

# Blacks Still Face Disparities in Healthcare



It's more than just "a Black thing":  
Minorities' mounting medical expenses could have  
calamitous consequences for the entire country.

BY KENNETH J. COOPER

**F**OR TWO DECADES, the federal government has taken small steps to reduce the health disparities that lead to people of color getting sicker and dying from serious diseases more often than Whites do.

What Washington has done is better than nothing at all, yes, and government by itself can't solve this problem. People need to take better care of their bodies, and their communities should do more to promote healthy living and access to medical care. The nation's healthcare system also needs to heal itself so that African Americans — even

those with the best private insurance — no longer receive lower-quality care.

Big problems require government to act in big ways. When African Americans make up half of the new AIDS cases each year, suffer from diabetes twice as often as Whites, and are more likely to die from cancer or heart disease, that's a major problem. Aging Baby Boomers will strain the healthcare system as the 21<sup>st</sup> century unfolds, and the country will become less White with each passing decade. The economy will not maintain its productivity for long if health disparities continue to afflict the growing percentage of workers from racial and ethnic minority groups.

True, most people who run the government don't take the long view on any issue. Dr. Louis W. Sullivan, a former secretary of the U.S. Department of Health and Human Services, thinks they can be convinced to do so in this case. All that is needed, as he has been constantly advocating for several years, is a comprehensive study estimating the medical costs and productivity losses resulting from health disparities.

"I think that would go a long way, because that would show justification to the budgeteers in the administration and Congress—if you can make the economic case for people who only look at the numbers that it's worth the investment," Sullivan says.

Nobody knows how much of a financial drain the disparities are, though a partial accounting suggests the medical costs alone run into the tens of billions of dollars a year. Sullivan, the founding president of the Morehouse School of Medicine, expects a thorough study would more than justify the federal government spending several billion dollars more each year over a couple decades to boost biomedical research on health disparities and train more health professionals of color.

"We can't do it on the cheap," Sullivan says. "The problem we've had up to now is people have tried to fund minimal cost or no-cost programs."

The federal government took a first

step in 1986 when it set up an Office of Minority Health at the Department of Health and Human Services (HHS), which Sullivan led from 1989 to 1993. The federal Centers for Disease Control and Prevention in Atlanta created an office of its own in 1988. The National Institutes of Health (NIH) in Bethesda, Md. added one in 1990.

After two decades, the three offices remain small operations by federal standards. The National Center on Minority Health and Health Disparities at NIH is the biggest, with an annual budget of \$199.4 million this year. The HHS Office spends \$53 million, and the CDC's Office of Minority Health and Health Disparities has nearly \$3 million.

Together, the budgets of the three offices total \$255 million, though other agencies do spend funds to try to eliminate disparities. Financially, this is not a serious federal effort. As an old Washington joke goes, anything less than a few billion is not "real money."

The federal government is getting away with doing so little, in part, because most people don't understand

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what disparities are all about.

A 2005 survey for the Harvard School of Public Health and Robert Wood Johnson Foundation showed 32 percent of Americans—and just 25 percent of Whites—believed minorities received poorer-quality health care. Less than half of African Americans (44 percent), and a slim majority of Latinos (56 percent), thought so—surprising findings, given how much attention Black and Latino leaders have paid to the issue.

The states have followed Washington in creating minority health offices—and in making meager commitments to them. The Ohio Commission on Minority Health, formed in 1987, is the oldest. Today, 49 states have offices.

The Ohio commission's 2-year bud-

get is \$10 million. "That's more than most [similar state] offices have," says Cheryl Boyce, the commission's director and chairwoman of the National Association of State Offices of Minority Health. "Most offices are one- or two-person shops. They have enough resources to raise issues but not to address them."

Two of those offices have taken the lead in making part of Sullivan's argument to state legislatures. Maryland and Colorado have estimated how much a few chronic diseases cost Medicaid, the state-federal program for low-income people.

In Maryland, African Americans are 20 percent more likely than Whites to have asthma. What's more, 53.8 percent of asthma hospitalizations among African Americans are preventable if the disparity in asthma treatment success were eliminated. The state's Office of Minority Health and Health Disparities figures that if the asthma treatment Blacks receive were as effective as that for Whites, African Americans would spend less time in the hospital and Medicaid would save as much as \$2 million a year. That's about 5 percent of what the state spent on hospital stays for asthma.

"We're trying to make the business case why investment in reducing disparities is a payoff down the road," says David Mann, an epidemiologist in the Maryland office.

Colorado's Office of Health Disparities calculated that racial and ethnic disparities in prevalence of diabetes, obesity and HIV/AIDS cases together cost its Medicaid program \$128 million in 2005. Diabetes cost the most, about \$80.2 million a year, followed by obesity at \$40.4 million and HIV/AIDS at \$7.6 million.

State taxpayers are not the only ones taking those hits: In Maryland and Colorado, about half the funding for Medicaid comes from federal taxpayers.

"Everyone loses. Everyone pays the cost," says Mauricio Palacio, director of Colorado's office.

Plugging federal data into Colorado's formula, the sums get much bigger: The disparate prevalence of diabetes, kidney failure and HIV/AIDS costs the health system as much as \$20 billion a year. Surely, this is "real money." Not long ago, President Bush touched off a fight with Congress by proposing to cut that much from Medicare, the federal program for the elderly and disabled.

That's \$20 billion for only three diseases: diabetes, \$10.8 billion for African Americans and Native Americans; kidney

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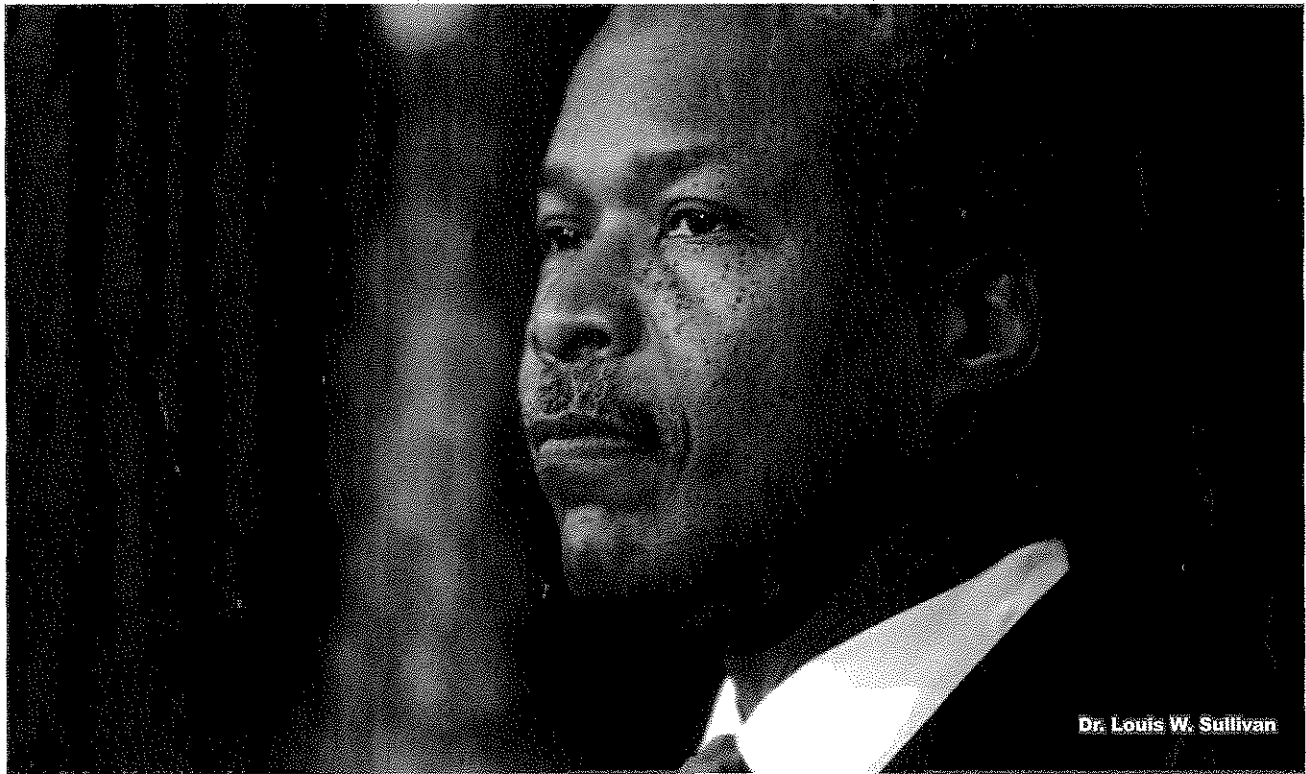
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**Dr. Louis W. Sullivan**

failure, \$7.7 billion for African Americans, Asians and Native Americans; and HIV/AIDS, \$1.2 billion for African Americans, Latinos and Native Americans. In each case, African

Americans accounted for the bulk of the excess costs.

Medical expenses for disparities in different forms of heart disease and cancer — big killers of minorities — would push the overall total much higher.

Even less research exists on productivity losses, but what little has been done suggests the hit there would out-strip medical costs.

Americans and Hispanics tend to have strokes earlier in life, causing them to lose earnings over a longer period.

“As the minority groups age,” the researchers predicted, the inequalities in stroke “will result in mounting economic consequences.”

Sullivan says a comprehensive study of health disparities would show how huge that burden is for all diseases. Congress and the White House, he believes, would see the sense of boosting the budget of the NIH office to several billion dollars a year, upgrading it to a full-fledged institute like the National Cancer Institute and committing significant sums to train more people of color as doctors, nurses, dietitians and other health professionals.

Sullivan says he has been trying for three or four years to persuade a private foundation to fund a study. The ones he has approached, he says, are not sure the research would be valid. He hasn’t given up. “I do believe we are getting closer,” he says.

If Sullivan succeeds, and the study’s findings match his expectations, more people would know and care enough about health disparities to demand real government action. It is people of color who are suffering more and dying earlier, but everyone is paying a price.

**Kenneth J. Cooper** is a Pulitzer Prize-winning journalist who lives in Boston.

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Registration Volunteer from Detroit

Shot by a KKK sniper on March 25, 1965 returning from a march to the Alabama state capital.

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Nobody knows how much of a financial drain the disparities are, though a partial accounting suggests the medical costs alone run into the tens of billions of dollars a year.

Researchers have projected that lost income for stroke victims between 2005 and 2050 will exceed the amount spent on their health care. The combined costs per person were highest for African Americans, about \$26,000, compared with \$17,000 for Hispanics and \$16,000 for non-Hispanic Whites. African