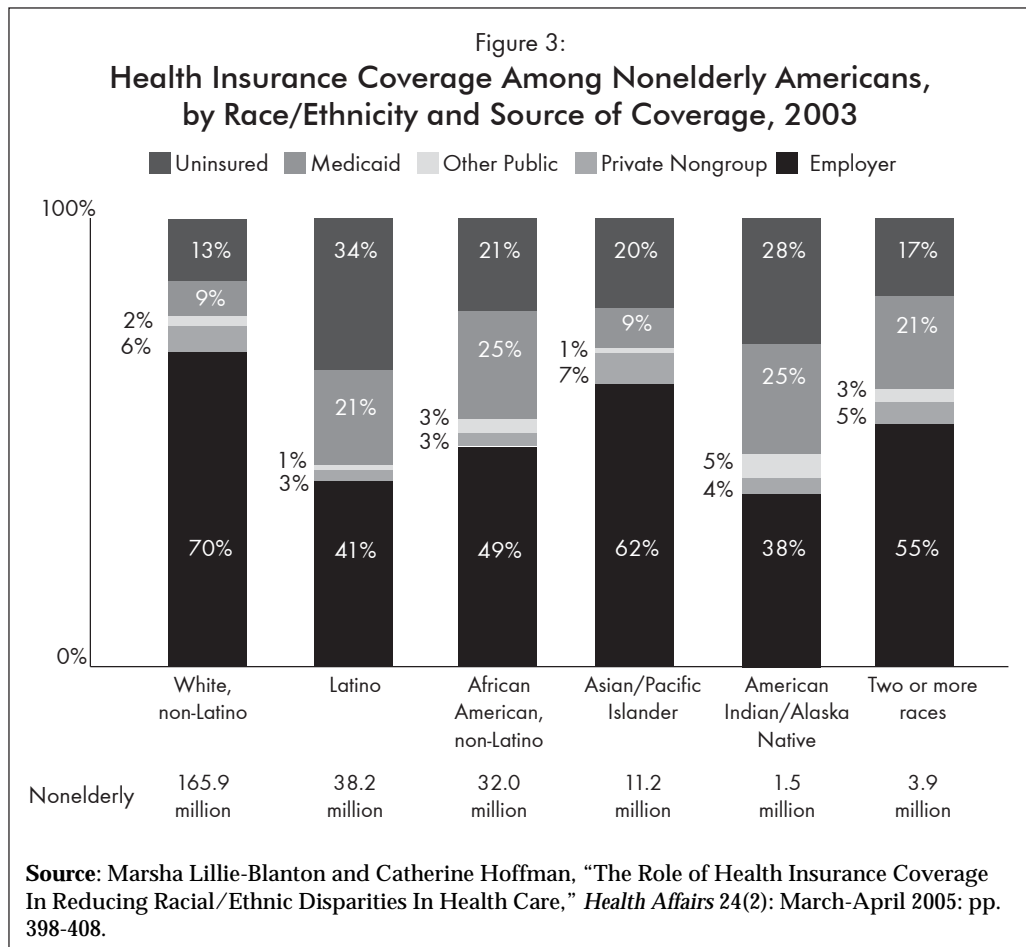
Much of these disparities can be attributed to the fact that racial and ethnic minorities are more likely to be employed in industries that do not offer job-based health insurance, a source of coverage for most Americans (60 percent in 2004). Although 70 percent of whites are insured through an employer-sponsored health plan, less than half of African Americans and Hispanics—the two largest U.S. racial and ethnic minority groups—had such coverage in 2003 (Figure 3).¹⁰ According to one study, as much as 80 percent of low-income Hispanics were uninsured during a four-year period, compared with 66 percent of low-income African Americans and 63 percent of low-income whites. Ironically, low-income Latinos were more likely than any other group to have stable employment over this same period.¹¹

“Minority Americans in low-wage jobs work hard and play by the rules, but are too often shut out of the health care system because they are not offered coverage through work, or if coverage is offered it’s unaffordable. Policy solutions to help low-income working families afford coverage would be an effective way to address these persistent inequities in health coverage and access to health care.”

– Karen Davis, president of The Commonwealth Fund

The Role of Public Programs in Reducing Health Disparities

Racial and ethnic minorities are more likely to rely on public programs for insurance coverage. For example, 27.5 percent of African Americans, 22.3 percent of Latinos, and 29.9 percent of American Indians/Alaska Natives obtain care through public programs, compared with 11 percent of whites.¹² This is due to a variety of reasons, including higher rates of poverty, increased likelihood of employment in industries that lack employer-sponsored health care, and the inability to afford coverage even when it is offered.



Overwhelming evidence indicates that the single most effective way to reduce racial and ethnic health disparities is through the expansion and preservation of public programs, which have a proven track record of serving low-income and minority Americans.¹³ Medicaid and SCHIP have the administrative systems already in place to enroll beneficiaries and pay providers, and they have demonstrated how responsive they can be when unemployment increases and family incomes decrease. According to Lillie-Blanton and

Hoffman, several changes in public policy could have a sizable impact on the health coverage of communities of color. For example, an estimated 74 percent of the 23 million uninsured minority Americans could be covered by using Medicaid and SCHIP to:

1. expand outreach and enrollment efforts to assure that all children who are eligible—children in families with incomes less than 200 percent of poverty—are enrolled in these programs (approximately 4.6 million low-income minority children);
2. expand coverage to parents of children who are enrolled in these programs (approximately 5.0 million low-income minority parents); and
3. expand coverage to low-income adults without dependent children (approximately 7.5 million adults).¹⁴

Conclusion

The problem of racial and ethnic health disparities has been well documented. Although numerous sources contribute to these disparities, and several opportunities exist for addressing this issue, increasing access to insurance coverage is vital to closing the gap.

Public programs have a proven track record for increasing access and improving care for millions of racial and ethnic minorities. In fact, several models for treating minority patients and reducing disparities originated in public-sector programs, such as the collection of data on racial and ethnic minorities and making trained interpreters available for patients with limited English skills. Unfortunately, these programs are currently under threat, and conversations about scaling back have moved us in the direction of preservation rather than innovation.

Given the vital role that public programs play in the lives of racial and ethnic minorities, any efforts to restructure, scale back, or cut these programs must take into account the unique needs and inferior health status of minorities. At the state level, proposals to restructure or alter Medicaid programs must consider the proportion of racial and ethnic minorities enrolled and how these changes might affect existing health disparities. Similarly, proposed policy changes at the federal level must include an analysis of the impact these changes would have on minority populations, particularly if eliminating racial and ethnic health disparities is still the goal of the federal government.

Endnotes

- ¹ Kaiser Family Foundation, *Policy Challenges and Opportunities in Closing the Racial/Ethnic Divide in Health Care* (Menlo Park, CA: March 2005), available online at <http://www.kff.org/minorityhealth/7293.cfm>.
- ² American Cancer Society, *Cancer Facts and Figures, 2003* (Atlanta: American Cancer Society, 2003), available online at <http://www.cancer.org/downloads/STT/CAFF2003PWSecured.pdf>.
- ³ E. Richard Brown, Victoria D. Ojeda, Roberta Wyn, et al., *Racial and Ethnic Disparities in Access to Health Insurance and Health Care* (Los Angeles: UCLA Center for Health Policy Research and Kaiser Family Foundation, April 2000), available online at <http://www.kff.org/uninsured/1525-index.cfm>.
- ⁴ Indian Health Services, *Trends in Indian Health, 2000-2001* (Washington: Indian Health Services), p. 7, available online at http://www.ihs.gov/NonMedicalPrograms/IHS_Stats/Trends00.asp.
- ⁵ Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage and Access to Care Among Asian Americans and Pacific Islanders* (Washington: Kaiser Family Foundation, June 2000).
- ⁶ Andrew Karter, Assiamira Ferrara, Jennifer Liu, et al., "Ethnic Disparities in Diabetic Complications in an Insured Population," *Journal of the American Medical Association* 287 (19), pp. 2519-2527.
- ⁷ Neil Calman, "Making Health Equality A Reality: The Bronx Takes Action," *Health Affairs* 24(2), March/April 2005, pp. 491-498.
- ⁸ Kaiser Family Foundation, op. cit.
- ⁹ Eugene Lewit, Courtney Bennet, and Richard Behrman, "Health Insurance for Children: Analysis and Recommendation," *The Future of Children* 13 (1), Spring 2003, pp. 5-29.
- ¹⁰ Marsha Lillie-Blanton and Catherine Hoffman, "The Role of Health Insurance Coverage In Reducing Racial/Ethnic Disparities In Health Care," *Health Affairs* 24 (2), March/April 2005, pp. 398-408.
- ¹¹ Michelle M. Doty and Alyssa L. Holmgren, *Unequal Access: Insurance Instability among Low-Income Workers and Minorities* (New York: The Commonwealth Fund, April 2004).
- ¹² Kaiser Family Foundation, op. cit.
- ¹³ Edward M. Kennedy, "The Role of the Federal Government in Eliminating Health Disparities," *Health Affairs* 24 (2), March/April 2005, pp. 452-458.
- ¹⁴ Marsha Lillie-Blanton and Catherine Hoffman, op. cit.

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