



**Student National Medical Association
Universal Health Care Position Statement and Appendix**

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Since the inception of the Student National Medical Association (SNMA) in 1964, the mission of the non-profit organization has been to address the concerns of medical students of color, as well as attempt to resolve health care issues of minority and underrepresented populations. Despite tremendous efforts of the SNMA to achieve healthcare equity for all people, health disparities continue to persist due to a healthcare system that is failing millions of Americans. Many factors, including lack of primary care physicians, and accessibility to healthcare facilities, contribute to the health disparities that minorities experience in the United States. However, the most significant risk factor for being a victim of poorer health outcomes is lacking sufficient health insurance. Although it is estimated that nearly 47 million U.S. citizens and legal residents are uninsured, underrepresented minority populations are over-represented among those who lack health coverage. Currently, Hispanics comprise 32.5% of our nation's uninsured, followed by American Indians and Asian Pacific Islanders (30%), and African-Americans (15.4%)¹.

As we have seen in recent history, the state of our healthcare system is subject to the volatility and fluctuations in the overall economy. All elements of the healthcare landscape from its delivery system to the number of individuals insured have all been negatively impacted. Premiums which were previously escalating at an alarming rate have risen at a more heightened rate and have forced families and individuals who were once insured to un-enroll. Due to the increasing job losses (i.e the unemployment rate is currently 9.7%), there is a new group of individuals who are joining the uninsured population. As the above ideas demonstrate, the US healthcare system is extremely complex and before reform attempts can be explored, it is important to understand and demographics of this group.

There were 45 million uninsured people under the age of 65 in 2007. (Figures from 2008 have yet to be released.) Children represent nearly 1 in 5 of the uninsured and prior to the passage of the State Children's Health Insurance Program (SCHIP) legislation in 2009, accounted for the fastest growing segment of the uninsured.² The gaps in our health care system affect individuals of all ages, races and ethnicities, and economic strata; however individuals from the lowest income group are at a greater risk of being uninsured and the consequences associated with this status. Employer-sponsored coverage is the most common form of health insurance. Millions of individuals who are employed are uninsured because it is either unaffordable or simply not offered. Approximately 86% of the uninsured are employed adults.³ As the economy continues to dwindle and employment trends continue to shift in the direction of employment structures that are less apt to offer coverage (i.e. part-time or temporary employment), the number of uninsured is slated to continue to increase at a steady pace of one million per year.

Health insurance not only improves people's access to care and but it ultimately makes a difference in one's overall health status. Healthcare behavior studies show individuals who lack coverage, either delay or forgo needed medical attention until a preventable illness develops. Despite spending more on health care than any industrialized country in the world, the United States receives failing grades when compared to other countries in the areas of patient satisfaction, hospital inpatient days, quality, and health outcomes. For

instance, in the US, the infant mortality rate, one of the most sensitive indicators of a nation's health, is 8 per 1,000 live births despite spending over \$4,000 per capita on pregnancy related expenditures. Our neighbor, Canada, on the other hand, who has similar infant mortality rates (7 per 1,000 live births) spends half as much (\$2,095 per capita).^{4,5} Life expectancy, another indicator of health, one finds that that the average life expectancy in the United States is 70 years of age versus 74.5 years of age in Japan.⁴

In the US, health care spending is disproportionate to achieved health outcomes; despite ranking 1st in health care expenditures, the U.S. ranks 24th in overall health of the nation. According to the World Health Organization, the US's ranking is due to the existence of racial and geographical health care disparities. Native Americans, African-Americans, as well as those residing in rural communities and inner-cities have extremely poor health outcomes that are more characteristic of a poor developing country than a rich industrialized one.⁴ As mentioned previously, these poorer health outcomes are largely attributable to the lack of health insurance.

The United States is alone among virtually every industrialized nation in its refusal to recognize health care as a basic human right. Other nations, such as Canada, Germany, and the UK addressed the problem of the uninsured by providing universal health care. As a result, these countries cover more individuals and receive better health outcomes, all at a fraction of the cost of health care in the U.S. By extending health coverage to all citizens, these countries are able to: 1. provide coverage to everyone regardless of race, ethnicity, or income level; 2. improve access to coverage by requiring no co-pays or premiums; and 3. increase preventive care to cut down on long-term costs of tertiary care.

We, the members of SNMA, recognize the shortcomings of the ailing U.S. health care delivery system. Many will agree that health care in the U.S. costs too much, covers too little, and excludes too many. The hopelessness and frustration of our communities have urged us to become advocates for those that have not secured a place in the health care insurance market. Our sense of social responsibility deems it necessary for us to provide recommendations and possible solutions to the problem. All U.S. citizens and legal residents should be guaranteed:

1. Universal health insurance coverage.
2. A portable, comprehensive benefits package including: prescription drugs, dental care, inpatient/outpatient mental health services, long-term care, optometry services, choice of provider, and more focus on preventive health.
3. Equal access to care.
4. Increased numbers of culturally competent and committed health care workers (i.e. physicians and allied health professionals) to address the needs of underrepresented minorities.

Appendix:

CANCER

Colorectal cancer is the third most common cancer in adults

Overall, the percentage of adults age 50 and over who received colorectal cancer screening increased from 2000 to 2005. The disparities between Blacks and Whites in the percentage of adults age 50 and over who received colorectal cancer screening increased.

In 2005, Blacks were less likely than Whites to receive a colonoscopy, sigmoidoscopy, or proctoscopy or an FOBT (48.6% compared with 56.8%).

The disparities between Asians and Whites increased. In 2005, Asians were less likely than Whites to receive colorectal cancer screening (42.4% compared with 56.8%). The disparities between American Indian/Alaska Natives (AI/ANs) and Whites remained the same. In 2005, AI/ANs were less likely than Whites to receive a colorectal cancer screening (38.1% compared with 56.8%). The disparities between Hispanics and non-Hispanic Whites increased. In 2005, Hispanics were less likely than non-Hispanic Whites to receive colorectal cancer screening (37.3% compared with 58.5%).

From 2000 to 2005, the disparities between Blacks and Whites remained the same. In 2005, Blacks were more likely to be diagnosed at advanced stage with colorectal cancer than Whites (103.8 per 100,000 compared with 80.0 per 100,000) Asian-Pacific Islanders APIs were less likely than Whites to be diagnosed at advanced stage with colorectal cancer (66.7 per 100,000 compared with 80.0 per 100,000).

From 2000 to 2005, there was no statistically significant change in the rate for AI/ANs, who were less likely than Whites to be diagnosed at advanced stage with colorectal cancer (42.3 per 100,000 compared with 80.0 per 100,000).

Hispanics were less likely than non-Hispanic Whites to be diagnosed at advanced stage with colorectal cancer (65.6 per 100,000 compared with 81.5 per 100,000).

BREAST CANCER

From 1999 to 2005, the disparities between Blacks and Whites remained the same. In 2005, Black patients with breast cancer were less likely than Whites to receive radiation therapy to the breast within 1 year of diagnosis (68.1% compared with 75.3%; Figure 2.5).

From 1999 to 2005, the disparities between Hispanics and non-Hispanic Whites increased. In 2005, Hispanic patients with breast cancer were less likely than non-Hispanic Whites to receive radiation therapy to the breast within 1 year of diagnosis (61.5% compared with 76.0%).

DIABETES

From 2002 to 2005, the disparities remained the same between Blacks and Whites in the percentage of adults age 40 and over with diabetes who received three recommended services. In 2005, there were no statistically significant differences between Blacks and Whites for this measure (37% compared with 41%).

The disparities increased between Hispanics and non-Hispanic Whites in the percentage of adults age 40 and over with diabetes who received three recommended services. In 2005, this percentage was significantly lower for Hispanics than for non-Hispanic Whites (33.8% compared with 42.4%).

From 2002 to 2005, the disparities between poor people and high-income people remained the same. In 2005, this percentage of receiving the three recommended services was significantly lower for poor (30.3%), near-poor (28.5%), and middle income populations (38.4%) than for high-income populations (52.6%).

The disparities remained the same between people with less than a high school education and people with at least some college education. In 2005, the percentage of adults age 40 and over with diabetes who received three recommended services was lower for people with less than a high school education (31.5%) and high school graduates (39.9%) than for people with at least some college (47.7%).

While the rate of hospitalizations for lower extremity amputations improved overall from 2001-2003 to 2004-2006; however the disparities between Blacks and Whites increased. The percentage of hospitalizations for lower extremity amputations among diabetes patients remained higher for Blacks than Whites (5.7 admissions per 1,000 population with diagnosed diabetes compared with 2.5 admissions per 1,000 population with diagnosed diabetes).

From the 1988-1994 to 2003-2006 periods, the percentage of adults with diagnosed diabetes who had their HbA1c under optimal control improved. However, in 2003-2006, only 54.6% of adults with diagnosed diabetes had their HbA1c under optimal control. The disparities between Blacks and Mexican Americans Whites increased. In 2003-2006, the rate of optimal HbA1c control was significantly lower for Blacks and Mexican Americans than Whites (43.0% compared with 60.5% and 37.6% compared with 60.5%, respectively). In 2003-2006, there were no statistically significant differences among income groups.

END-STAGE RENAL DISEASE

From 2001 to 2006, the disparities decreased between Blacks and Whites in hemodialysis patients with adequate dialysis. However, in 2006 Blacks were less likely than Whites to have adequate dialysis (85% compared with 88%).

From 2001 to 2006, the disparities between Asians and Whites remained the same. In 2006, the percentage with adequate dialysis continued to be higher for Asians than for Whites (94% compared with 88%). The percentage with adequate dialysis improved for Hispanics (from 87% to 90%) and for non-Hispanic Whites (from 85% to 87%). In 2006, women were more likely than men to have adequate dialysis (92% compared with 83%).

From 1998 to 2004, the disparities between Blacks and Whites in the percentage of dialysis patients registered for transplantation remained the same. In 2004, Blacks were still less likely to be registered for transplantation than Whites (11.8% compared with 16.8%).

Although the disparities between AI/ANs and Whites decreased, in 2004, AI/ANs were still less likely to be registered for transplantation than Whites (10.6% compared with 16.8%). Likewise, the disparities between Hispanics and non-Hispanic Whites decreased; however, in 2004, this percentage was still lower for Hispanics than for non-Hispanic Whites (13.9% compared with 17.6%).

HEART DISEASE

The percentage of obese adults told that they were overweight was significantly lower for Blacks (60.5%) and Mexican Americans (57.1%) compared with Whites (66.4%); for poor (61.5%), near-poor (62.5%), and middle-income (62.4%) people compared with high-income people (70.6%); and for adults with less than a high school education (59.2%) and high school graduates (64.2%) compared with adults with any college education (70.3%).

In 2006, the percentage of patients with heart failure who received recommended hospital care was higher for Blacks than for Whites (91.4% compared with 90.0%) and lower for AI/ANs than Whites (86.3% compared with 90.0%).

From 2002 to 2004, the overall percentage of Medicare patients with heart failure who received recommended hospital care improved from 73.4% to 77.7%. During the same period, this percentage was significantly lower for Hispanics compared with Whites. In 2004, the percentage was also significantly lower for AI/ANs compared with Whites (72.3% compared with 77.9%).

From 2002 to 2004, the percentage of Medicare patients with heart failure who received recommended hospital care improved significantly for the total population and for Whites, Blacks, and Hispanics.

HIV/AIDS

Although the number of new cases of HIV and AIDS from 2001 through 2005 decreased (by 1% for men and 19% for women), HIV and AIDS are having an increasing impact on women of color, particularly on African-American women (68.7% of estimated AIDS cases among adult women were Black). Women with HIV and AIDS face particular challenges to accessing care. Women are often the primary caregivers in their families, thus making their own health a lesser priority. Risk behaviors such as drug use and sex

trading also put HIV-infected women at higher risk for depression, violence, family problems, and inadequate social support.

In 2006, the overall rate of new AIDS cases decreased to about 15 cases per 100,000 population. From 1998 to 2006, the rate of new AIDS cases decreased for Blacks (from 80.7 to 60.3 per 100,000), Hispanics (from 31.3 to 20.8 per 100,000), and Whites (from 8.2 to 6.4 per 100,000).

During 2001 to 2005, the disparities between Blacks and Whites decreased. However, in 2006, the rate of new AIDS cases was still almost 10 times higher (60.3 per 100,000 compared with 6.4 per 100,000) for Blacks than for Whites.

From 1998 to 2006, the disparities between Hispanics and non-Hispanic Whites decreased. However, in 2006, the rate of new AIDS cases was still more than three times higher for Hispanics than for Whites (20.8 per 100,000 compared with 6.4 per 100,000). In 2006, the rate of new AIDS cases was almost three times higher for men compared with women (22.4 per 100,000 compared with 7.8 per 100,000).

MENTAL HEALTH AND SUBSTANCE ABUSE

From 2003 to 2006, the disparities between Blacks and Whites decreased. In 2006, the disparity was eliminated between these groups in the percentage of people age 12 and over who needed treatment for illicit drug use and received it at a specialty facility in the past year.

From 2003 to 2006, the gap between Hispanics and non-Hispanic Whites decreased. In 2006, the disparity between these groups in those who needed and received treatment for illicit drug use was eliminated; there was no statistically significant difference.

From 2003 to 2006, the disparities between people with less than a high school education and people with some college education decreased. In 2006, people with less than a high school education who needed treatment were significantly more likely to receive treatment for illicit drug use than people with some college education (31.7% compared with 15.9%).

The percentage of adults with a major depressive episode in the last 12 months who received any treatment for depression in the last 12 months was significantly lower for Blacks than for Whites (58.9% compared with 71.1%) and lower for Hispanics than for non-Hispanic Whites (51.8% compared with 73.3%).

RESPIRATORY DISEASES

The disparities between Blacks and Whites increased. In 2006, the percentage of adults age 65 and over who ever had pneumococcal vaccination was significantly lower for Blacks than for Whites (36.8% compared with 59.9%). From 1999 to 2006, the disparities between Hispanics and non-Hispanic Whites decreased. However, in 2006, the percentage of Hispanic adults age 65 and over who ever had pneumococcal vaccination

was still about half that of non-Hispanic Whites (33.2% compared with 61.9%). The disparities between poor and high-income people remained the same. In 2006, the percentage was significantly lower for poor older adults than for high-income older adults (45.1% versus 60.9%).

From 2003 to 2005, the disparities between Blacks and Whites remained the same. In 2005, Blacks with asthma were less likely than Whites with asthma to take daily preventive medicine (27.4% compared with 34.0%).

From 2003 to 2005 the disparities between Hispanics and non-Hispanic Whites increased. In 2005, Hispanics with asthma were less likely than non-Hispanic Whites with asthma to take daily preventive medicine (21.1% compared with 35.9%).

In 2005, people with asthma who were poor (27.1%), low income (29.3%), and middle income (30.1%) were less likely than high-income people (38.5%) to take daily preventive medicine.

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