NESRI NATIONAL ECONOMIC & SOCIAL RIGHTS INITIATIVE

People of Color and the Human Right to Health Care: A Perspective on the Federal Health Reform Law

Despite a growing U.S. movement for realizing health care as a human right and a public good for all, recent efforts to reform the market-based health system continue to treat health care as a commodity. The new federal health law maintains an inequitable system, characterized by entrenched racial and ethnic disparities in access to and quality of health care.

People of color have more difficulty getting health care, have fewer choices in where to obtain care, and receive lower quality care than Whites.[1] Evidence shows that the quality of care given to people of color is generally lower, including in the treatment of cancer, heart failure, and pneumonia.[2] The 10 year survival rate for Black people with cancer is 48%, compared to 60% for Whites.[3] People of color comprise more than half of those without health insurance, despite representing only one third of the total population.[4] At the same time, most communities of color experience higher rates of disease and mortality than Whites.[5] Racial inequities in health care are one of many factors contributing to significantly poorer health outcomes for people of color in the United States.

What is the human right to health care?

All people have a right to the health care they need, as recognized in the Universal Declaration of Human Rights. This right guarantees a system of health protection for all.

- **Universality:** Everyone must have access to equal high-quality and comprehensive health care.
- **Equity:** Costs and resources must be shared equitably, with everyone getting what they need and contributing what they can.
- **Accountability and Public Goods:** The people oversee the provision of health care as a public good, shared equitably by all.

Does the new law measure up for the human rights of people of color?

We measure the new law against the human rights standards of **universality** and **equity**, and assess whether health care is treated as a **public good**, accessible and accountable to all.

Our assessment finds that the law fails to protect and fulfill the human right to health care for people of color. Although the law greatly improves access to Medicaid for people of color who are poor, those with lower to middle incomes will likely struggle to afford meaningful coverage that they can use to get comprehensive care. The level and quality of care will continue to depend on how much a person can pay, where they live and whether they are employed, among other factors, thus perpetuating health care disparities.

What is the Patient Protection and Affordable Care Act (P.L. 111-148)?

Signed into law by President Obama on March 23, 2010, this Act, together with the Health Care and Education Reconciliation Act (P.L. 111-152), expands Medicaid and tightens some insurance industry regulations, while leaving the current market-based system largely intact. Many provisions of the law will come into effect in 2014.

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People of Color and UNIVERSALITY

Human Rights Principle
Everyone must have guaranteed access to equal high-quality and comprehensive health care.

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Market-Based System
Different groups get different types of coverage and different levels and quality of care.

What will health reform change?

- ↑ Medicaid eligibility will be expanded to everyone earning less than 133% of the federal poverty level (FPL), including childless adults. This will increase coverage for people of color, as the poverty rate for Blacks and Latinos is nearly three times higher than for Whites.[5]
- ↑ Insurance companies will be prohibited from discriminating based on health status and selling coverage only to healthy people. If they can afford to buy coverage, this may benefit Blacks and Latinos, who have higher rates of ill health.
- ↑ A national quality strategy will be established, whose many priorities will include an attention to disparities in care. Activities to be funded include quality measures development and technical assistance to providers.
- ↑ Enhanced data collection in Medicare, Medicaid and CHIP programs (not in private insurance) to monitor disparities (by race, ethnicity, sex, disability, and primary language).
- ↑ Insurance plans in state-based exchanges will have to provide culturally and linguistically appropriate information.
- ↑ Potential funding for cultural competence tools and training.

- ↓ Most newly eligible adult Medicaid enrollees will receive "benchmark coverage" (an essential benefits package) rather than traditional, full Medicaid benefits, and they can be charged up to 10% of the cost of services used.
- ↓ Low income people, among whom people of color are overrepresented, may have to transition frequently between Medicaid and the insurance exchanges. Any change in income may affect eligibility for Medicaid or a subsidized exchange plan, which could disrupt coverage.

What will stay the same?

- → No universal guarantee of access to health care, and 23 million people will remain uninsured.[6] A majority of the uninsured are likely to be lower-income, among which people of color are overrepresented.
- → Immigrants, among whom people of color are overrepresented, continue to be barred from Medicaid/ CHIP for the first 5 years (or entirely excluded, if undocumented).
- → Strict citizenship verification requirements for Medicaid will continue to deter eligible applicants, particularly people of color who are U.S. citizens. 25% of Black and 16% of Latino citizens (18 years and up) have no current government-issued ID compared to 8% of Whites.[7]
- → Many measures to reduce disparities depend on discretionary funding, voluntary uptake by providers, or are limited to demonstration projects. Without secure funding and enforcable mandates, initiatives may remain underused.
- → No positive responses will be required to remedy the persistent disparities problems evidenced by data collection over the past ten years. Without a legal obligation to ensure equity, direct and institutional racism will likely continue. Cultural competence measures are insufficient to tackle systemic problems such as the greater likelihood of Blacks being admitted to hospitals that have high mortality rates, even if they live closest to a lower-mortality facility.[8]

What reforms would ensure UNIVERSAL ACCESS for people of color?

Universality Standard: People of color have a human right to get the health care they need. No one should be discriminated against on the basis of income, health status, gender, race, age, immigration status or other factors.

Examples for advancing universality for people of color:

- ► In the United Kingdom, health care is universal and free at the point of use through the public National Health Service (NHS). The NHS Constitution affirms everyone's right to equal access and to protection from racial discrimination. UK law (the Race Relations Act of 1976 as amended in 2000) places a legal responsibility on the NHS to take positive action to ensure racial equality. While discrimination and inequality have been extensively documented in governmental and independent reports, all health sector organizations and institutions must now plan, implement, monitor, and report their actions to achieve equality in health care in order to comply with the law.[9]
- ► As the U.S.'s largest health insurance program, Medicare is a public single-payer plan providing health coverage to 39 million seniors and 8 million people under 65 regardless of income, health status, or race/ethnicity. Although disparities exist within Medicare, they are smaller than those experienced by people of color prior to becoming eligible for Medicare.[10]

People of Color and EQUITY

Human Rights Principle
Health care costs and resources must be shared equitably, with everyone getting what they need and contributing what they can.

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Market-Based System
Health care costs place a greater burden on lower-income people; more resources are available in wealthier, profitable areas.

What will health reform change?	What will stay the same?
↑ Low-income people (between 133%-400% FPL) will be eligible for premium and cost-sharing subsidies to buy insurance in the exchanges. About 80% of nonelderly Blacks, Latinos, and Native Americans earn below 400% FPL, compared to 57% of Whites.[11] ↑ Workforce incentive programs may be funded to bring health professionals into underserved communities. ↑ Workforce diversity initiatives, including loan repayment, scholarships, training, and grants for educational institutions serving people of color, may be funded to bring more people of color into the health workforce.	→ Health care costs will remain high despite premium and cost-sharing subsidies. For a family earning between 300% to 400% FPL, subsidized premiums would be up to 9.5% of income, plus up to $7,973 out-of-pocket costs per year.[14] → Coverage may not fully pay for care (as little as 60% of costs) nor cover all health needs (e.g. adult dental care). People of color will be disproportionately affected by cost-sharing, as they tend to suffer from poorer health than Whites—largely due to socio-economic inequities—and may need more care, resulting in higher out-of-pocket costs. Low-income people, among which people of color are overrepresented, will continue to forgo or delay care at a higher rate than wealthier people. → Lack of providers who accept Medicaid due to low reimbursement rates. An increase of Medicaid rates will be temporary (in 2013 and 2014). Compounded by a growing primary care provider shortage, the Medicaid expansion may not translate into increased access to actual care. → No comprehensive strategy exists for rectifying the inequitable distribution of health resources across different communities. Despite some funding promises, the law fails to systematically shift resources to community-based efforts for reducing the concentration of health risks in poor communities of color. Instead, a continued focus on costs over needs may adversely affect people of color living in low resource, high cost areas. → Health workforce incentives for individuals largely depend on discretionary funding, and are unlikely to meet the need for adequate, sustainable resources for communities of color. → Workforce diversity programs largely depend on discretionary funding and do not address structural barriers faced by people of color, starting with inequities in primary education.[15]
↓ Federal payments to hospitals with a large proportion of uninsured and low-income patients, among which people of color are overrepresented, will be lowered. This will likely reduce services for these patients. Medicare's Disproportionate Share Hospital payments will be cut by 75% in 2014; Medicaid's DSH payments to states will be reduced by $14 billion over 10 years. ↓ An expansion of pay-for-performance in Medicare may exacerbate the inequitable distribution of resources, as the performance of hospitals located in disadvantaged areas tends to be poorer.[12] Any shift of funds away from these hospitals would increase disparities. Similarly, financial penalties for preventable hospital readmissions may adversely impact people of color by neglecting the causes of their higher readmission rates, such as poor outpatient care linked to a lack of access to doctors.[13]	

What reforms would ensure EQUITY for people of color?

Equity Standard: People of color have a human right to access care on the basis of clinical need, not privilege, payment, geographical location, immigration status, or other such factors.

Example for advancing equity for people of color:

► As the provisions of the new law are not required to have a positive effect on reducing health disparities, many measures are bound to fail people of color. In contrast, a health system that works for everyone would be based on the principle of equity. It would redistribute resources to those areas, communities, and people that need it most. Therefore, the World Health Organization recommends that "*governments ensure public sector leadership in health care systems financing, focusing on tax-/insurance-based funding, ensuring universal coverage of health care regardless of ability to pay, and minimizing out-of- pocket health spending*."[16] In fact, pursuant to national obligations under the International Convention on the Elimination of All Forms of Racial Discrimination, the United Nations has called upon the United States to "*eliminate the obstacles that currently prevent or limit [racial and ethnic minorities'] access to adequate health care, such as … unequal distribution of health care resources, [and] persistent racial discrimination in the provision of health care*."[17]

People of Color and Health Care as a PUBLIC GOOD

Human Rights Principle
Health care is a public good that belongs to all. Publicly financed and administered care is the strongest vehicle for making care accessible and accountable to all.

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Market-Based System
Health care is a commodity bought and sold in the marketplace. Private, for-profit entities are primarily accountable to shareholders.

What will health reform change?	What will stay the same?
↑ Expansion of the public Medicaid program will benefit poor people, among whom people of color are overrepresented. ↑ Community health center funding will increase by $11 billion, which will benefit people of color who represent around half of all health center users. Patients of publicly funded and patient-governed community health centers experience fewer disparities in care.[18]	➔ Medicaid has been privatized in many states, reducing accountability to the millions of people of color it serves. Pressure is growing to privatize the Medicaid expansion, and concerns abound over for-profit insurers abusing Medicaid. The Government Accountability Office found oversight of private Medicaid managed care contracts to be inconsistent, which places billions of federal and state dollars at risk for misspending.[20] ➔ Health insurance remains a market commodity, excluding those who cannot pay and for whom limited public subsidies are insufficient. Since people of color tend to be poorer, they are particularly disadvantaged by the market model.
↓ New insurance marketplaces will be publicly subsidized, yet not all will have equal coverage. A tiered structure offers better benefits and lower cost-sharing for those who can afford a top-tier plan. ↓ Around $464 billion in public subsidies for private insurers will dwarf community health center funding and further privatize the system without guaranteeing health care access for people of color.[19]	

Making health care a PUBLIC GOOD: what's in it for people of color?

- People of color have long fought for equal access to health care as part of the struggle for civil rights. Demands for non-discrimination and integration have been effective in addressing problems such as segregation within hospitals and have helped create a public safety net. Yet to challenge systemic inequities, a more substantive vision of a human rights-based health system is needed. To move beyond stopgap programs designed for those falling through the cracks, our health system must distribute resources equitably and make services available according to people's health needs.
- If the public sector, funded and overseen by the people, were to provide health care as a public good, many people of color would no longer have to rely on limited programs that are constantly threatened by budget cuts and provider shortages. Instead, access to care would be secured for all through sharing costs and benefits equitably.

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