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HEALTHCARE FOR ALL: WHY MINORITIES CONTINUE TO FALL

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HEALTHCARE FOR ALL: WHY MINORITIES CONTINUE TO FALL

A Look at the Disparities in the Quality of Care in the Healthcare System, Especially Among Minorities, and What We Can Do To Change The Racial Inequality That Persists.

ABSTRACT

The enactment of the Patient Protection and Affordable Care Act is a step in the right direction to bridge the gap between healthcare and poverty. While it seeks to help all, there are some citizens who continue to be at a disadvantage even with insurance coverage. Why? Because, an extrinsic change with a temporary fix will not deracinate discrimination.

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INTRODUCTION

In 2010, the enactment of the Patient Protection and Affordable Care Act (PPACA) or the Affordable Care Act (ACA) signed into law by Congress marked major change.[1] The PPACA is an expansion of Medicaid and provides added care and coverages for eligible individuals.[2] The goal of the healthcare reform is to ensure that every person living in the United States would have accessible and affordable healthcare. Healthcare coverage is an expensive necessity that most families, especially those with low income, are unable to afford. While this system is positive for society as whole, and while the focus is often on the expense of the program, there is often little attention given to the quality of healthcare that many receive. A legal reform in healthcare that should be beneficial to all cannot fulfill its intended purpose because the law is not applicable to everyone. Moreover, the quality of care offered is inconsistent across the nation. Quality care goes beyond the physical locations of providers; it involves the mental and emotional care that patients should receive. Some patients receive better care than others. Studies show that race plays a major part in the quality of care that patients receive, and minorities most often than not are the recipients of poor quality care. Unless there are significant changes that address the disparities in healthcare, minorities will remain in a disadvantageous position.

BACKGROUND

The Patient Protection and Affordable Care Act is composed of several parts and subparts. A few areas that it focuses on include the improvement of the coverage that prevents lifetime or annual limitations.[3] Specifically,

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[1] *Summary of the Affordable Care Act*, HENRY J. KAISER FAMILY FOUNDATION (Apr. 25, 2013), https://www.kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/.
[2] *Keeping America Healthy Affordable Care Act*, MEDICAID.GOV, https://www.medicaid.gov/affordable-care-act.
[3] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 131 (2010).

> A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish: (1) lifetime limits on the dollar value of benefits for any participant or beneficiary; or (2) unreasonable annual limits (within the meaning of section 223 of the Internal Revenue Code of 1986) on the dollar value of benefits for any participant or beneficiary.[4]

Another benefit of the act is the coverage of preventive health services. "A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for" any of the following.[5] If there are evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force, then those items or services should be covered.[6]

An important coverage is immunizations that are recommended practices of the Centers for Disease Control.[7] Evidence-informed prevent care and screenings for infants, children and adolescents; as well as preventive care and screenings for women; and recommendations regarding breast cancer screening, mammography and prevention all fall within coverage of preventive health services.[8]

The Patient Protection and Affordable Care Act also states that individuals should not suffer discrimination based on their salaries:

> The plan sponsor of a group health plan (other than a self-insured plan) may not establish rules relating to the health insurance coverage eligibility (including continued eligibility) of any full-time employee under the terms of the plan that are based on the total hourly or annual salary of the employee or otherwise establish eligibility rules that have the effect of discriminating in favor of higher wage employees.[9]

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[4] *Id.*at §2711.
[5] *Id.*at §2713.
[6] *Id.*
[7] *Id.*
[8] *Id.*
[9] Patient Protection and Affordable Care Act § 2716.

Most importantly, the quality of care offered needs monitoring by law. The statute provides:

> "Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures."[10]

These reimbursement structures would "improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives." [11] They would also "implement activities to prevent hospital re-admissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional."[12] In addition, they would also "implement wellness and health promotion activities."[13]

I. CHALLENGES TO THE AFFORDABLE CARE ACT THAT ALLOWS INTERSTATE DISPARITY

The Patient Protection and Affordable Care Act states its purpose is to strengthen "quality, affordable healthcare for all Americans."[14] For some states, the law as it stands is enough. These states acknowledge the general rule of law and offer no challenges nor amendments. These states

[10] *Id.* at §2717.
[11] *Id.*
[12] *Id.*
[13] *Id.*
[14] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 131 (2010).

include California, Washington, Oregon, Nevada, Colorado, New Mexico, and others.[15] Whereas, other states challenge or amend the terms of the law.,

For example, Alabama passed two constitutional amendments that utilized both citizen votes and legislative approval. "Amendment 6 **Passed** with 59.0% Yes votes" while "oppos[ing] elements of federal health reform."[16] The amendment stated that "residents may provide for their own health care, and that 'a law or rule shall not compel any person, employer, or health care provider to participate in any health care system.'"[17]

The second amendment established "the interstate 'Health Care Compact' in the state of Alabama," which allowed states to "join the compact to propose state health policies that could replace federal provisions."[18] It further provided that "each member state, within its state, may suspend by legislation the operation of all federal laws, rules, regulations and orders regarding health care that are inconsistent with the laws and regulations adopted by the member state pursuant to this compact."[19] The changes continue with, "the laws also seek to use appropriated federal funds, redirected to state-specified programs."[20] Likewise, states like Arizona, "prohibits the 'funding or implementation of a state-based health care exchange or marketplace. Also prohibits the state and political subdivisions from using any personnel or financial resources to enforce, administer or cooperate with the Affordable Care Act.'"[21]

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[15] *See* Richard Cauchi, *State Laws and Actions Challenging Certain Health Reforms*, NAT'L CONF. ST. LEGIS., (2/27/2018), http://www.ncsl.org/research/health/state-laws-and-actions-challenging-ppaca.aspx.
[16] *Id.*
[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.*

A. THE PENALTY THAT DISPARITIES CREATE FOR CITIZENS WITH AND WITHOUT ACA COVERAGE

Besides the Constitutional challenges of the Affordable Care Act, citizens who cannot afford to keep the coverage face the real burden. The law mandates that anyone not eligible under Medicaid is required to purchase health insurance from a private insurance company, most likely through employment.[22] If citizens are unable to acquire insurance and have shown not to have coverage for the calendar year, then they are required to pay a tax penalty.[23] Plans are ranked in accord with premium costs. From lowest premium to highest, the plans are categorized as Bronze, Silver, Gold, or Platinum.[24] The highest-priced insurance plans (Platinum level) secure the lowest out-of-pocket expenditures at the time of service, and vice versa.[25] Depending on the income of the family, if the cost of insurance outweighs the penalty, then they are more likely to pay the penalty and forego the policy, especially if they are healthy.[26] This creates an imbalance in the healthcare system, as some citizens gain from the healthcare reform, while others are repressed.

Because there are inconsistencies with the acceptance of the Affordable Care Act in its current status, the quality of care citizens receive varies nationwide. While some states are accepting and fulfill the requirements of the law, there are other states, as aforementioned, that have rejected or made amendments to the law making it difficult for "all Americans" to have affordable and quality healthcare.[27] Much emphasis focuses on the expense of giving and

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[22] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 131 (2010).
[23] June Mary Zekan Makdisi, *The Affordable Care Act: Does It Improve Health and Does It Live up to Human Rights Standards?*, 10 INTERCULTURAL HUM. RTS. L. REV. 117, 130 (2015).
[24] *See Prescription Drug Costs and Health Reform: FAQ*, WEBMD, https://www.webmd.com/health-insurance/aca-prescription-drug-costs-faq#1 (last visited Nov. 3, 2017); *FAQs About Affordable Care Act Implementation (Part XIX)*, EMPLOYEE BENEFITS SECURITY ADMIN., U.S. DEP'T LAB., (May 2, 2017), https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xix.pdf.
[25] 42 U.S.C. § 18022(d) (2012).
[26] *See, e.g.*, 26 U.S.C. §5000A(c) (2012); *Individual Shared Responsibility Provision – Reporting and Calculating the Payment*, IRS http://www.irs.gov/uac/ACA-Individual-Shared-Responsibility-Provision-Calculating-The-Payment (last visited Feb. 25, 2015).
[27] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 131 (2010).

supporting the Affordable Care Act. Although the law clearly includes the requirement that people should be getting quality health care, some states operating under the Affordable Care Act are still subjecting individuals to poor treatment from health care physicians and unclean health facilities.[28] Ichiro Kawachi, John L. Loeb and Frances Lehman Loeb Professor of Social Epidemiology and chair of the Harvard T.H. Chan School of Public Health's Department of Social and Behavioral Sciences were in agreeance on one issue: "If you're born a black man in, let's say, New Orleans Parish, your average life expectancy is worse than the male average of countries that are much poorer than America."[29] It is unfortunate that a nation that is so rich in diversity practices more exclusion than inclusion, even within healthcare.

II. DISPARITY THAT LEADS TO POOR QUALITY CARE FOR THE ELDERLY, THE ETHNIC, AND THE POOR

The elderly class face their own discrepancy with the law. According to a Medicare recipient, the experience has not been wonderful, and the quality of care received has been questionable; she wrote, "I think we have a serious problem on our hands in relation to health care, not only from the standpoint of the financial picture, but also in terms of the quality of care that our older persons are getting."[30] The cause for concern is selfless, as she speaks on behalf of other recipients who are experiencing the same challenges. The recipient further provided insight to the process, especially after the hospital discharges an ill patient. She stated, "when the patient is discharged from the hospital, because we do not have adequate services, do not have the adequate planning for the posthospital care of the older person."[31] She continued by adding, "these

[28] Alvin Powell, *The Costs of Inequality: Money = Quality Health Care = Longer Life,* HARV. GAZETTE, (Feb 22, 2016), https://news.harvard.edu/gazette/story/2016/02/money-quality-health-care-longer-life/.
[29] *Id.*
[30] *The Effects of PPS on Quality of Care for Medicare Patients: Hearing Before the Spec. Comm. on Aging*, U.S. S. 99th Cong. 4 (1986) [hereinafter *Hearings*] (statement of Eva Skinner, R.N., California Medical Review, Inc.).
[31] *Id.*

often are the determining factors on whether or not the person will recover to the best of health possible."[32] She followed up by saying that the practice is ongoing, "we find this happening again and again."[33] This is clearly a lack of empathy attributable to being old, poor, or a minority. This is how society labels an individual, and these are all characteristics upon which we frown.

To support this finding, the recipient gave examples of specific cases where the elderly face both physical and financial ramifications. An elderly widow of eighty-one years had Parkinson's disease, was admitted for a mastectomy, and discharged after twenty-four hours.[34] Her condition made it difficult to care for herself, and with the hospital cutting corners by releasing her prematurely, her recovery was delayed and it cost her more out of pocket because "she could [not] receive Medicare benefits for a nursing home placement."[35]

Another example of an elderly woman facing affirmative ramifications was a seventy-six-year-old woman with a serious lung condition and high blood pressure; she was admitted with a high temperature and rapid heartbeat.[36] She was prematurely discharged within a twenty-four-hour timeframe, prescribed nine medications, and had no follow-up or supervision.[37]

Yet another example of an elderly person receiving substandard care was a sixty-seven-year-old man with a heart condition and high blood pressure who was admitted to the hospital and sent home within a day; he was discharged "with what could be considered a serious life-threatening condition."[38] These examples are just a small representation of the widespread

[32] *Id.*
[33] *Id.*
[34] *Id.* at 5.
[35] *Id.*
[36] *Id.*
[37] *Id.*
[38] *Id.*

epidemic of limited care that hospitals provide for elderly patients who are recipients of the Affordable Care Act.

III. THE FIDUCIARY ROLE OF PHYSICIANS

In all fairness, it is understandable that health care facilities have profit margins and costs associated with their daily operations to meet. It follows that physicians have a fiduciary duty to treat their patients with the best care and attention. A fiduciary relationship is "a relationship in which one person is under a duty to act for the benefit of another on matters within the scope of the relationship."[39] Accordingly, a physician is a fiduciary to their patient and should act in their best interest. Since individuals who benefit from the Affordable Care Act are patients, their physicians should give them the same treatment as individuals who pay out of pocket or with private insurance.

Maxwell J. Mehlman wrote:

> Good health is essential to patients' well being and is important to society. Physicians are in a position to take advantage of patients because they have greater knowledge and experience, and because they often have control over patients, especially when the patients are unconscious or so ill, afraid, or in pain that they cannot adequately fend for themselves.[40]

Much like the duty owed to the elderly patients mentioned above, it is a physician's duty to ensure that patients leave the hospital within a reasonable time. It stands to reason, however, that those patients with a debilitating condition should ideally be monitored longer than a day.

[39] *Fiduciary Relationship*, BLACK'S LAW DICTIONARY (10th ed. 2014).
[40] Maxwell J. Mehlman, *Why Physicians Are Fiduciaries for Their Patients*, 12 IND. HEALTH L. REV. 1, 2-3 (2015).

A. INEFFECTIVE COMMUNICATION CONTRIBUTES TO POOR QUALITY CARE

The breakdown in care amongst the elderly is not only the patient-physician barrier that patients experience. There is also a communication barrier that patients face with their physicians. The communication breakdown can present issues that lead to ineffective patient care.[41] "Minority Americans were more likely than whites to experience difficulty communicating with their physicians," with around one-third of Hispanics and one-fourth of Asian Americans and African Americans experiencing these communication problems.[42]

The breakdown in communication can stem from difficulties such as "not understanding the doctor, not feeling the doctor listened to them, or that they had questions for the doctor but did not ask."[43] Hispanics and Asians often experience this problem. Indeed, Hispanics experience this problem more than any other minority groups.[44] Asian Americans come in at a close second for communication problems with their physicians.[45] Minority patients, however, are not solely responsible for the communication between them and their physicians.[46] Physicians, as professionals, should be held to a higher standard. Otherwise, we should all be certified, licensed, and approved by any state board of medical examiners to treat ourselves.

B. PATIENTS TREATED IN UNCLEAN FACILITIES CAN CREATE FURTHER HEALTH COMPLICATIONS

When giving quality health care, the belief would be to ensure that the facilities in which people receive this care are hygienic, sanitized, and kept in a manner that promotes good health

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[41] *See Minority Americans Lag Behind Whites on Nearly Every Measure of Health Care Quality*, COMMONWEALTH FUND (Mar. 6. 2002), http://www.commonwealthfund.org/publications/press-releases/2002/mar/minority-americans-lag-behind-whites-on-nearly-every-measure-of-health-care-quality.
[42] *Id.*
[43] *Id.*
[44] *See id.*
[45] *See id.*
[46] *See id.*

and well-being. Some healthcare facilities are still not running at the level of cleanliness that aforementioned standard. Based on my experience, many of the less hygienic facilities are located in poor neighborhoods or communities where there is a lack of wealth and privilege.

From a personal perspective, it was one of the few times that I can recall being afraid to leave the confines of my car. United Healthcare assigned me to a clinic that was closest to my zip code, and I later discovered that was not the case. The clinic was in an area of town that was a cross between the boondocks and a public squalor. I cancelled the appointment from the car. Other health care facilities are bug infested and keep areas, such as the restroom, in deplorable conditions. Not being a native of Houston, it was the second clinic that I tried to visit. This time I was brave enough to go inside. The restroom was unsterilized and smelled like a combination of urine and Clorox. Furthermore, the in-patient room was a playground for cockroaches.

These facilities give the impression that, although the Affordable Care Act is meant to provide affordable health care to everyone, the ACA does not guarantee that the facilities providing this care are unblemished. A 2017 study conducted by the Infectious Diseases Society of America regarding the percentage of surfaces that were clean in clinics, revealed that less than forty percent of examination rooms and less than thirty percent of waiting rooms were clean.[47] The same study revealed that, of the clinics assessed, at least four of the clinics had waiting rooms that were zero percent clean.[48]

One can only imagine the effect unclean clinics would have on patients. Things such as bacteria and infections are likely to spread from person to person. A study conducted of clinics

[47] Mark E. Rupp, Courtney Olsen, R. Jennifer Cavalieri, Elizabeth Lyden & Philip Carling, *How Clean are the Clinics? Assessment of Environmental Cleanliness in Ambulatory Care*, OX. U. PRESS. OBO INFECTIOUS DISEASES SOC'Y AM. (Oct. 5, 2017, 12:30 PM), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5631767/table/T1/.
[48] *Id.*

and hospitals in Texas revealed that the patient was the most commonly touched item within a hospital and therefore had the most potential for contamination of others and other surfaces.[49] The Affordable Care Act Section 2717(C) states, that the health care facility should ‘‘implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage.”[50] Although section 2717 (2) requires the reporting of such information and sub-section (D) outlines the penalty, it is hard to determine whether the penalty is for non-reporting, or if it is for not being in compliance with the quality care requirement. “In developing the reporting requirements under paragraph (1), the Secretary may develop and impose appropriate penalties for non-compliance with such requirements.”[51]

IV. MINORITIES RECEIVE WORSE CARE THAN WHITES

With the standard of cleanliness so low, one cannot help but to wonder which groups of people the poor-quality health standards affect more. The Agency for Healthcare Research and Quality (AHRQ) began in 2003 to conduct annual progress and opportunity reports aimed at improving the quality of health care and to reduce the disparities within the health care system.[52] A 2010 study conducted by AHRQ revealed that the disparity in the quality of care minorities received in comparison to Whites was quite common.[53] The statistics were broken down between Blacks, Hispanics, Asians, and the generally poor.[54] The report showed that Blacks received worse care than Whites for forty percent of measures, and Asians received worse care than Whites for

[49] *Id.*
[50] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 128.
[51] *Id.*
[52] *Disparities in Healthcare Quality Among Racial and Ethnic Minority Groups: Selected Findings from the 2010 National Healthcare Quality and Disparities Reports*, U.S. DEP’T HEALTH & HUMAN SERV., AGENCY FOR HEALTHCARE RES. & QUALITY, (last reviewed Oct. 2014) [https://archive.ahrq.gov/research/findings/nhqrdr/nhqrdr10/minority.html].
[53] *Id.*
[54] *Id.*

twenty percent of measures.[55] Hispanics received worse care than Non-Hispanic Whites for an alarming sixty percent of core measures. In addition, people who were poor received worse care than others who earned a higher income for eighty percent of core measures.[56] "Disparities due to poverty hurt racial and ethnic minorities more than other groups because they make up a large proportion of the poor. Not only do they have more ailments, but they often get worse care."[57]

A. PATIENTS FEEL THERE IS A LACK OF MUTUAL RESPECT

Besides the aesthetics of healthcare facilities, minority groups experience poor quality care in other areas as well. They are often not treated with the same level of respect and care as White patients and often encounter a negative experience.[58] "Nearly one out of six African Americans (15%), one out of seven Hispanics (13%), and one of ten Asian Americans (11%) feel they would receive better health care if they were of a different race or ethnicity, compared with one percent of whites."[59] Professor Vernellia Randall highlights specific examples of how minorities experience discrimination in practices that contribute to the disparity in healthcare.[60] Providers engage in practices such as "excessive wait times, unequal access to emergency care, deposit requirements as a prerequisite to care, and lack of continuity of care."[61] "Linguistic training and cultural competence are not often incorporated into medical training and health care standards, minorities often report lack of quality care, especially in Hispanic and Asian American populations."[62] Hispanics, as compared to other minority groups, feel that they are more

[55] *Id.*
[56] *Id.*
[57] Powell, *supra* note 28.
[58] COMMONWEALTH FUND, *supra* note 41.
[59] COMMONWEALTH FUND, *supra* note 41.
[60] Julie Hwang, *The Road to Reducing Racial Disparity in the Healthcare System: Affordable Care Act as a Domestic Implementation of CERD*, 8 GEO. J. L. & MOD. CRITICAL RACE PERSP. 171, 176 (2016) (citing Vernelia R. Randall, *Racial Discrimination in Health Care in the United States as a Violation of the International Convention on the Elimination of All Forms of Racial Discrimination*, 14 U. FLA. J.L. & PUB. POL'Y 45, 54-68 (2002)).
[61] *Id.*
[62] *Id.*

susceptible to this level of disrespect.[63] They often attribute the behavior of health care officials to their prejudicial view of a Hispanic minority's inability to pay.[64] In a perfect world an individual's inability to pay for care that he or she needs should not be a topic of discussion. Quoted in the Harvard Gazette, Katherine Baicker, a well-respected health economist, stated, "Insurance is not just supposed to get you access to care, it's supposed to keep you from getting evicted from your apartment because you paid your hospital bill instead of your rent."[65] All minority groups face a disadvantage with the current health care system despite what the law says. Ashish Jha, the K.T. Li Professor of International Health, Professor of Medicine, and Director of the Harvard Global Health Institute said, "If you're having a heart attack, there are very standardized protocols. If you're African-American, you're less likely to get those, even with the same health insurance, even with the same presentation."[66] David Williams, Florence Sprague Norman and Laura Smart Norman Professor of Public Health at the Harvard Chan School and Professor of African and African-American studies in Harvard's Faculty of Arts and Sciences assert that the root of the problem may stem from racism.[67]

B. MINORITIES ARE DIAGNOSED WITH MORE CHRONIC CONDITIONS

It is no wonder that minorities suffer from the worst chronic conditions. Poor quality in health care for minorities would mean that conditions in minorities are either misdiagnosed, undiagnosed, diagnosed too late, or goes untreated. The roach infested clinic I visited is a perfect example. My purpose for the visit was to have a physical examination. I left feeling both disturbed and appalled. After waiting for over forty-minutes, my visit was over in seven minutes. The

[63] *Id.*
[64] *Id.*
[65] Powell, *supra* note 28.
[66] *Id.*
[67] *Id.*

physician asked the reason for me being there, I told her, she listened. Without physical contact during a physical examination, she prescribed an eye drop. I walked out never to return. Thankfully I am healthy because that experience was another possibility for me to be a statistic. "Minority adults are more likely to have health problems than whites. One of five Hispanics (22%), one of six African Americans (17%), and one of six Asian Americans (17%) rate their health as fair or poor, compared with one of seven whites (14%)."[68] The numbers may not appear to be alarming; however, the statistics reflect that minorities diagnosed with chronic conditions are younger than Whites on average.[69] In addition, further study shows that there are huge disparities between ethnicities based on how likely each group is to be diagnosed with a chronic condition.[70] "African Americans age 50 and older are more likely to have been diagnosed with a chronic disease or condition such as high blood pressure, heart attack, cancer, diabetes, anxiety or depression, obesity, or asthma. Three-quarters of African Americans age 50 and older (77%) have been diagnosed with one of these conditions, compared with 68% of Hispanics, 64% of whites, and 42% of Asian Americans 50 and older."[71]

C. RACE AND POVERTY FUEL DISPARITIES

Given more minorities are diagnosed with chronic conditions than Whites, it is difficult not to question the level of disparity between the numbers. African Americans receive a comparable percentage of care to Whites, yet, they remain in poor health.[72] "African Americans are getting preventive services at rates at least comparable to whites, their health outcomes remain

[68] COMMONWEALTH FUND, *supra* note 41.
[69] *Id.*
[70] *Id.*
[71] *Id.*
[72] *Id.*

worse."[73] One justification could be that minorities do not have adequate accessibility to health insurance.[74] One would argue that the Affordable Care Act was enacted to ensure that everyone has equal access to healthcare.[75] A study revealed that "Nearly one-half of working-age Hispanics (46%) lacked health insurance for all or part of the year prior to the survey, as did one-third of African Americans."[76] Not only are minorities lacking in health care coverage but they are just as likely to not have access to obtaining coverage.[77] "Uninsured minorities are even more likely than uninsured whites to experience problems obtaining access to health care."[78] Geographical differences play a huge role in the disparity as well.[79] Katherine Baicker, C. Boyden Gray Professor of Health Economics at the Harvard Chan School and acting chair of the Department of Health Policy and Management cited in the Harvard Gazette said, "Health disparities exist regionally across America — Southern states, for example, have poorer care, according to a 2014 government report. There also are smaller pockets of poverty, such as depressed urban areas."[80] Baicker continues:

> I think an important factor that is sometimes overlooked is there are a lot of observed disparities in care … based on income, race, or ethnicity, that are attributable to the quality of care in some parts of the country lagging behind other parts of the country, Baicker said. So, it's as much about where you live as what your characteristics are.[81]

It is unfortunate that even within the healthcare system, minorities continue to face setbacks.[82]

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[73] *Minority Americans Lag Behind Whites On Nearly Every Measure Of Health Care Quality*, COMMONWEALTH FUND (Mar. 6, 2002), http://www.commonwealthfund.org/publications/press-releases/2002/mar/minority-americans-lag-behind-whites-on-nearly-every-measure-of-health-care-quality.
[74] *Id.*
[75] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 131 (2010).
[76] COMMONWEALTH FUND, *supra* note 41.
[77] *Id.*
[78] COMMONWEALTH FUND, *supra* note 41.
[79] Powell, *supra* note 28.
[80] *Id.*
[81] *Id.*
[82] *See* Hwang, *supra* note 60, at 176.

V. WHAT RESOLUTIONS DO WE HAVE?

The huge disparities will continue to exist unless the system makes a concerted effort to examine the quality of care patients receive. The Affordable Care Act is a step in the right direction to ensure by law that the possibility to receive benefits exists to everyone.[83] "The best way to eliminate health disparities is through improvements in the care we deliver to each patient, emphasizing patient dignity and empowerment."[84] According to William H. Frist, one solution in improving the disparities in the quality of care patients receive is to revive the patient's "dignity" by holding them accountable for their health.[85] While that may work for some, and it is a plausible idea, I cannot disagree with this approach. It appears to be a deflection rather than a solution. "Public policies must encourage patients to embrace personal responsibility."[86]

Essentially, that statement is commanding the law to make it the patient's responsibility to take control of their health. I, however, believe the solution should focus on ensuring that patients feel that sense of empowerment first. Empowerment can only come from the physicians with whom they interact who should be giving quality care. Quality care should include the reassurance that patients feel secured, heard, comforted, and encouraged. Because, if stress is a factor that contributes to chronic conditions and other health ailments, an unempathetic physician does not help to alleviate that distress that patients face, instead, it only adds to it. "Providers must understand the communities they serve."[87] I agree.

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[83] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 131 (2010).
[84] William H. Frist, *Perspective Overcoming Disparities in U.S. Health Care: A Broad View of the Causes of Health Disparities Can Lead to Better, More Appropriate Solutions*, HEALTH AFFAIRS VOL. 24 NO. 2, 445, 447 (Apr. 2005), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.24.2.445.
[85] *Id.*
[86] *Id.*
[87] *Id.*

A. HEALTHCARE PROVIDERS NEED BETTER TRAINING

For solutions to be effective the change should begin with providers. On an airplane, the flight attendant tells passengers especially mothers or care givers in an emergency to put on their own oxygen mask before helping others. The same principle would apply to providers. They should equip themselves with the tools needed to handle the communities they serve. Being prepared includes better training in communication, and more effective strategies to appeal to each diverse group of ethnicities with whom they interact. There cannot be a standardized approach for every patient because the need of each patient is different. Furthermore, not all patients speak the same language. "We also must give providers incentives to promote innovative clinical redesign, which will improve the overall quality of care and close the gaps."[88] "We also need health care providers who are trained to work with health disparity populations. Providers need to know the patients they are caring for; they need to understand, if not be a part of, these communities."[89] Race and ethnic minorities are more likely to be impoverished. It has been shown that poverty sometimes stems from one ethnicity.[90] Being poor affects one's health.[91] Providers should be trained to take into consideration the diverse needs of their patients.[92] Thankfully the Affordable Care Act is a step in the right direction. However, there needs to be an in-depth look at the quality of care patients especially minorities receive beyond the access to care.[93] "Addressing those social and behavioral factors would need government officials and community leaders to think

[88] *Id.* at 448.
[89] *Id.* at 449.
[90] Sharmila Choudhury, *Racial and Ethnic Differences in Wealth and Asset Choices*, SOC. SEC. BULL., VOL. 64, NO. 4, (2001/2002), https://www.ssa.gov/policy/docs/ssb/v64n4/v64n4p1.html.
[91] Alvin Powell, *The Costs of Inequality: Money = Quality Health Care = Longer Life,* HARV. GAZETTE, (Feb 22, 2016), https://news.harvard.edu/gazette/story/2016/02/money-quality-health-care-longer-life/.
[92] *Id.*
[93] *Id.*

innovatively and cooperatively about the everyday realities that affect health, even down to the designs of neighborhoods and transportation systems."[94]

B. EMPLOY MORE MINORITIES IN HEALTHCARE

One way that might happen is by hiring more minorities in the health care field.[95] Strong efforts have been made since the 1970s to increase the number of health professionals in medically underserved areas, yet members of racial and ethnic minority groups are still underrepresented in the health care workforce.[96] "Excellence in health professions education is difficult to achieve in a culturally limited environment. Missing the experience of cultural diversity diminishes the overall quality of health professions education and adversely affects the health status of minority populations."[97] According to the *Commonwealth Fund Health Care Quality Survey 2001*, twenty-eight percent of Latinos and twenty-two percent of African Americans reported that their options to locations for seeking care was extremely limited or nonexistent.[98] On the other hand, only fifteen percent of Whites had this difficulty.[99]

C. LEGISLATION SHOULD SUPPORT AN EQUITABLE HEALTHCARE SYSTEM

It is also important to take into further consideration the areas not currently addressed by the Affordable Care Act. The areas of legislation that have been held back or the funding that has been cut should be made a priority.[100] "For instance, political opponents have attacked the $15 million Prevention and Public Health Trust Fund that provides grants to address poor housing, air

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[94] *Id.*
[95] Frist, *supra* note 84, at 449.
[96] THE SULLIVAN COMM'N, MISSING PERSONS: MINORITIES IN THE HEALTH PROFESSIONS: A REPORT OF THE SULLIVAN COMMISSION ON DIVERSITY IN THE HEALTHCARE WORKFORCE 4 (2004), https://depts.washington.edu/ccph/pdf_files/SullivanReport.pdf.
[97] *Id.* at 6.
[98] *2001 Healthcare Quality Survey*, THE COMMONWEALTH FUND, http://www.commonwealthfund.org/interactives-and-data/surveys/quality-of-care-for-vulnerable-populations-surveys/2001/2001-health-care-quality-survey.
[99] *Id.*
[100] Alvin Powell, *The Costs of Inequality: Money = Quality Health Care = Longer Life*, HARV. GAZETTE, (Feb 22, 2016), https://news.harvard.edu/gazette/story/2016/02/money-quality-health-care-longer-life/.

quality, and lack of exercise, calling the spending wasteful. Legislators have cut a third of its funds."[101] It would be beneficial to keep the law uniformed across the nation.[102] When the Supreme Court allowed states to opt out of the expansion of the Patient Protection Affordable Care Act, it did more harm than good.[103] The opt out option allowed the disparities to continue to thrive.[104] This lack of uniformity puts minorities at a further disadvantage.[105] John McDonough, professor of the practice of public health at the Harvard Chan School said, "Under the ACA, we created a new structure where just about every American citizen and legal resident has access to some kind of affordable health insurance coverage, except for poor adults in states that have not accepted Medicaid expansion under the ACA."[106] While the Affordable Care Act was sufficient in at least getting some to have access to care, others were still left out:

> The law requires people above a certain income to have health insurance, and it expands the Medicaid program to cover those who can't afford it. A 2012 Supreme Court ruling created a significant pothole on the road to universal coverage, however, allowing states to opt out of the Medicaid expansion. That left 4 million poor Americans in 20 states ineligible and on their own.[107]

VI. CONCLUSION

While all proposed resolutions are plausible and could affect some change, we still need to address the root of the problem. Racism rears its ugly head in every side of our daily lives. People with discriminatory dispositions need to change from within, especially those within the medical profession. Otherwise, the giant sore festering under each band aid will continue to ooze inequality, inefficiency, and disparity in our healthcare system.

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[101] *Id.*
[102] *Id.*
[103] *Id.*
[104] *Id.*
[105] *Id.*
[106] *Id.*
[107] *Id.*