The State of Health Care in the United States
Introduction

The State of Health Care in the United States

By Jane Perkins

This issue of Human Rights focuses on health and health rights, highlighting some of the extreme disparities that exist for millions of people living in the United States due to the lack of health care and health rights and making some recommendations for what we can do. As these articles point out, in contrast to many other countries, the United States does not recognize a constitutional or legal right to health or health care (unless you are in prison). This does not mean, however, that there are not laws that establish some rights to health coverage.

The oft-repeated phrase, facts matter, applies here. This issue’s authors offer a parade of facts:

- From Khiara M. Bridges: People of color are less likely to be given appropriate cardiac care, receive kidney dialysis or transplants, or receive the best treatments for stroke, cancer, or AIDS.
- From Mary Smith: Funding of the Indian Health Service would need to nearly double to match the level of care provided to non-Indians.
- From Erika Ziller and Andrew Coburn: The mortality rate for rural working-class whites is rising, driven by “despair deaths” from suicide, liver disease, and accidental poisoning, in particular from opioid and other drug overdoses.
- From Gretchen Borchelt: Women need more health care but are more likely to be poor and routinely forgo needed care or struggle with medical debts.

What has been happening to address disparities such as these? The articles identify three notable changes over the last 10 years. First, the Affordable Care Act (ACA)—the most significant advancement toward universal health coverage in the United States since passage of Medicare and Medicaid over 50 years ago—requires most individuals to have health insurance, provides pre-existing condition protections, bars health insurers from refusing coverage based on things like pre-existing conditions, and expands Medicaid to individuals with incomes below 138 percent of the federal poverty level (primarily childless adults who are not pregnant or eligible for Medicaid). After the ACA was implemented, the rate of uninsured fell from 36 percent in 2010 to 9 percent in 2016. In those states taking up the Medicaid expansion, health access and utilization improved across the board; medical debts decreased; hospital uncompensated care decreased dramatically; rural hospitals regained footing, and jobs were created within and outside of the health care field. As Timothy Stoltzfus Fjust points out, the ACA expanded benefits for the bottom quintile of the population, financed considerably by taxes on the wealthiest Americans.

As Timothy Stoltzfus Fjust points out, the ACA expanded benefits for the bottom quintile of the population, financed considerably by taxes on the wealthiest Americans. (Not) My Plate: The Factors That Affect the Diets of Impoverished Communities

By Raquel Yurco

An individual’s health is impacted by a number of societal factors, including education, economic stability, and environment. These factors also contribute to disparities in health, particularly for minority women.

...continued on page 13
HEALTHCAREASAHUMANRIGHT

By Mary Gerisch

In the United States, we cannot enjoy the right to health care. Our country has a system designed to deny, not support, the right to health. The United States does not really have a health care system, only a health insurance system. Our government champions human rights around the world, insisting that other countries protect human rights, even imposing sanctions for a failure to do so. Our government is not as robust in protecting rights at home. The right to health care has long been recognized internationally. Ironically, the origins of this right are here in the United States. Health care was listed in the Second Bill of Rights drafted by Franklin Delano Roosevelt (FDR). Sadly, FDR’s death kept this Second Bill of Rights from being implemented. Eleanor Roosevelt, however, took his work to the United Nations (UN), where it was expanded and clarified. She became the drafting chairperson for the UN’s Universal Declaration of Human Rights (UDHR). That committee codified our human rights, including, at Article 25, the essential right to health. http://www.un.org/en/universal-declaration-human-rights. The United States, together with all other nations of the UN, adopted these international standards.

Since the adoption of the UDHR, every other industrialized country in the world—and many non-industrialized countries—have implemented universal health care systems. Such systems ensure that all persons within their borders enjoy their right to health care. In 1966, years after passage of the UDHR, the UN proposed another treaty including health care, the Covenant on Economic, Social and Cultural Rights (CESCR), http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx. The CESCR further clarified, at Article 12, “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” “Health” in this context is understood as not just the right to be healthy and have health care, but as a right to control one’s own body, including reproduction.

Article 12 goes on to require that “states must protect this right by ensuring that everyone within their jurisdiction has access to the underlying determinants of health, such as clean water, sanitation, food, nutrition, and housing, and through a comprehensive system of health care, which is available to everyone without discrimination, and economically accessible to all.” This treaty was signed by all UN countries. It was ratified by all countries except three—Palau, Comoros, and the United States of America. All signatory nations to CESCR are subject to periodic review of progress on the human rights so protected. The UN High Commissioner of Human Rights also reviews progress on rights protected by the UDHR. In preparation for these reviews, the U.S. government submits a report, touring its successes in the area of human rights.

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Shocking, or maybe just realistically, the U.S. report to the UN in 2015 fails to even identify health as a human right. Instead, it refers to efforts on health and "measures," intentionally avoiding use of the word "right" relative to health. (UPR report of the U.S. government, section H, paragraphs 100 and 101.) A reading of that report generates near disbelief among health advocates; "health measures" are not even remotely akin to "health rights." But it was the only appropriate term to use. The only progress the United States had to report was the Affordable Care Act (ACA), a health insurance law, not a health care law. The United States could not admit to the UN that it had made no progress on so basic and fundamental a right as health.

What the government did not want to say is that contrary to ensuring the right to health, it continues to violate the UDHR with a system that discriminates against minority groups and/or all in poverty. This results in a "non-system" of health care. The UDHR does not condition health upon ability to pay, citizenship, or any other condition. The United States does. By codifying a system allowing huge corporate profits in health care as a commodity, our government has actually impaired, not improved, our right to health care. So maybe, and refreshingly, the United States was just being honest with the UN about its failure to ensure and protect the human right to health care.

This failure to protect the right to health is puzzling. From FDR’s drafting of the Second Bill of Rights to Dwight Eisenhower’s success in passing Medicare, our country’s leaders have attempted to ensure our right to health. The crucial and intersectional nature of that right was recognized in the 1960s by Martin Luther King Jr. during the Poor People’s Campaign. He affirmed that: “Of all the forms of inequality, injustice in health care is the most shocking and inhumane.” Chicago press conference held on March 25, 1966, in connection with the annual meeting of Medical Committee for Human Rights.

It is equally puzzling that our government has lauded, and continues to laud, the passage of the Patient Protection and ACA as a way to guarantee the right to health care. It is true that there have been improvements in our country’s health statistics since the passage of the ACA. As a result of the ACA, many people, through Medicaid expansion, are now able to see a medical professional when needed. And prior to enactment of the ACA, the death rate for lack of health care was appalling: Three people in our country died every 30 minutes for lack of health care. Since the ACA, that death rate has gone down, but it is still present.

No matter how it is spun, health insurance is simply not health care.

Nowhere is that contrast clearer than in personal stories of suffering. After codification of cost barriers by the ACA, people were shocked; they had been convinced this law was a reform that would actually increase access to health care. While collecting stories, I spoke to Susan in Vermont. She is 27 years old and says: “I simply don’t understand what happened. I was told that the ACA would let me get the health care I need. I pay my premium every month. Now that I’m really sick, I can’t go to work and have very little income. It turns out I can’t see my doctor without paying because I haven’t yet spent $2,000 this year out of my own pocket—after paying all my premiums which are thousands of dollars, and paying the $2,000 deductible, I still have to bring money with me for a co-pay.”

[Image: health care access, human rights]
Another heartbreaking failure of the ACA is told by Paul from Vermont. He relates the story of his wife’s death—an other victim of the insurance system we call health care:

On Jan. 23, 2014, my wife Jeanette died of cancer. She was first diagnosed with thyroid cancer back in 2008. We were fortunate to have comprehensive health insurance at the time, and Jeanette responded well to treatment. Her cancer went into remission, and everything was great.

Then 15 months ago, Jeanette came down with a chronic cough. She went to the doctor and was told that she may have allergies. Looking for a second opinion, she went back to the oncologist who had treated her thyroid cancer and got X-rayed and tested. The news was terrible: Jeanette had advanced Stage 4 cancer that had spread to almost all of her internal organs.

We battled with our insurance company, Blue Cross Blue Shield, to get the chemotherapy pills Jeanette needed. They denied payment for the pills five times, saying that they needed to find the cheapest vendor. Finally, they paid for their pills just before the pills arrived. They were tossed onto our desk and left sitting in 20-degree temperatures.

Losing my wife of 34 years is one of the most painful things I’ve ever experienced, but it was made much worse by the battles Jeanette and I had over insurance and by the lingering questions over whether Jeanette might have survived or lived more comfortably if she’d gotten the right test and treatment. After Jeanette died, I asked her doctor why they’d done no testing during her remission to detect any growth of cancer beyond her thyroid. I was informed that testing was “cost prohibitive” and may not provide conclusive results.

Paul’s and Susan’s stories are but two of literally thousands in which people die because our market-based system denies access to needed health care. And the worst part of these stories is that they were enrolled in insurance but could not get needed health care. Our lives depend on the ability to access a nonexistent health care system.

Far worse are the stories from those who cannot afford insurance premiums at all. There is a particularly large group of these people who find themselves in this situation. Perhaps in passing the ACA, the government envisioned those persons being insured by Medicaid, a federally funded state program. States, however, are left independent to accept or deny Medicaid funding based on their own formalities. Some states have not expanded their Medicaid eligibility. People caught in that gap are those who are the poorest. They are not eligible for federal subsidies because they are too poor, and it was assumed they would be getting Medicaid. In the absence of insurance number at least 4.8 million adults who have no access to health care.

Premiums of $240 per month with additional out-of-pocket costs of more than $6,000 per year are common. Inability to pay these amounts systematically vitiates the right to health. Imposition of premiums, deductibles, and co-pays is also discriminatory: Some people are asked to pay more than others simply because they are sick. Fees actually inhibit the responsible use of health care as synonymous, we will never be able to claim our human right to health. The worst part of this “non-health system” is that our lives depend on the ability to access health care, not health as a community and society, take responsibility to ensure that each person can exercise this right. As individuals, we have a responsibility to contribute to making health care available to each of us. We have a right to the actual health care envisioned by FDR, Martin Luther King Jr., and the United Nations. We recall that Health and Human Services Secretary Kathleen She- lius (speech on Martin Luther King Jr. Day 2013) assured us: “We at the Department of Health and Human Services honor Martin Luther King Jr.’s call for justice, and recall

Health insurance companies make money by denying claims for care while still collecting premiums. That’s their business model.

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Article 25 of the 1948 Universal Declaration of Human Rights provides, “Everyone has a right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care … and the right to security in the event of sickness (and) disability…” The International Covenant on Economic, Social and Cultural Rights states more specifically at article 12, “The States Parties … recognize the right to everyone to the enjoyment of the highest attainable standard of physical and mental health.” The signatories of the Covenant—which do not include the United States—commit themselves to “the creation of conditions which would assure to all medical service and medical attention in the event of sickness.” The right to health care is widely recognized as a universal human right.

The election of 2008 brought to the presidency Barack Obama, supported by substantial democratic majorities in the House and Senate, with a mandate to expand coverage for the uninsured. Throughout 2009, the House and Senate worked on legislation to accomplish this goal and to address a host of other shortcomings in the American health care system. The House and Senate finally passed the Patient Protection and Affordable Care Act, and President Obama signed it into law in March of 2010.

The Affordable Care Act (ACA) contained 10 titles, addressing a host of issues beyond access to care, including the cost and quality of care and fraud and abuse in public programs, the health care workforce, prevention and public health, approval of biosimilars, and new taxes to pay for coverage expansion. The most important—and controversial—titles of the ACA, however, were the first two, which expanded Medicaid, reformed federal health care programs. Medicare for the elderly and disabled and Medicaid for the poor—our first and second most costly programs—have been around for over half a century. Indeed, for the past half-century, the only Americans who did not receive help with their health care were consumers who purchased coverage in the individual market and the uninsured.

The United States’ combined public/private strategy was reasonably successful in expanding coverage throughout the second half of the twentieth century, though it never came close to achieving full coverage. As health care costs increased year after year, however, more individuals and small businesses were unable to afford coverage and the number of uninsured crept upward. The great recession of 2008–09 brought further reductions in coverage. By 2009, more than 50 million Americans were uninsured.

The election of 2008 brought to the presidency Barack Obama, supported by substantial democratic majorities in the United States, goes back 70 years and is our third most expensive federal health care program. Medicare for the elderly and disabled and Medicaid for the poor—our first and second most costly programs—have been around for over half a century. Indeed, for the past half-century, the only Americans who did not receive help with their health care were consumers who purchased coverage in the individual market and the uninsured.

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As adopted in 1965, the Medicaid program provided federal matching funds for state programs to pay for health care for individuals and families eligible for public welfare programs. It covered the elderly, disabled, and blind, as well as families with dependent children. Eligibility was gradually expanded in the ensuing decades to pregnant women and more low-income children, while eligibility was delinked from welfare eligibility. But eligibility continued to vary considerably from state to state.

The ACA completed the process of uncoupling Medicaid coverage from traditional categories of the “worthy poor” by extending eligibility to all adults and children with incomes below 138 percent of the poverty level. The states were offered 100 percent federal support for the newly eligible enrollees for the first three years, with federal contributions phasing down to 90 percent by 2020. Congress made the judgment that this group needed health insurance coverage and was unable to contribute any significant amount to premiums for private health coverage.

The ACA also established health insurance consumer protections to ensure that private insurance coverage would be available to all applicants, regardless of their medical conditions. Insurers were prohibited from refusing coverage or increasing premiums based on health status or for excluding preexisting conditions from coverage. To ensure that private markets would be sustainable while covering individuals with high health care needs, the ACA included an individual responsibility requirement to encourage healthy as well as unhealthy people to purchase coverage. The ACA also included an employer responsibility mandate to encourage large employers to continue to provide health coverage.

Importantly, the ACA also offered premium tax credits to assist low- and moderate-income individuals and families in paying for coverage. The premium tax credits are available for individuals with incomes up to 400 percent of the federal poverty level, although the amount of assistance phases down as income increases. The tax credits ensure that health insurance remains affordable because the tax credits increase as premiums increase. Individuals and families with incomes below 250 percent of the federal poverty level additionally receive reductions in their cost-sharing, such as deductibles, coinsurance, and out-of-pocket limits, so that care as well as coverage remains affordable. Finally, the ACA established online exchanges, also called marketplaces, where individuals could compare private qualified health plans available to them and purchase the one that was most appropriate for their needs and budget.

The ACA strategy for expanding
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*completely unprecedented constitutional theory, which no federal court at any level had endorsed below. How has the ACA strategy for expanding coverage worked out? It has been largely a success. Between 2010 and 2016, the number of uninsured fell from 47.5 million in 2010 to 28.7 million in 2016. Although Marketplace enrollment has fallen short of original predictions (as discussed below), Medicaid enrollment has exceeded projections, growing by over 16 million since 2013. About 2.5 million remain in the Medicaid gap, however, in the 19 states that have not expanded Medicaid, which is a state-level policy decision.

The United States does not recognize a health care right, so the United States is one step closer to actually providing federal and state governments with a right to health care. The ACA was the first major health care reform in the United States since the Affordable Care Act of 2010, and it has been controversial ever since. The ACA included provisions to expand health care coverage, including Medicaid expansions, Medicaid work requirements, and Marketplace enrollment. In the years since the ACA was enacted, there have been repeated efforts to repeal or weaken the ACA. The Trump administration has taken several actions to weaken the ACA, including efforts to defund the ACA's premium stabilization programs and efforts to reduce enrollment in the Marketplaces. In addition, the Supreme Court has ruled in Trump v. California that the ACA is unconstitutional.

The ACA has been a controversial law, with some arguing that it has been successful in expanding coverage and reducing the number of uninsured, while others argue that it has been a failure. The ACA has also been subject to significant legal challenges, including challenges to the individual mandate and challenges to the Medicaid expansions.

While the Medicaid expansion remains controversial, a large and growing body of evidence demonstrates that it has accomplished its goals.

Medicaid enrollees work at jobs with little security and may lose their job while working. Medicaid enrollees have more difficulty affording care and more difficulty accessing care than people with employer-sponsored coverage. Medicaid enrollees have higher rates of obesity, diabetes, and other chronic diseases. Medicaid enrollees are less likely to have access to health care, are less likely to have access to medications and services, and have lower rates of receiving preventive care. Medicaid enrollees have higher rates of hospital readmissions, emergency room visits, and medication errors. Medicaid enrollees have higher rates of suicide and overdose. Medicaid enrollees have higher rates of mental health issues and lower rates of access to mental health care. Medicaid enrollees have higher rates of mortality and lower rates of life expectancy. Medicaid enrollees have higher rates of poverty and lower rates of income. Medicaid enrollees have lower rates of employment and lower rates of income. Medicaid enrollees have higher rates of food insecurity and lower rates of access to healthy foods. Medicaid enrollees have higher rates of housing instability and lower rates of access to stable housing. Medicaid enrollees have higher rates of incarceration and lower rates of access to legal services. Medicaid enrollees have higher rates of abuse and neglect and lower rates of access to safe environments. Medicaid enrollees have higher rates of discrimination and lower rates of access to fair treatment.

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Health Equity Challenges in Rural America

By Erika Ziller and Andrew Coburn

Exacerbating efforts to tease out these differences, rural health experts have noted increasingly poor access to data on rural health, as financial issues and concerns for privacy have limited the availability of geographic indicators in many federal health surveys. Still, across the country, we have observed that many rural communities actually do embody the small town Rockwellian image that is often equated with life outside the city—places with county fairs, church dinners, strong bonds between neighbors, and children thriving under the collective community eye. However, many others suffer economic and environmental hardships, and neighborhoods or even entire places are exacerbated by poorer health care access among rural residents and a more anemic rural health services infrastructure. Prior to passage of the Affordable Care Act (ACA), data across nearly four decades demonstrated that rural residents are more likely than urban residents to be uninsured. This has been particularly true in the southern and western United States, where as many as 29 percent of rural residents lacked health insurance in 2011. Even when rural residents have private health insurance, the coverage tends to be poorer and creates conditions under which rural residents are more likely to face high out-of-pocket costs for care. While the ACA held promise for reducing these disparities in coverage, the Supreme Court decision that made Medicaid expansion optional has resulted in uneven impact across the country. States with substantial rural population have been less likely to expand Medicaid under the ACA so that, overall, rural places have not experienced the same decline in uninsured rates as urban places.

Compounding these financial barriers to care, rural residents face access problems because many of their communities lack a sufficient number of health care professionals. Compared to large urban counties, remote rural places have less than half the per capita rate of primary care providers, that is, providers who provide day-to-day checkups, screenings, and chronic disease management. Because of the lower availability of health care providers within rural communities, many rural residents must travel great distances to seek health care. Given these travel requirements, reliable transportation is critical for ensuring rural health care access; however, many rural residents (particularly those at lower income) face transportation challenges including poor road conditions, unreliable vehicles, or difficulty affording gasoline. This rural-urban difference in availability of health care professionals is particularly pronounced for specialty care providers. Compared to rural counties, urban counties have nearly nine times the per capita number of specialists. Specialty care providers include many mental health professionals, which tend to be severely lacking in rural places. Around 60 percent of rural residents (particularly those in remote rural communities) have a behavioral health problem. With a parent who has been incarcerated or who has a behavioral health problem. Without appropriate intervention, including child-focused mental health services, these children are at greater risk for a lifetime of poorer economic and health consequences that may spill over into the next generation.

The economic trends affecting many rural communities, the more limited participation in the ACA by rural states, and poorer rural health in the face of continuing county closures and other rural health crises is the loss of certain types of hospital services or the complete closure of rural hospitals. In the past 15 years, more than 120 rural hospitals have closed, and the rate of closure has increased in the current decade. Another 9 percent of rural hospitals are at high risk of closure in the near future based on estimates of their financial health. According to researchers at the University of North Carolina who monitor the well-being of rural community hospitals, the people most adversely affected by the closures include impoverished individuals, racial and ethnic minorities, and sick elderly adults who need ongoing care for chronic illness.

In addition to outright closures, some rural hospitals find themselves unable to do exist. Also, cultural norms of personal responsibility that may be stronger in rural areas may help to mitigate concerns of stigma associated with use of mental health care. Yet, the need for mental health services in rural places is clear. As noted previously, the so-called despair deaths that are growing among white rural residents are linked to drugs (e.g., liver disease, overdose, and suicide) and have an obvious connection to behavioral health concerns, including addiction and depression. Among children, those living in rural areas are more likely to experience Adverse Childhood Experiences (ACEs), including exposure to domestic violence and/or living with a parent who has been incarcerated or who has a behavioral health problem. With appropriate intervention, including

Around 60 percent of rural residents live in a designated mental health professional shortage area.
sustain certain services that are vital to the well-being of rural populations and places. For example, researches at the University of Minnesota found that 9 percent of rural counties lost their hospital obstetric unit in recent years, leaving more than half of all rural counties without access to inpatient labor and delivery services. Any mother-to-be can relate to the tepidation that surrounds the birth process, even in the best of circumstances. Add to that the need to travel 10s or 100s of miles, in all weather conditions, on roads that are unevenly maintained, and it’s hard to argue that this nation is doing in best for our rural mothers and babies. Certainly, the outcomes for mothers and babies are of concern. In 2015, the rate of remote rural mothers who died from causes related to pregnancy and birth was more than 60 percent higher than that of urban mothers (29 per 100,000 rural live births versus 18 in urban). While we can’t specifically link these maternal deaths to travel distances, it is clear that the last thing rural mothers need is another barrier between them and healthy pregnancies and births. As noted previously, rural communi- ties and whole regions of rural health may mask important regional and intra-rural differences. Key among these are the consistently poorer conditions and outcomes experienced by racial and ethnic minorities who live in the rural United States. For example, counties with substantial minority populations are more likely to lack access to hospital obstetrics, and rural black mothers are at particularly high risk for maternal death. While the death rate has been growing among rural whites, minorities still account for most of the deaths and continue to bear a disproportionate burden. Non-Hispanic counterparts, nationally, the relative rate of death for rural whites is almost three-fourths that of rural blacks. Because of their concentration in southern states and other vulnerable populations, such as work requirements (the vast majority of Medicaid recipients already work or cannot work), high premiums and co-payments (for decades, researchers have found that premiums and co-sharing shut low-income people out of necessary care), ongoing reporting requirements and lookouts for failing to submit a report (Kentucky’s program relies heavily on the Internet, however, over 60 percent of non-elderly adult Medicaid enrollees lack Internet or broadband access), and ending coverage of non-emergency Medicaid transportation (vital for rural transportation options being undermined in court cases. Regardless of how these cases are resolved, it is clear that the Trump administration intends to tear the Medicaid safety net apart. Whether it be Medicaid, Medicare, the Children’s Health Insurance Program, or the individual coverage offered through the ACA, over the last 60 years, the most significant advances in health and health access have occurred when health coverage has been unthreatened from the workplace. As these articles show, intentional, sustained, and whole communities—the frailty of our “system” will continue to be exposed. Access to health care and health will continue to ebb and flow with political elections and corporate profits.
B y any measure, health care for Native Americans lags behind other groups, despite a legal obligation on the part of the United States to provide health care to American Indians and Alaska Natives. Native American communities face significant inequity in health care and health status compared to other U.S. populations. Health outcomes for Native Americans are adversely impacted by wholly inadequate access to health care and health status compared to other U.S. citizens. For example, recent attempts to roll back Medicaid expansion or add new barriers to obtaining Medicaid would have devastating effects on Native Americans. In FY 2016, the IHS collected over $649 million in Medicaid reimbursements—comprising over two-thirds of total third-party reimbursements. Third-party coverage also plays a significant role in the provision of health care services by non-Indian health care providers when certain services are not available through the Indian health system. Between 2014 and 2015, when Medicaid expansion took effect, IHS saw a considerable increase in health care services in the user population that had Medicaid coverage.

In July 2003, the U.S. Commission on Civil Rights published a report that outlined civil rights disparities in health care for Native Americans. In the report, most of the findings in that report are still true 15 years later. Moreover, the scale of the crisis has expanded given population increases and the inability of funding to keep pace. Health status of Native Americans can be better than it is today. There are signs of hope. Demonstrable progress has been made in decreasing diabetes, the leading cause of kidney failure in the United States. For Native Americans, 2 out of 3 with kidney failure have diabetes. In 2017, the IHS reported that it had decreased kidney failure from diabetes by 54 percent among Native American adults (American Indians/Alaskan Natives) between 1996 and 2013. Kidney failure from diabetes in Native Americans was the highest of any race, but now has declined the fastest through IHS strategies focused on population management approaches to diabetes care as well as improvements in clinical care.

Native Americans continue to die at higher rates than other Americans in many categories of preventable illness. Nonetheless, despite pockets of good news, decades of well-documented challenges and underfunding remain. To begin to put Native Americans on a path to health equity, adequate funding that supports evidence-based, outcome-based, and community-based approaches is essential. Quantifiable goals need to be set that focus explicitly on chronic illness reduction, and associated measures need to be defined and closely monitored. A strong investment in public health and illness prevention is essential to turning the tide on severe chronic diseases impacting these populations. Additionally, access to specialty care, a greater pipeline of health professionals to serve in tribal communities, including much larger scholarship and loan repayment programs, as well as technology investments and strong leadership and associated training are all needed. As Henry Ford said, “If we keep doing what we have always done, we will keep getting what we have always gotten.” We know how to reverse health inequities. Working with tribal leadership, the U.S. government has a moral and legal responsibility to address this crisis in health equity.

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Native Americans: A Crisis in Health Equity

By Mary Smith

Since IHS began providing scholarships in 1978, nearly 7,000 students have received awards. The Loan Repayment Program awards repayment of up to $40,000 for qualified health profession education loans to clinicians. These new providers are typically placed in Indian Health Program facilities with the greatest staffing needs. With shortages of clinicians that number in the thousands across American Indian and Alaska Native communi- ties, markedly expanding these programs is essential to ensuring communities have needed providers. Changes contemplated in other federal programs will also be felt by Native Americans. For example, recent attempts to roll back Medicaid expansion or add new barriers to obtaining Medicaid would have devastating effects on Native Americans. In FY 2016, the IHS collected over $649 million in Medicaid reimbursements—comprising over two-thirds of total third-party reimbursements. Third-party coverage also plays a significant role in the provision of health care services by non-Indian health care providers when certain services are not available through the Indian health system. Between 2014 and 2015, when Medicaid expansion took effect, IHS saw a considerable increase in health care services in the user population that had Medicaid coverage.

In July 2003, the U.S. Commission on Civil Rights published a report that outlined civil rights disparities in health care for Native Americans. In the report, most of the findings in that report are still true 15 years later. Moreover, the scale of the crisis has expanded given population increases and the inability of funding to keep pace. Health status of Native Americans can be better than it is today. There are signs of hope. Demonstrable progress has been made in decreasing diabetes, the leading cause of kidney failure in the United States. For Native Americans, 2 out of 3 with kidney failure have diabetes. In 2017, the IHS reported that it had decreased kidney failure from diabetes by 54 percent among Native American adults (American Indians/Alaskan Natives) between 1996 and 2013. Kidney failure from diabetes in Native Americans was the highest of any race, but now has declined the fastest through IHS strategies focused on population management approaches to diabetes care as well as improvements in clinical care.

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Imagine being forced to choose between paying for necessary health care and buying food, rent, or your child’s school supplies. This is the untenable situation in which many poor women find themselves. Despite the Affordable Care Act’s advancements in making health care more available and affordable for millions of women across the country, poor women still face significant challenges when it comes to getting the care they need, including abortion. Court decisions, policies, and the Trump administration are pushing poor women to make difficult choices. Uninsured and underinsured women are more likely to struggle with medical debt or bills, with 1 in 4 women reporting trouble paying medical bills in 2016, and reporting they used most of their savings or borrowed money.

**Affordable Care Act’s Expansion of Health Insurance Access and Affordability**

Insurance coverage matters for poor women, and the Affordable Care Act (ACA) made great strides in expanding coverage, improving women’s health and financial security. Health insurance is critically important for poor women because it helps make health care accessible, keeps people healthy, and covers health care costs. But low-income women remain more likely to go without health care due to poverty or lack of insurance. Half of uninsured women reported going without health care in 2016 because of the cost burden. Uninsured and underinsured women are more likely to live in poverty or extreme poverty than men. More than 36 million women lived below the poverty line in 2016, 24.1 percent of black women, 22.8 percent of native women, 18.7 percent of Latina women, and 10.7 percent of Asian women. The poverty rate for families with children headed by women is higher than those headed by men or those headed by married couples. This makes women particularly vulnerable to health care costs. To stay financially secure, women routinely forego needed care. Roughly 1 in 4 women reported in 2017 that they delayed or went without care due to costs. Low-income women are also more likely to cite poor health care, prescription drugs, substance abuse and mental health services, and preventive care. The ACA helps individuals afford health insurance. It provides tax credits designed to ease the cost burden, so as of 2014, 9 million women who would otherwise have gone without affordable health insurance were eligible for the tax credits, including a disproportionate number of women of color. The ACA also contains additional “cost-sharing reductions” available to low- and moderate-income families, which effectively buy down the enrollee’s cost-sharing obligations. These forms of financial assistance are critical to low-income women’s ability to access the care they need. The ACA expands eligibility for public insurance by allowing states to expand Medicaid. Regardless of family structure or health status, Medicaid expansion is enormously important to women. Medicaid covers a range of essential benefits, including basic maternity care, prescription drugs, and hospitalization, addressing most of women’s major health needs throughout their lives. A growing body of research has demonstrated how important Medicaid coverage is to women, including care, overall health, and mortality rates. But lawsuits shortly after the ACA’s passage challenged the constitutionality of the individual responsibility provision, which requires individuals (unless exempt) to obtain health insurance or pay a penalty. The challengers argued that Congress’s power to regulate interstate commerce did not allow it to require people to obtain health insurance. Several states also brought a lawsuit challenging the requirement that states expand Medicaid eligibility as a condition of future receipt of Medicaid funding, arguing it was an unconstitutional exercise of Congress’s spending power. In 2012, the Supreme Court decided National Federation of Independent Business, et al. v. Sebelius, holding that the individual responsibility provision was a valid exercise of Congress’s constitutional authority to tax. The Court upheld the requirement that state plans must cover at least a set of benefits to qualify for federal matching funds. The required coverage of women’s preventive services without cost-sharing—which in 2014 covered 63.4 million women—also made a difference; the birth control benefit alone saved women $1.4 billion in one year just on oral contraception. By providing health care not tied to employment, the ACA is allowing women to seek positions that may offer higher wages or better opportunities. To stay financially secure, women routinely forego needed care.
low-income individuals—the majority of whom are women out of poverty. So far, the Trump administration has taken a number of steps to undermine the ACA that will harm women’s health and financial security. For example, it cut off cost-sharing reduction payments to insurers that are too low to help meaningful numbers of people afford health insurance. It issued rules (currently blocked by courts) allowing virtually any employer to refuse to cover birth control without out-of-pocket costs as required by the ACA, and it recently proposed rules to expand the sale of junk plans that discriminate against women.

**Harfma: Changes to Medicaid**

The Trump administration is putting into place one of the biggest threats to Medicaid, the most pernicious being its decision to allow states to establish work requirements. The idea that Medicaid enrollees need an incentive to work—Medicaid coverage—or should be punished if they don’t work—through loss of coverage—is based on the false narrative that they don’t work—through loss of coverage. The Title X program serves 4 million individuals a year—who are disproportionately low-income, and women of color—and Planned Parenthood health centers serve 41 percent of them. Preventing those patients from going to Planned Parenthood health centers would leave many with nowhere else to turn for critical preventive health care because other providers cannot fill the gap.

**Lack of Access to Abortion**

Abortion is an essential part of comprehensive reproductive health care. Yet, poor women have trouble accessing abortion. This is due to other barriers that compound in their lives and that are exacerbated by abortion restrictions being imposed by politicians.

Between 2011 and 2015, state legislatures enacted 288 abortion restrictions. Many of these restrictions—such as mandatory delays and forced ultrasounds—are meant to dissuade women from having a safe and legal abortion. Other unnecessary and burdensome restrictions on abortion providers are intended to shut down abortion access. These restrictions affect poor women’s ability to obtain an abortion, putting additional obstacles in their path and increasing costs and delays. For example, the restrictions included as part of Texas’s anti-abortion law—which the Supreme Court struck down as an unconstitutional undue burden in 2016 in Whole Woman’s Health v. Hellerstedt—would have closed the vast majority of Texas abortion clinics, leaving at most 10 clinics in the entire state. Those clinic closures would have forced women to travel much further—sometimes hundreds of miles—to a clinic. For poor women—who often depend on public transportation—long-distance travel is a grave burden. And transportation is not the only cost; many will also need to cover hotel expenses and childcare costs blocking Kentucky's attempt to impose a Medicaid work requirement.

**Damaging Changes to the Title X Program**

The Trump administration is proposing fundamental changes to the nation’s family planning program, Title X, a vital source of birth control and other preventive services for poor women. The administration recently released a draft proposed rule designed to bar patients from going to Planned Parenthood health centers and making other harmful changes. The Title X program serves 4 million individuals a year—who are disproportionately low-income, and women of color—and Planned Parenthood health centers serve 41 percent of them. Preventing those patients from going to Planned Parenthood health centers would leave many with nowhere else to turn for critical preventive health care because other providers cannot fill the gap.

**Implicit Bias and Racial Disparities in Health Care**

**Heather M. Bridges**

**Women struggle to make ends meet who are denied abortion coverage and are also forced to confront additional costs imposed by abortion restrictions are left with little choice but to postpone paying for other basic needs like food, rent, heating, and utilities to save the money for an abortion. In one study, more than 1 in 20 women who had an abortion in the second trimester stated that they would have preferred to have the procedure earlier but couldn’t afford it because they needed to raise money. The greater the delay in obtaining an abortion, the more expensive the procedure becomes, catching poor women in a vicious cycle. Other poor women may be forced to carry an unwanted pregnancy to term, which could harm their future well-being. A study comparing women who terminated a pregnancy to those who wanted but were unable to obtain an abortion found that women denied an abortion were more likely to be in poverty, less likely to be employed in a full-time job, and more likely to be receiving public assistance for four years after being forced to forego an abortion could push more women and their families closer to poverty and others deeper into the poverty they endure.

But health insurers and courts need to recognize the reality of poor women’s lives. Poor women need access to quality, affordable comprehensive health care that includes reproductive health care. Their lives and financial security depend on it. While the Affordable Care Act has made great strides, there are still far too many women who face ongoing barriers and are left without the care they need. Insurance and courts often mean to shut down access to health care by themselves are not enough to help poor women out of poverty and secure their health care. Instead, one of the “essential health benefits” that a Medicaid funded abortion is equivalent to denial of legal abortion altogether.”

Many of these private insurance also cannot get abortion coverage. The ACA treats abortion differently. It explicitly prohibits abortion from being covered under the “most comprehensive health benefits” that certain plans must cover. And it allows states to pass laws prohibiting insurers from covering abortion. Twenty-six states have passed laws prohibiting private insurance plans from offering coverage of abortion as part of their comprehensive health care plans.

Women struggling to make ends meet who are denied abortion coverage and are also forced to confront additional

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**Why are black people sicker, and why do they die earlier, than other racial groups?**

Many factors likely contribute to the increased morbidity and mortality among black people. It is undeniable, though, that one of those factors is the care that they receive from their providers. Black people simply are not receiving the same level of care that white patients receive, because they lack access to health care.

Scores of studies buttress NAM’s findings by documenting that providers are less likely to deliver effective treatments to people of color when compared to their white counterparts—even after controlling for characteristics like class, health behaviors, comorbidities, and access to health insurance and health care services. For example, one study of 400 hospitals in the United States showed that black patients with heart disease received older, cheaper, and more conservative treatments than
Vol. 43 No. 3

The Impact of Structural Racism in Employment and Wages on Minority Women’s Health

By Ruqaiijah Yearby

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n 2010, at the end of the great recession that disproportionately harmed racial minorities and women, the federal government recognized that health disparities are caused by the social determinants of health (SDOH) (Figure 1), which are outside an individual’s control. (Sec'y’s Advisory Comm. on Nat’l Health Promotion & Disease Prevention Objectives for 2020, Phase I Report: Recommendations for the Framework and Format of Healthy People 2020 (2008), Steven Schroeder, We Can Do Better—Improving the Health of the American People, 357 New Eng. J. of Med. 1221 (2007)). In fact, research shows that SDOH account for 80 to 90 percent of health factors that contribute to health outcomes. (Sanne Magnus, Social Determinants of Health 101 for Health Care: Five plus Five, PERPECTIVES (Nat’l Acad. of Med., Oct. 9, 2017), https://nam.edu/wp-content/uploads/2017/10/Social-Determinants-of-Health-101.pdf) One of the five SDOH is economic stability (employment and wages), which accounts for 40 percent of the health factors that contribute to health outcomes.

To address the SDOH and health disparities, state and local governments adopted the health-in-all-policies (HiAP) approach to integrate policy responses across sectors and used health impact assessments (HIAs) to ensure decisions regarding laws and policies consider the health impacts. Unfortunately, recent research has shown that the application of HiAP and use of HIAs has potential for broad changes or actual reductions in the SDOH or health disparities. (Richard Hall & Peter L. Worden, The Health-in-All-Policies Approach Promotes Health Equity, 37 Health Affairs 364 (2018)). This is because neither the HiAP nor the HIAs require government officials or policymakers to understand or address historical and contemporary structural racism in laws and policies affecting the SDOH that cause poverty and lead to racial health disparities. Structural racism operates at the societal level and is the power used by the dominant group to provide members of the group with advantages, while disadvantaging the nondominant group. (Amy J. Schulz & Leith Mullings eds., Intercultural Health: An Introduction, GENDR, RACE, CLASS, AND HEALTH 3, 12 (2006) (examining the different forms of racism that affect an individual’s health status.) The dominant group over time structures racism not only to obtain resources, such as employment and wages, but also to limit the nondominant group’s access to these resources. During the Jim Crow era, structural racism sponsored by the federal and state governments explicitly created advantages for Caucasians and disadvantages for African Americans. Structural racism still exists after the Jim Crow era, which significantly disadvantages minority women and limits their access to health care. In 2016, women had higher poverty rates than men in the United States (Jessica L. Semega, Kayla R. Fontenot & Michael M. Kall, U.S. Census Bureau, Income and Poverty in the U.S. 16 (2016)) In fact, women have higher poverty rates than men in every state except Colorado.

Black people simply are not receiving the same quality of health care that their white counterparts receive. Perhaps more disturbing is that black patients are more likely to receive less desirable treatments. The rates at which black patients have their limbs amputated is higher than those for white patients. Additionally, black patients suffering from bipolar disorder are more likely to be treated with antipsychotics despite evidence that these medications have less likely to receive mastectomies.

In light of these studies, some scholars have concluded that racial disparities in health can be explained by looking to the individuals who are choosing not to prescribe the most effective, health- and life-saving treatments to racial minorities. The argument is that if people of color are sicker and are dying at younger ages than white people, this may be because physicians have racial biases. Their test takers cause them to give their patients of color that negatively impact the way they practice medicine. However, Matthew notes that there is little reason to believe that physicians have not been exposed to the negative narratives about racial minorities that circulate in society—discourses that become the stuff of unconscious negative attitudes about racial groups. Matthew proposes that physicians, like the rest of the American public, have implicit biases. They have views about racial minorities of which they are not consciously aware—views that lead them to make unintentional, and ultimately harmful, judgments about people of color. Indeed, when physicians were given the Implicit Association Test (IAT)—a test that purports to measure test takers’ implicit biases by asking them to link images of black and white faces with pleasant and unpleasant words under intense time constraints—they tend to associate white faces and pleasant words (and vice versa) more easily than black faces and pleasant words (and vice versa). Indeed, research appears to show that these anti-black/pro-white implicit biases are as prevalent among providers as they are among the general population. Matthew concludes that physicians’ implicit racial biases can account for the inferior health care that the studies discussed above document; thus, physicians’ implicit racial biases can account for racial disparities in health.

A number of experiments support her claim. One study showed that physicians whose IAT tests revealed them to harbor pro-white implicit biases were more likely to prescribe thrombolysis—an aggressive, yet effective treatment for coronary artery disease—to patients presenting symptoms for coronary artery disease. The experiment revealed that physicians whom the IAT tests revealed harbor anti-black implicit biases were less likely to prescribe thrombolysis to black patients and more likely to prescribe the treatment to white patients. Proposing that implicit biases are responsible for racial disparities in health might seem dangerous if one believes that individual and structural factors can never operate simultaneously. But this is not the case. United States’ policies make public health insurance unavailable to undocumented immigrants as well as documented immigrants who have been in the country for less than five years. Our residential neighborhoods remain dramatically segregated. We have a two-tiered health care system that provides wonder- ful care to those with private insurance and mediocre care to those without. The list of structural factors that make people of color sicker than their white counterparts is long. If providers’ implicit racial biases contribute to excess morbidity and mortality among people of color, we must recognize that individuals with implicit biases practice medicine within and alongside structures that compromise the health of people of color.

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The poverty rate of African American women is almost twice the rate of Caucasian women in every state except Montana.

In 2017, African American women had a poverty rate of 24.9%, compared to 12.1% for Caucasian women. In many states, the poverty rate for African American women is more than twice the rate of Caucasian women. For example, in North Carolina, the poverty rate for African American women was 31.5%, while the rate for Caucasian women was 14.7%. The poverty rate for African American women is especially high in the Deep South, where the rate is 33.6%. In contrast, the poverty rate for Caucasian women in those states is 14.4%.

The poverty rate for African American women is higher than for any other race or ethnic group. In 2017, the poverty rate for Hispanic women was 19.5%, for Asian women it was 12.6%, and for Native American women it was 28.2%. The poverty rate for women of two or more races was 22.3%. The lowest poverty rate for women was for Asian women, at 12.6%.

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I t is well known that America is dealing with a nutrition crisis as many communities deal with poor diets and health concerns such as diabetes and obesity. While some communities have access to fitness and nutrition resources, many do not have such luxuries. The imbalance in resources has resulted in a disproportionately high rate of obesity in poorer areas. (James A. Levine, Poverty and Obesity in the U.S., 60 Diabetes 11 (November 2011).) However, many politicians, lobbyists, and policy organizations have debated over what factors are causing the imbalance and how food health concerns should be addressed.

Many policies have been put in place, such as food stamps and systems to entice grocery store corporations to open in underserved areas, but there is still a question if these policies are addressing the correct factors. Are the impoverished communities able to access the grocery stores? Are they purchasing the right foods? Should their food choices be controlled? The problem is that many policies only address one or two factors that might be affecting the nutritional health of underserved communities, but the issue is actually more complex. In reality, there are five factors that have been identified as affecting the nutritional health of underserved communities, and all five factors need to be addressed for effective policy-making. The factors are food insecurity, food deserts, food swamps, mobility, and nutritional education.

Food insecurity addresses the affordability of healthy food. Research has shown that a person’s ability to afford healthy food, such as fresh fruits and vegetables, plays a large role in the person’s nutritional health and risk of obesity and diabetes. (Seth A. Berkowitz, et al., Food Insecurity, Food “Deserts,” and Glycemic Control in Patients with Diabetes: A Longitudinal Analysis, 41 Diabetes Care 5 (May 2018); Ghosh-Dastidar, et al., Distance to Store, Food Prices, and Obesity in Urban Food Deserts, 45 A M. J. OF PREVENTIVE MED. 5 (November 2014).) Communities that cannot necessarily afford healthy food have been found to have higher obesity rates, higher glucose levels, and higher rates of uncontrolled diabetes. Researchers have concluded that for food insecurity to be addressed, healthy food costs need to be closer to the cost of junk foods to make the healthy food more accessible as well as entice the buyer to buy the healthy food. As long as junk food is less expensive, the junk food will be considered a smarter economic choice to the buyer, regardless of the long-term health effect. Therefore, the cost of healthy food needs to be more competitive when compared to junk food.

Food deserts are areas that have limited or no access to grocery stores. A food desert is determined based on the distance to the nearest grocery store. Food deserts typically affect impoverished communities because grocery stores, like many businesses, do not want to be located in lower-income areas. There is some debate as to how much food deserts affect the health of impoverished communities, but there is a general consensus that there is an effect. Researchers have found that communities in which food are in desert have higher rates of obesity. (Daosheng Chen, Edward C. Jaenicke & Richard J. Volpe, Food Environments and Obesity: Household Diet Expenditure Versus Food Deserts, 106 A M. J. OF PUBLIC HEALTH 5 (May 2016).) Limited access to grocery stores means there is limited access to healthy food, and the communities become more reliant on stores that sell higher-calorie, less-nutritional food. Therefore, to help improve the health of impoverished communities, geographic access to healthy food needs to be addressed.

In the same vein, food swamps are areas that have more stores selling high-calorie, less-nutritional foods than stores selling healthy food. A food swamp does not necessarily have to be a food desert. The community could have a grocery store that is stationed within the community, but if the grocery store is surrounded by fast-food restaurants, the community is considered to be in a food swamp and still tends to have a nutrition problem. Studies have shown there is a strong correlation between food swamps and obesity. (Kristen C. Cooksey-Stowers, Marlene B. Schwartz & Kelly D. Brownell, Food Swamps Predict Obesity Rates Better Than Food Deserts in the United States, 14 INTe.J. OF RESEARCH AND PUBLIC HEALTH 11 (2017).) Some policymakers have suggested addressing this issue by restricting areas where unhealthy stores are allowed to exist, though that may lead to heavily concentrating the food swamp that will inevitably exist. Instead, it may be better to entice more healthy food stores to settle in the underserved communities.

Another factor that affects the health of impoverished communities is the mobility of the communities. Mobility is defined as the ability of the community to travel from their homes to the grocery stores using either their personal transportation or public transportation. To increase a person’s ability to have access to healthy food and limit their risk of obesity, the person must have access to reliable transportation. (Id.) Therefore, policies that increase public transportation options also have an effect on the nutritional health of the underserved communities.

Finally, health education is an important factor that cannot be ignored. Without the proper nutritional education, underserved populations will not know what it means to choose healthy food options and what options are available. Researchers have found that when the above factors are addressed, there are still high rates of junk food consumption and obesity in impoverished communities if they aren’t educated about healthy food options. (Hunt Alcott, Rebecca Diamond & Jean-Pierre Dube, The Geography of Poverty and Nutrition: Food Deserts and Food Choices Across the United States, NBER Working Paper Series (January 2018).) Therefore, the communities require proper education about purchasing healthy food and what a balanced meal looks like.

Nutrition policies and decreased diet-related diseases in impoverished communities must go beyond simple actions such as providing food stamps or enticing grocery stores to build in food desert areas. The five factors addressed above, food insecurities, food deserts, food swamps, mobility, and nutrition education, must all be addressed. Moving forward, policymakers, lobbyists, and policy researchers should consider all five factors to truly address diet-related health risks in impoverished communities.

By Mariam K. Ahmed

(Not) My Plate: The Factors That Affect the Diets of Impoverished Communities

Mariam K. Ahmed is a health care attorney at Healthcare Legal Solutions, LLC and specializes in Medicare and Medicaid regulation and compliance. She also has an interest in studying how laws and policies affect public health.
Health Care in the United States

After the ACA was implemented, the rate of uninsured fell from 16 percent in 2010 to 9 percent in 2016.

BY 2009, MORE THAN 50 MILLION AMERICANS WERE UNINSURED

ABOUT 2.5 MILLION REMAIN IN THE MEDICAID GAP

Medicaid picks up the cost of individuals with incomes between 100 and 138 percent of the federal poverty level.

In 2014, the rate of suicide was 54% higher for those living in remote rural counties.

In the past 15 years, 120+ rural hospitals have closed.

20% OF THE U.S. POPULATION LIVES IN A RURAL PLACE

In 2015, the rate of remote rural mothers who died from pregnancy or birth-related causes was 60% higher than that of urban mothers.

Native Americans have a life expectancy that is 4.4 years shorter than the United States' all races population.

ALMOST 90% of women in the United States now have health insurance coverage.

Between 2011 and 2015, state legislatures enacted 288 abortion restrictions.

16+ MILLION WOMEN LIVED IN POVERTY IN 2016

HOSPITALS CHARGE AN AVERAGE OF $32K-$51K FOR BIRTHS