

Health Care Disparities, Health Care Justice, and Health Care Reform: Race, Politics and Money

Making the Connection Between Health Disparities and the Uninsured

SPEAKERS

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A summary of a forum held in New York City on April 29, 2003.

Race & Politics: Making the Connection Between Health Disparities and the Uninsured

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The issues of race and racism are still very much with us, as they were 40, 100, and hundreds of years before that.

The Urban League has been concerned about the health needs of African Americans since its founding in 1910, when Blacks migrating North experienced health problems resulting from poor sanitation and housing conditions.

Today, the war against minority health continues and extends to poor, working class and even middle class families.

This war is being fought on four fronts affecting health: (1) personal, where people are unable to improve their lives or receive information that can help them escape negative behaviors; (2) environmental, where minorities are forced to live in the most unhealthy areas such as near waste dumps; (3) administrative, where the structure of health care builds in barriers to access and to improving one's well-being; and (4) political, with policies and practices that undermine the ability of minorities to succeed in the interconnecting spheres of education, jobs, and health insurance.

This includes barriers to coverage under Medicaid and Medicare as well as to the safety net programs on which many minorities depend, including Temporary Assistance for Needy Families (TANF), SSI, and food stamps.

Institutionalized racism overlays every sphere of American life. It is no surprise, then, that minority

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Americans under 65 have the highest rates of uninsurance. Compared to whites at 10%, for African Americans it is 19%, Hispanic Americans, 33%, and Asian/Pacific Islanders, 18%.

To get the kind of job that carries health insurance, increasingly an education is needed. Unfortunately, the urban setting where many African Americans attend public school is not conducive to advancement. Also, part-time work, with no health insurance, is common among minorities. At every step along the way, institutionalized racism holds back individuals from achieving the higher standards of well being found in white communities.

The poor health status of minority Americans is well known. We need to make the connection between the well-documented poor health status of minorities and the systemic barriers that influence their ability to receive health care.

The welfare "reform" legislation of 1996 is likewise contributing to the lack of health insurance. The Personal Responsibility and Work Opportunity Act of 1996 ended AFDC (Aid to Families with Dependent Children) and replaced it with TANF. PRWOA allowed states to levy sanctions for non-compliance with work requirements and de-linked Medicaid from TANF participation, so that theoretically everyone below State-determined income levels would still have health insurance. However, many have lost their health insurance anyway, for when they are hired they often earn more than the income limit to qualify for Medicaid. At the same time, their jobs do not provide health insurance. In addition, those who still qualify for Medicaid end up not receiving it due to bureaucratic gaps in service.

A GAO report found that 44 percent of TANF recipients had chronic health problems, and their

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children had mental or physical health impairments. Further, those with health problems had significantly greater difficulty making a successful transition from welfare to work.

A W.K. Kellogg-funded National Urban League study has shown that African Americans and other racial minorities make up 17 percent of those on Federal disability insurance but are 23 percent of those with preventable chronic diseases.

Recommendations

Vigorous advocacy is needed to achieve coverage for the uninsured. At every opportunity, advocacy groups need to make the connection between health disparities and the uninsured. It is not enough to talk about racial disparities — we must continue to show how institutionalized racism generates barriers to health insurance. Advocacy groups need to highlight the often-overlooked cost of inadequate access to preventive health care. More work is needed to examine the relationship between safety net programs, debilitating chronic health conditions, and access to care.

All too often those fighting for universal health care, and those fighting health care disparities have worked in isolation from one another. They must join forces and work together.

Health Care Disparities and Immigrant Health

MARCIA BAYNE SMITH, DSW

In attempting to access primary and preventive health care, immigrants face barriers that are similar to those of low-income minority groups, but they must confront issues of language, culture, and legal status as well.

The foreign-born population of New York City has increased over the last decade to 2.9 million or 35.9% of the City's population. Latin Americans, at 52.6%, are the largest immigrant group, followed by Asians at 23.9%, Europeans at 19.4%, and Africans at 3.2%. Black and Latino immigrants from the circum-Caribbean region, Cen-

tral/South America and sub-Saharan Africa live in poverty in communities with dense concentrations of families with children. Many do not speak English well and, as a consequence, have difficulty accessing health services.

Health Department data show that immigrants of color, especially from the Caribbean and Africa, have the greatest infant mortality and the highest prevalence of HIV-AIDS.

Immigrants most often hold jobs that do not offer health insurance, the cost of private health insurance and medications is out of reach, and Federal restrictions built into immigration and welfare reforms limit access to Medicaid. But non-financial barriers to health care are also severe: These include fear of deportation, especially in the post-9/11 climate. Immigrants encounter language barriers and providers who are

culturally insensitive, especially in addressing the persistent influence of long held cultural beliefs and behaviors.

Recommendation

Universal health care is essential for everyone in this country, immigrant and non-immigrant alike. But the movement for universal health care must address not only the financial barriers faced by immigrants in obtaining health care, but the non-financial barriers and cultural issues as well.

The forum was sponsored by the NY Metro Chapter of PNHP and co-sponsored with Region IX of the Student National Medical Association, Region II of American Medical Student Association, the New York Urban League, Metro NY Health Care for All Campaign, and the Public Health Association of New York City. This report was prepared by Mary Klein, RN, MSPH and Leonard Rodberg, PhD.

Distribution of Immigrant Population living with HIV-AIDS in NYC

- 40% Caribbean
- 13% Central America
- 12% South America
- 8% European
- 5% Africa
- 4% Asian Pacific Islanders
- 18% Other

PNHP-NY Metro FORUM REPORT

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THE LUKOMNIK FORUM SERIES

This Forum was the second sponsored by the Joanne Lukomnik Fund for Health Care Reform. As with last year's forum on the Future of Medicare, we seek to continue Joanne's activism in support of decent, compassionate, accessible health care as the right of every human being. Joanne, who died at the age of 51 in 1998, served as medical director and consultant to community health centers in New York City and across the country and was one of the founders of Physicians for a National Health Program. This year's Lukomnik Forum emphasized two passions of her life – the fight against racism and for a health care system that would serve everyone. The Fund, along with the NY Metro Chapter of PNHP, will continue that fight.