

The Recently Passed Health Care Reform and Its Impact on Health Care Disparities Among Racial and Ethnic Minorities: Utilizing New Media Technologies to Teach It

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The paper begins to discuss healthcare disparities faced by racial and ethnic minorities and the low quality of healthcare they received, also arguing that disparities will continue until drastic change occur. After discussing the newly passed healthcare bill, we ask if its implementation will reduce those disparities. As discussed, while progressive analysts response will be affirmative, for conservatives analysts disparities will even become worse. To enhance my teaching of MHA courses, these issues will be discussed, and new media, which can provide more information to students and would make them more actively engaged, would be utilized.

INTRODUCTION

The United States is a diverse country whose minority population, which is economically less advantaged, is about 30 or so percent of its total population. However, since the growth of U.S. minority population is higher than that of its majority, as suggested by the U.S. Census Bureau, by the year 2080 the minority population will reach over 50 percent of the U.S. population.

Being less prosperous (and due to other reasons), as discussed in the paper, members of the U.S. minority population have, on the average, less access to healthcare. (Of course, healthcare disparity is not exclusive to minorities, since disparity also has a class dimension). And, the care they receive is also of a lower quality. As discussed below, of course, this health disparity is nothing new.

In the Spring of 2010, the United States Congress passed the Health care reform bill, and President Obama signed it. Although the reform bill is not what many proponents of health care reform and health equity had hoped for, since various progressives desired a much more universal reform bill, still many progressives view it as a step forward. Can the above mentioned health disparities (among minorities or even the less-advantaged members of the majority) be reduced as a result of the recently passed healthcare reform bill, provided that it opponents will not be successful in the Courts/Supreme Court to put an end to it? After discussing the specifics of this newly passed healthcare reform bill, and the complexity of those disparities, attempt will be made to demonstrate that, at least in terms of access, health disparities among (mainly) racial and ethnic minorities can potentially be reduced. Of course, as we will see, conservative opponents of the bill may disagree.

The author discusses health disparities, as well as the impact of health reform on these disparities, whenever appropriate in her health administration classes, and wishes to even emphasize them more in the future. Given the rise of poverty rates in the US as a result of the recent Great Recession, familiarizing students of healthcare administration with less than adequate healthcare is even more crucial. The author

believes that utilization of new media technologies can help enhance teaching the recently passed care reform and its impact on the health situation of minorities (and other less advantaged persons) in the U.S. in our graduate courses in health administration. After all, today's students are technologically savvy. Since a great deal of information about the debate that led to the passage of the healthcare reform bill, or information about health disparities, are available online, today's students are capable of seeking knowledge and active learning through the new information technologies that they regularly use in their daily lives. Utilization of the new technology sources such as Blackboard, Discussion Board, Wiki, Blog, Second Life and Skype , and the interaction, and communication resulting from these technologies, can enhance teaching by complementing information contained in textbooks, academic journals, or the information provided through lecturing. In other words, the information about the above obtained through Blackboard, and the interaction resulting from those technologies, can be well-integrated in the graduate courses in our MHA program.

Health Disparities in the United States

As stated above, health care disparities are a fact of life in the United States. For, racial and ethnic minorities, immigrants, those are not proficient in English, and even many less educated /less prosperous whites have less access to health care services , and to the quality of healthcare they receive. As stated by Brian Smedley of Health Policy Institute, in the United States: "Healthcare disparities are not new-they are a persistent relic of segregation and inadequate healthcare for communities of color." (2009, p. 2). To him "Like access to other opportunities, healthcare for minorities suffered from government inattention (and in some cases, explicit blessing of inequality) for over 100 years after the end of the Civil war."(Ibid).

As stated above, health disparity in the United States is not new. In his 1944 classic study, Swedish Noble Prize economist /social theorist Gunnar Myrdal, comparing the healthcare of the American whites and black (then by far the largest racial minority in the United States) stated that: "Area for area, class for class, Blacks cannot get the same advantages in the way of prevention and care of disease that Whites can". (Quoted by Hengameh Hosseini, 2010, p. 113).

Forty one years later, and almost twenty years after the inception of Medicaid/Medicare, the Report of the Secretary's Task Force on Black and Minority Health (DHHS 1985) concluded that "Despite the unprecedented explosion of scientific knowledge and phenomenal capacity of medicine to diagnose, Black, Hispanics, Native American and those of Asian/Pacific Islander heritage have not benefited totally or equally from the fruits of science or from the systems responsible for translating and rising health technology".

And, more than two decades later than the above report, Byrd and Clayton stated the following:

"Despite steady improvements in the overall health of the United State's population, the health of American's racial and ethnic minorities varies from the mainstream. For example, the health status of African Americans- a racial-ethnic group already burdened with deep and persistent history –based health disparities-has been recently characterized as tangent or deteriorating." (2003, p. 455).

To emphasize their argument/point, those two authors stated that:

"A body of nearly 600 scientific publications documenting racial and ethnic disparities in healthcare provides ample evidence of this problem." (Ibid).

The above should not imply that healthcare disparities are exclusive to minorities, since they also exist among less advantaged whites in the United States.

The impact of less access to healthcare and its quality can be seen in the following statistics, as suggested in the U.S. Department of Health and Human Services sources (2006).

- The likelihood of diabetes among Native Americans and Alaska Natives is more than twice that of the average of all in the United States.

- Among Black Americans, the age-adjusted death rate for cancer is approximately 25 percent higher than for white Americans.
- The black-white gap in infant mortality during 1980-2000 time periods widened.
- African –Americans have a 6-10 fewer years of life expectancy than white Americans. According to Wolf-Johnson, et al, had mortality rates for African-Americans been equal to those of White Americans in that period, over 88000 deaths among African Americans would have been prevented.

Racial and ethnic minorities in the United States experience significant disparities compared to whites in terms of both access to healthcare and the quality of healthcare they receive. According to a 2006 report by the U.S. Agency for Healthcare Research about healthcare disparities in the United States, minorities in the United States had much less access to healthcare, and for various health measures. According to that report, Hispanics/Latinos experienced the worst access problems of all ethnic groups. While in 17 percent of health measures they (Hispanics) had the same access; in the remaining 83 percent of measures Hispanics/Latinos had by far less access than whites. According to the same study, minority groups also fared poorly in health quality as compared to whites. According to that report, African Americans receive poorer quality of healthcare than white Americans on 73 percent of measures , Hispanics/Latinos receive 77 percent of those measures , Asian Americans on 32 percent, and Native Americans receive 41 percent. According to Smedley, “ from 1999 to 2004 the proportion of adults age 65 and over who received a pneumonia vaccine increased for whites (from 52 percent to 59 percent) but decreased for Asians (from 41 percent to 35 percent), and from 2000 to 2003 colorectal cancer screening rates increased for whites while falling sharply for American Indians and Alaska Natives.” (2009, p.3). As argued by Smedley, “these growing gaps are not unexpected given that the increase in the numbers of the uninsured has been more dramatic in communities of color than in non-minority communities.” (Ibid).

Even for those with health insurance, health disparities persist. In fact, a substantial body of evidence demonstrates that racial and ethnic minorities receive a lower quality and intensity of healthcare than white patients, even when they are insured at the same levels, have similar incomes and present with the same types of health problems. Examples (provided by the above author) are the following:

- African-Americans with health insurance are less likely than white- Americans with health insurance to receive many potentially life-saving or life extending procedures, particularly high-tech care, such as cardiac catheterization, bypass graft surgery, or kidney transplantation.
- Black American cancer patients fail to get the same combinations of surgical and chemotherapy treatments that white Americans with the same disease presentation receive.
- African-American heart patients are less likely than white American patients to receive diagnostic procedures, revascularization procedures and thrombolytic therapy, even when they have similar incomes, insurance and other patient characteristics.
- According to Smedley, the same is also true of routine care. He gives the example of African-American and Hispanic/ Latino patients who are less likely than whites to receive aspirin upon discharge following a heart attack, to receive appropriate care for pneumonia and to have pain-such as the kind resulting from broken bones- appropriately treated.
- U.S. Minorities are also less likely to receive treatments such as limb amputation for diabetes. Disparities also exist in long-term care. While U.S. minorities constitute the fastest-growing segment of U.S. population, and are burdened with a higher prevalence of chronic diseases, thus requiring more long term care, yet minority patients are less likely to receive long-term care. (See MN AKhter and AR Levinston, 2003, pp. 88-93). The same can be said of dental service. Eliminating those healthcare disparities is a desirable goal, not only because it is humane and is the right thing to do, but also because it is good economically. In fact, in their 2009 study entitled “The Economic Burden of Health Inequalities in the United States”, Laveist, Gaskin, and Richard, demonstrate that reducing health inequality is in fact beneficial economically. In the executive summary of their study, those authors argue the following:

“We estimated the economic burden of health disparities in the United States using three measures: 1- Direct medical costs of health inequalities, (2) indirect costs of health inequalities, and (3) costs of premature death. Our analysis found:

- Between 2003 and 2006 the combined costs of health inequalities and premature death in the United States were \$1.24 trillion.
- Eliminating health disparities for minorities would have reduced direct medical care expenditures by \$ 229.4 billion for the years 2003 and 2006. (p.1).
- Between 2003 and 2006, 30.6% of direct medical care expenditures for African Americans, Asians, and Hispanics were excess costs due to health inequalities.
- Eliminating health inequalities for minorities would have reduced indirect costs associated with illness and premature death by more than one trillion dollars between 2003 and 2006.” (p.1).

The New Health Care Reform and Its Impact

Progressives in the United States have for a long time advocated reform of the American healthcare system, and have desired some type of universal coverage. Among American progressives, including many physicians, have even supported a single –payer system. In fact, the Journal of American Medical Association, in its August 2003 issue, included a proposal for a single –payer system that was proposed by a large number of physicians. That proposed single-payer system had the following attributes:

- A single –payer
- Comprehensive coverage without co-payments and deductible.
- Maximum choice of doctors, nurse practitioners and hospitals.
- Improved quality.
- Expansion of primary care.
- Publically-funded, but privately delivered.

More recently, in fact when the recently-passed health reform bill was being debated in the congress, Congressman Conyers (D-Michigan) and 85 other members of the U.S. House of Representatives also advocated a single-payer system, as did many other progressive Americans and Democrats. Of course, President Obama and some Democrats advocated a system that was less drastic than a single-payer system and included what became known as Public Option. Of course, Republicans and conservatives (including conservative Democrats) in the U.S. opposed any government involvement in the healthcare system-thus opposing the single-payer system, the Public Option or even a lesser government involvement. In fact, even Obama’s Public Option was rejected by the U.S. Congress, thus leading to the bill that was eventually passed in March 2010.

In the spring of 2010, the United States congress passed the Health care reform bill, and President Obama signed it. (Of course, its future is not very certain, since more conservative states have begun to take it to the courts. This is why the 11th Circuit Court of Appeals found its individual mandate unconstitutional). Although the reform bill is not viewed as a perfect one by the most progressive elements in the U.S. still it is viewed as a step forward by many progressives, believing that it is providing health insurance to millions of uninsured Americans, preventing insurance companies from denying health insurance companies from denying health insurance to individuals with pre-existing conditions, and other positive points. These include: to incentive small business owners to cover their employees, to establish new competitive health insurance markets, and to bring greater accountability to keep premiums down and prevent insurance industry abuses and denial of care. The bill also provided certain benefits to the elderly. Case in point is the coverage for the so called donut hole. Under the Medicare Prescription Drug plan or Medicare part D., Medicare Part D is a federal program established to subsidize the cost of prescription drugs for Medicare beneficiaries which was enacted-under President George W. Bush in 2003, and went into effect in January of 2006. Donut hole is the coverage gap between two cash benefits when an individual has to take full out –of pocket responsibility for the cost of their prescription drugs. Under the Medicare Prescription plan, once a senior reaches \$2,250 of drug

costs, he/she will have to pay 100% of the next \$2,850, before Medicare part D covers drug costs again (which is called the donut hole). Once the senior has purchased \$ 5,100 in covered prescription drugs, the senior's costs are again covered. However, the Health Care and Education Reconciliation Act of 2010 section 1101 provides for a \$250 rebate to Medicare beneficiaries who reach the part D coverage gap in 2010. In any quarter when an individual reached the threshold for the donut hole coverage gap, Medicare, by the 15th of the third month following that quarter, shall send a \$250 rebate (being entitled to only one such rebate). Additionally, starting in the year 2011, Medicare will provide free annual wellness visits and personalized prevention plans. Of course, Medicare will be required to cover such services with no co-pay.

There seems to be more unpublicized benefits to the elderly. According to June, 2010, AARP Bulletin, the health care bill has set aside \$20 billion over five years to encourage states to use Medicaid dollars to help older people transition out of nursing homes to move independent living arrangements-their homes or assisted living. The bill is also supportive of preventive medicine. According to a June statement by Health and Human services Secretary Kathleen Sibelius, the bill will allocate \$250 million for public health initiatives on preventing measures that concern chronic diseases that also deal with the curbing of tobacco and alcohol abuse. The bill has also allocated \$500 million as Prevention and Public Health Fund as a part of Medicare. This provides money, through grants, to community clinics and hospitals, and to those who do research. Beginning with 2011, Medicare patients will have free access to all preventive screening and tests that include mammograms, colonoscopies and annual comprehensive physical exams. At present, Medicare patients have had to pay 20 percent of the cost of these measures and use their yearly deductibles. As emphasized by Center for Medicare Advocacy, Inc., in the newly-passed health care bill, Medicare Advantage Prescription Drug Plans may not manipulate premiums for low-income beneficiaries in order to force them into other plans. However, health and human service secretary has been authorized by the newly-passed bill to auto-enroll low-income beneficiaries who have lost their plans into more advantageous plans. In fact, beginning with January 2011, a person whose spouse has died in the middle of a low-income eligibility period will have the opportunity to continue that plan by exactly one more year after the person's eligibility would discontinue. Further, the person may also reapply for that low-income benefit, if qualified. Very often, poor elderly who receive Medicare benefit cannot get the full benefits of Medicaid if they are under home care or in a nursing facility. As emphasized by Garry Matters in his "Health Care Reform Benefits for Elders"(June 26,2010), beginning with January 1,2012, the reforms call for the elimination of cost-sharing (co-pays) for part D drugs for all full benefits, dual-eligible beneficiaries who receive both Medicare and Medicaid at home or in a nursing institution. This provision, supposedly, creates equity in part D cost sharing between those in institutions and those getting the same services at home or in assisted living.

Needless to say that the bill passed in March 2010 has had many opponents, including those who find aspects of it unconstitutional. Many conservatives believe the Federal Government has no right to force individuals, businesses, etc. to purchase health insurance (explaining why various states have taken the issue to Federal courts).

Interestingly enough, some conservative opponents of the above bill have opposed it on the grounds that it even widens healthcare disparities. For example, Kathryn Nix, in her September 14, 2010 article "Side Effects: Obama care widens Health Care Disparities" criticized President Obama's statement to the Spanish media that the new health reform law would ensure that minorities like Latino's would have access to health care services through better coverage options. In her critical response to President Obama's statement, Kathryn Nix made the following points:

1. "This coverage is pushing many Hispanic and African Americans into an inefficient program that has seen a sharp drop in physician participation. Obamacare puts an additional 16 million Americans into Medicaid, a poorly performing welfare program".
2. The expansion is expected to exacerbate problems that riddle the poor performing program-namely, poor quality and low reimbursement rates to primary care providers that have resulted in a physician shortage for Medicaid patients.

3. Only about half of U.S. physicians accept new Medicaid patients, compared to 70 percent who accept Medicare patients.
4. Minority populations will be disproportionately forced into Medicaid, while Americans with higher incomes will receive generous subsidies to buy private insurance.
5. Ultimately, expanding Medicaid will further divide American healthcare into two tiers.
6. Increasing the number of Medicaid beneficiaries will make it more difficult for present Medicaid patients to find doctors, and ...

Of course, progressives disagree. As we will see, to them, the reform law is a step forward, including in its ability to reduce healthcare disparities.

Would the above changes contained in the new healthcare law improve the healthcare of United States' minority population, leading to the reduction of health disparities? Obviously, if maintained, the new reform bill will benefit U.S. minorities, since they are disproportionately poor. Among the benefits to minorities leading to a reduction in health disparities, we can include the following:

- Since the bill is expected to provide health insurance coverage to 32 million people who are currently uninsured, and because the uninsured are more likely to be minority, minorities will end up with more access to health insurance, thus care.
- According to the bill, subsidies are to be provided to individuals and families who make 100 percent-400 percent poverty level (which include a larger minority population) and want to purchase their own insurance. This too will to provide more insurance, thus more healthcare, to minorities.
- Starting with 2010 (after its passage of March 2010), according to the bill, insurance coverage was extended to dependent children (young adults) until they are 26 years old. Since minority young adults are much more likely to be unemployed, thus without insurance, minorities would benefit from this coverage more than others.
- Under the healthcare reform bill, after 2014, most uninsured (thus minorities) who are currently uninsured will either obtain coverage through Medicaid's expansion or through government subsidies, thus providing more healthcare coverage.

The above changes in the health care system, especially those leading to more insurance and access, will lower health disparity to the extent that it provides more access. However, since the healthcare reform bill does not deal with all dimensions of health disparity, thus not providing access to everyone, it cannot end health disparity all together thus, although the newly passed health care reform legislation is a step forward and provides various benefits to the public, it is not by any means perfect. While it is admirable that more people have access to health insurance , that insurance companies do not and cannot deny health insurance to those with pre-existing conditions, and..., the United States still faces the challenges of the rising cost of health care which , to a large extent, stems from the aging of American society. In fact, in the long run, if the rising health care costs continue, these costs will not be sustainable, to the extent that Medicare and Medicaid programs will collapse, and individuals for the most part will not be able to purchase private insurance. These require drastic cost reducing measures.

Utilizing New Media Technology in Teaching MHA Courses

In her attempt to improve the teaching of her MHA courses (whether on -line or on-campus), including her attempt to familiarize her students with healthcare disparities in the United States, the recently –passed healthcare reform and its impact on health disparities, the author has found that by integrating new technologies into these courses, students become more engaged; each of the new technologies utilized will enhance the coordination, collaborations and communication needed to achieve the objectives of each of the courses the author teaches. In other words, students can meet the needed competencies and objections in each of my courses if I utilize Blogs, Wikis, Second Life, Skype and other such new technologies. In fact, one of the challenges faced by those of us in the academia today,

including in our field of healthcare administration, is to engage and meet the requirements of computer-savvy internet- oriented students. Utilization of the above technologies will facilitate all of what is needed –providing necessary information and engagement of students, etc. . . .

Wikis are one of the several we.20 components that can be used in the learning process, including the learning of the various types of health disparities that exist in the United States. A Wiki, as a web communication and collaboration tool, can be used in my healthcare administration courses in order to engage students in learning with others within collaborative environments. Each student in this type of a collaborative environment can share with fellow students what he/she has learned about health disparities and the possibility of its reduction as a result of the healthcare reform law, he/she can also learn from fellow students in these collaborative environments.

The author's discussion of the healthcare reform law and its impact on healthcare disparities can also be enhanced by the utilization of Blogs. Through this medium, students can leave comments and messages that concern the healthcare reform and healthcare disparities, thus creating a great deal of interaction between and among myself and my students. The ability of my students , as readers, to leave comments about their views of, or newly found information about, healthcare disparities in the United States, provides a very interactive formal which enhances the learning process in my teaching, particularly as it relates to healthcare disparities in the United States.

The author's discussion the healthcare reform bill and its impact on healthcare disparities in our MHA classes can also be enhanced by the utilization of Second Life, which is a Web-Based multi-user 3D virtual world developed by Linden Lab in 2003. Since its emergence in 2003, Second Life one of the most popular virtual reality tool, also becoming very popular in the academia by providing opportunities for interaction among students and faculty, and a sense of community. In fact, many institutions of higher learning are utilizing Second Life in their teaching, particularly in their online classes. It is possible to integrate second life with web 2.0 tools such as wikis and blogs.

The author's discussion of the healthcare reform bill and its impact on health care disparities in my MHA classes can also be enhanced by the use of Skype. Author has learned that with Skype students can learn from other students and expand their knowledge in amazing ways.

REFERENCES

- Akter, M., & Levingston, A., (2003). Eliminating health disparities associated with long term care to promote graceful aging in place", *Care Management Journal*, 4(2), p. 88-93.
- Byrad, W., & Clayton, L., (2003). Racial and ethnic disparities in healthcare, in Smedley B., Stith, B., and Nelson, (editors). *Unequal treatment: Confronting racial and ethnic Disparities the National Academic Press*, Washington, D.C.
- Hosseini, H., (2010). Strategies to contain the high and rising costs of health: Will they increase the existing healthcare disparities and are they ethical? *Humanomics*, Vol, 26, #2, pp.112-123.
- Laveist, T., Gaskin, D., & Richard, p., (2009). The economic burden of health inequalities in the United States, Working paper.
- Matters, G., (2010). Health reform benefits for elders. Online (June 26).
- Myrdal, G., (1944). *An American Dilemma: The Negro problem and modern economy*, Harper and Row, New York.
- Nix, K., (2010). Side effects: Obamacare widens healthcare disparities. *Foundry: Heritage Foundation's Conservative Political Blog*.

Smedley, B., (2009). Addressing racial and ethnic healthcare disparities; testimony to the House Energy and Committee, Health Subcommittee, March 24, published by *Health Policy Institute*.

The AARP Bulletin, the June 2010 issue.

The Physicians Working Group for Single-Payer National Health Insurance (2003). Proposal of the physician's working group for single-payer national insurance. *Journal Of American Medical Association* 290 (6). P. 798-80's.

U.S. Department of Health and Human Resources (DHHS), 1985, the Report of the Secretary's Task Force on Black and Minority Health. Washington, D.C.

U.S. Department of Health and Human Resources (DHHS), 2007, Health Statistic, Washington D.C.