Minority Health and Public Policy: Developing an Agenda Toward the Year 2000

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The most eloquent statement of the nature of the health care disparities between blacks and other minorities and the majority populations can be found in the report by the Secretary's Task Force on Black and Minority Health (1):

"Despite the unprecedented explosion in scientific knowledge and the phenomenal capacity of modern medicine to diagnose, treat, and cure disease, black and other minorities have not benefited fully or equitably from the fruits of science or from those systems responsible for translating and using health sciences technology."

The contextual fabric of minority America can be described as a myriad of intercausal factors, an amalgam of cause-and-effect relationships that exert an inordinate effect on the quality of life and well-being of millions of minority Americans. It is an environment typified by competing priorities for those scarce but seemingly unlimited resources.

For those of us who live in the reality of minority America, life is a daily struggle with environmental circumstances which are antithetical to the realization of full human potential. For people in these communities, life is a maelstrom, a turbulent field where the unacceptable and the unthinkable are the order of the day.

To be young and foolish in minority America is not to be carefree. Being young, especially being male and young, is to have serious life-wrenching risk factors which are not easily overcome by good intentions, determination, or hard work. Life has risks and no guarantees; there is no shelter from the compelling dangers that lurk in the byways and avenues of minority America.

In these communities which exist in the shadows of America, we see growing evidence of community-wide warfare, the gaping and festering wounds of communities caught in the middle. Young children play the blissful games that all children play, alongside the vestiges of a human drama, the conspicuous yellow tape that outlines the site of the night's crime scene. It is a place not unlike Beirut, Lebanon, where the vicious scars of battle are everywhere; in minority America, as in Beirut, it is not unusual for a child to have seen death up close. It is not unusual in the classrooms of elementary schools for children to fall instinctively to the floor at the moment they hear the loud backfire of a passing car. In Beirut, psychologists call it "the Beirut syndrome." What shall we call it in south central Los Angeles, in southeast Washington, DC, or Detroit?

My intentions are not to reinforce negative or stereotypical images of these communities but to place the reality of their existence into context, to share an aspect of public health rarely addressed from the lecterns in our graduate centers of higher education. It is a side of public health not easily explained to those who have never lived it or felt its harsh, cruel reality. It cannot be reduced to simple data or examined by paradigms or other analytical heuristics, for its effects exist at the level of the human psyche and are by definition visceral and emotive. It is the side of public health with veritable gut-wrenching realities. It is a saga acted out on the streets of many cities, in the communities and neighborhoods where the actors are real people and mortality is real death.

As we begin the last decade of this century, it is clear that the unmet needs of minority populations, particularly the problems of access to and financing of health, will not simply go away. These issues remain among the most compelling challenges our health care system faces. These issues are not about reducing disparities in health status among minority Americans. They are about a country whose annual expenditure for health is estimated at 12% of the gross national product (GNP), larger than that of any other country in the world. Yet, all across America people lack the basics of health care that this marvelous post-industrial society can produce. These issues are about changing for all time the dichotomy between those who have and those who don't.

Who could have imagined that Medicare and Medicaid, when enacted into law in 1965, would have such a profound effect on provider and patient? Who would have understood that the very essence of health care delivery would be changed for all time by

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the financial arrangements of the health care delivery system? Who could have anticipated the range and magnitude of some of these second- and third-order consequences on that very same health care delivery system? Who could have anticipated the systemic changes that would occur as a result of this legislation? Who could have predicted the extent to which cost reimbursement would shape health care and become so much a part of the problem? Who could have forecast the extent to which the infusion of high-cost medical technologies would drive the spiraling inflation of health care costs? Who could have told us that in our efforts to help the aged, the disabled, and the disadvantaged we would construct a dual system, a medical version of Jim Crow, in which the use of resources was tied inextricably to dollars and not to deeds? Who, indeed, could have imagined all of this?

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Our health care system exists on a precipice. The issues we face are profound. On one hand, we live in an incredible era, surrounded by the marvel of a growing, technologically advanced postindustrial society, a society in which life-saving medical technologies allow many to live fuller lives. Medical science now enables us to transplant hearts, livers, kidneys, and gives hope where none had existed. We have new and constantly improving diagnostic technologies, which enable us to achieve perspectives of human anatomy and disease processes heretofore never imagined. These technologies which represent advances in state-of-the-art medicine have allowed us to make quantum leaps in diagnosing and treating a wide spectrum of diseases.

However, there is another side to this reality. It is a place where the human drama is felt even more acutely than that portrayed in the melodrama of television's fantasy hospitals. This other reality has a certain "twilight zone" quality where the senses are constantly overstimulated by vivid images of the human condition up close and real. Here, the real medical adventures begin and end. Here, the African-American, the Hispanic American, the homeless, the uninsured, and the human immunodeficiency virus (HIV)-infected drug abuser reside. This side of the health care system is overburdened and malnourished. It suffers, like some patients from a chronic and progressively debilitating disease. Its symptoms are readily discernible, but there is no clear therapy. It is enroiled in a struggle to rethink its commitment in light of its resources. The system is subject to many external decisions and issues, all of which have an impact on how its problems are defined—what is acceptable, who succeeds, and who fails.

As we consider what our health care agenda should be in the 1990s, several important themes need consideration:

1. The present system of health care delivery, financing, and provision of public health cannot be fixed by patchwork, superficial, or short-term measures. Our greatest challenge is to devise a system of health care that includes all segments of the population.

2. Historically, the poor, the disadvantaged, and many from minority populations have been outside the health system in this country. Our public policy treatment of the issues associated with these groups has been pitifully lacking. In a sense, these people are not unlike Ralph Ellison's Invisible Man: while they have a reality of their own, they do not exist in the reality of the rest of America.

3. Poverty and near poverty correlate highly with problems of access to care and the outcomes of health care. As reported by the National Research Council (2):

   "For people of the lowest economic status, overall mortality was 80 percent greater than for those at the highest socioeconomic level. In addition to increased mortality, almost every form of disease and disability is more prevalent among the poor. Because of the relationship between poverty and health, and because poverty has been a persistent problem for blacks in the United States, it is to be expected that blacks' greater poverty is responsible for much of the black-white disparity. Poverty rates among children cause special concerns for their future health status. Poverty in childhood often means lack of proper nutrition, unsafe housing and poor access to health care or other resources for healthy growth and development."

The issues of minority health are not about health or health care financing, Medicare or Medicaid, or health insurance. They are subsumed within a broader and more generic conceptualization called well-being and are directly related to many external factors. To understand the reasons why minority communities continue to experience persistent and widespread disparities in health status, we must examine the impact of income and of employment as a proxy for self-control and empowerment, as well as other nonhealth issues which are part of this intercausal contextual fabric.

The Enabling Economic Dimensions

The economic status of most African-American and other minority persons has been ravaged in the 1970s and 1980s by the fluctuating economic condition of their communities. Since the early 1970s, the economic status of African-Americans relative to whites has deteriorated. For the African-American family, particularly the poor and marginally poor, the effects of the economic climate have been severe. In 1985, 31% of blacks and 11% of white families lived below the federal poverty level, compared with 29.3% of blacks and 7.3% of whites in 1968. Median income for the nation's 1.3 million black families fell by 5.6% in 1987, for the first time slipping below the amount needed to keep a family of four out of poverty (2). In 1984, blacks' real per capita income was one-third higher than it had
Economics of Health Care: The Impact on the Health of Minority America

The American health care system is easily the wealthiest in the world. Almost 12% of the GNP is expended for health care. However, the price of this health care wealth includes one of the highest rates of inflation in the cost of goods and services provided. While the wealth of the American health care system has been of benefit in creating incentives for expanded health manpower, in diffusing health care technology, and for increasing life expectancy, it has produced a major economic dilemma.

In 1989 the average annual expenditure per employee for health insurance was $3,117. This represented 13.6% of total payroll. The increasing cost of health care has prompted many employers to initiate utilization controls, to move toward cost-containing mechanisms like managed care, and to pursue strategies to reduce the cost and volume of care provided.

Recent studies indicate that new medical technology and overuse of existing technology account for up to 50% of the rise in health care costs (3) and that much of this new technology finds its way into a hospital system which is the single largest component of health care outlays, about 40% (4). Many contemporary researchers argue that medical technology alone may account for the rise in health spending from $280 billion in 1980 to the estimated $620 billion in 1989 (4). These same researchers are convinced that uncontrolled growth in the adoption of these technologies is no longer a viable strategy for the American health care system.

Some argue that these expenditures are often made to keep comatose people alive or to rescue near-death low birth weight babies, knowing that the quality of the saved life will never be at normal levels and that most will die. Still others argue that the expenditures for this nation’s elderly are out of proportion. A Medicare study noted that 30% of annual Medicare outlays for hospitalization are made to beneficiaries who will be dead in 12 months, the majority in six months (5).

Casual examination of the American health system, in terms of the nation as a whole, reveals increased life expectancy, reduced rates of some chronic and acute illnesses, and generally improved health for the average American. While this formulation has a measure of truth for America, the reality is much different for those of shadows, the poor, particularly for many blacks and Hispanics. Evaluating the performance of the health care system depends on whose perspective is viewed. For those of us from minority populations, the issue of equity in the face of an expenditure of nearly 12% of the GNP is an issue of real significance.

How do we justify improvements to a “Cadillac” health care system when we have only a “moped” mentality when it comes to caring for this nation’s poor, disenfranchised, and minority populations? Our central task is to eliminate permanently the dichotomy between those who have and those who do not have access to quality health care.

The Principal Health Care Issues of the 1990s

There are a number of issues which are imperative for the minority communities to address in the 1990s. These issues are at the heart of the public policy debate and form the basis for reexamination of public policy. This reexamination should be sensitive to the issues and needs of the minority communities.

Medicaid

The report by the National Coalition of Hispanic Health and Human Services Organizations (6) provides a poignant assessment of Medicaid:

“When Medicaid was enacted just over 25 years ago, the program signaled a new era of hope—an era in which impoverished families would have the basic services they needed to wage their individual fights against poverty and secure their piece of the American dream. A quarter century later, that hope has been tempered by Medicaid’s continued inability to finance health care for the majority of impoverished Americans and the ability of poverty to remain a significant part of the American landscape…. Twenty-five years later, meeting the needs of Hispanics in poverty, especially the working poor, is the new humanitarian and economic imperative.”

Medicaid coverage of the nonwhite poor varies between states and depends on the state’s eligibility criteria. In general, Medicaid covers less than one-half of the poor. In 1983, that represented about one-third of poor whites and about one-half of the nonwhite poor. Despite an era where the number of poor have increased dramatically, coverage has remained relatively the same (7). That Medicaid is really a federal-state program results in many differences in coverage from one state to another. In states with large numbers of poor blacks, such as Mississippi, Alabama, and Georgia, less than 50% of the poor are covered by Medicaid. In Texas, a state with the highest number of Hispanics, only 32% of the poor are covered by Medicaid (7).

Provider participation is a critical issue with respect to access to health care. Many of the poor are not covered by Medicaid, but those who do have Medicaid coverage often do not have providers willing to accept the terms of coverage. This problem stems from the large differential between the cost of care provided and the amount which Medicaid will pay for a given ser-
vice (7). Thus, receiving prenatal care is difficult for many pregnant women with Aid to Families with Dependent Children (AFDC), because providers are unwilling to provide care for the amount of reimbursement.

Another issue stems from the distribution of Medicaid funds. Cursory review of Medicaid expenditure data seems to indicate that the poor receive a reasonable amount of care costing between $40 billion to $50 billion annually, but the reality is different. Only about one-third of Medicaid funds are spent on primary care, preventive care, or hospital care for the children and families with AFDC. The remainder is spent on care of the institutionalized elderly and disabled poor (7).

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For the 1990s, the issue of how to make the Medicaid program relevant to the needs of the poor, in particular the black and Hispanic communities, will be a subject for public debate. The states are bemoaning the high costs of the program, pressures on the federal budget limit the range of options, and the numbers of uninsured are creating enormous pressures on the system. Nonetheless, this issue is of central concern to the health and well-being of all minority communities; how Medicaid can be transformed. Another round of band-aids cannot reasonably be expected to provide the fix desperately needed by many.

Uninsured and the underinsured

One of the most significant factors contributing to the health status disparities between those from minority populations and whites is people without health insurance and the working poor who do not have adequate health insurance. For these people, normal preventive health care and care for episodes of acute illness or chronic disease are difficult to obtain.

Based on 1987 data, there are an estimated 31 million people with no insurance, 40% of which are racial and ethnic minority populations (8).

Based on an analysis of current population survey data, 10% of all whites, 20% of African-Americans, and 31% of Hispanics are uninsured (9). For Hispanics, the country of origin appears to be a factor in their probability of being insured. Approximately 15% of those of Puerto Rican descent, 22% of Cuban descent, and 35% of Mexican-American descent are uninsured. This occurs for two reasons. Few Puerto Ricans are uninsured because almost 40% are covered by Medicaid. Only 11% of Cubans have Medicaid (but more are underinsured) because more than 60% have incomes in excess of 220% of the poverty level ($11,200 in 1987) (9).

A recent study (10) provided some important observations on the relationship between health insurance status and the health status of newborns:

“Babies whose parents lack health insurance are about 30 percent more likely to die at birth or be born seriously ill than insured babies.... The increased vulnerability is especially high in uninsured black and Latino babies. The gap worsened between 1982, when the study began, and 1986 when it ended. Researchers cautioned against assuming that lack of insurance is a direct cause of newborn illness, but they concluded that elevated and increasing risks for uninsured newborns are explained at least in part by inadequate and diminished access to health care.”

Clearly, for those who are uninsured, the progression of disease can reach life-threatening levels. At best, individuals who have no insurance receive care later in the disease cycle and at costs which are higher than would have been the case had they received care earlier. In part, the growing number of the uninsured is a result of sustained unemployment and poverty. Moreover, many low-pay jobs do not include health insurance coverage. Most employers offer no benefit package to these employees. Consequently, health insurance is not available to many minority populations even when they are employed, while those who do have access to some form of health insurance may make deliberate decisions not to acquire health insurance for reasons of price, priority, or behavior.

Financial impact on hospitals

Perhaps the most chilling consequences of the complex financial realities facing our health care system are those that confront hospitals, particularly inner-city and public hospitals.

Based on data collected from a survey of US hospitals, public hospitals are losing about $131 per day (11).

One tactic which hospitals use for fiscal survival is to evaluate the services they provide to determine relative profitability. As a consequence, high cost, though high-benefit, services like obstetrics, mental health, wellness programs, and screening programs become early casualties of short-term economizing.

No matter the hospital, public or private, the cost of treating the typical patient with the acquired immunodeficiency syndrome (AIDS) is usually more than the revenue available. For the inner-city hospital this exacerbates an already critical situation, for these hospitals provide a disproportionate amount of indigent and uncompensated care. In New York City, where the hospital system is overwhelmed with uncompensated care, the impact of AIDS threatens some hospitals with closure and compromises the care rendered in all.

In 1987, northeastern hospitals lost an average of $600,000 per year, even with Medicaid reimbursement among the highest in the country. This results from uncompensated care and severe illness in their patients (11).

For many inner-city hospitals, the point of admission is not the outpatient clinic; over 50% of all admissions come through the emergency room. In fact, overcrowding of emergency rooms threatens the overall quality of care.


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Patient dumping

One increasingly common side effect of the pressure to contain the cost of health care, particularly in hospitals, is dumping patients unable to pay to the public health hospital system. Institutional dumping takes many forms. The most common is that a patient brought to the nearest emergency room is subsequently transferred to a public hospital as soon as arrangements can be made. Unfortunately, many of these patients are not medically stable, and the transfer places many at risk of exacerbated morbidity and even death.

Over the past six years, an increasing number of patients have been referred to other hospitals or “dumped” because they lacked basic health insurance coverage or were eligible for Medicaid. Dumping is a common, though little-known, practice which affects the care provided to minority populations. Some patients are sent to public hospitals without authorization, many times without even an advance telephone call from the attending physician at the transferring hospital. Patients in unstable or even in critical condition may be sent away from hospitals that have both the capability and the capacity to care for them.

The following cases relate two people’s experience with our health care system. These experiences which were presented to the House Committee on Ways and Means (12) indicate the sentiments, feelings, attitudes, and behaviors which are at the crux of what we as a public health community must address:

“A man sustained a shotgun blast to the back and was taken to a nearby private hospital. There, he received only minimal care—not even a cleaning of the fist-sized wound—while family members were sent home to search for proof of insurance coverage. The emergency room doctor at the hospital wanted to transfer the man immediately to the county hospital, but the county hospital had no intensive care beds available and could not accept the transfer.

“By late the following afternoon, the county hospital had an opening in its intensive care ward. Seventeen hours after he was shot, and in excruciating pain, the man was transferred. As soon as he arrived at the county hospital, doctors cleaned the wound and administered a painkiller. According to one doctor at the hospital, the wound had become infected and the leak of spinal fluid put the man at risk of meningitis. He underwent six hours of surgery to remove more than a dozen shotgun pellets from his back.”

This man survived to recall the incident. This 15-year-old didn’t:

“The director of clinical services at a local county hospital medical center received a call from one of the local hospitals saying that they had a 15-year-old boy who had been stabbed several times in the chest. Since the patient had no means of support, the hospital wanted to transfer him to the county medical center. The director of clinical services refused the transfer due to the grossly unstable condition of the boy and told the hospital he needed to be operated on where he was. An hour later the director received a call back and was told that the thoracic surgeon at the hospital believed this patient was stable enough to come to the county medical center and that they were going to send him.

“The director again refused emphatically. ‘I told him that no, while I didn’t have the patient in front of me, anyone who was stabbed in the chest three times, by my standards, is unstable.’ He received another call an hour later. The patient still was just lying in the emergency room at this other hospital. He had not been treated yet and the director was getting worried about the boy’s condition. So he said, ‘Well look, if you’re not going to do anything for this kid, send him over.’

“When the patient arrived at the medical center emergency room, 2½ hours after he was brought to the private hospital, he was very pale with barely palpable blood pressure. Although he was still very alert and talking, he had engorged neck veins, indicating that one of his stab wounds had entered the heart. He was in the operating room within five minutes of arrival at the county hospital. But 20 minutes later, this 15-year-old boy was dead.”

The tragedy is that this death might have been prevented had the care systems been more sensitive to the needs of this young boy than to the needs of the “bottom line.” The greater tragedy is that this boy’s death not only affects his immediate family and friends but also becomes part of the community experience. That experience will shape the health-seeking and health-promoting behavior of the community. How many people will view the experience that resulted in this child’s death as a behavior characteristic of hospitals generally and decide on that basis not to seek health care?

Do not think that these instances are rare or isolated. In 1983, Parkland Hospital in Dallas, TX, reported that it received 150 transfer patients per month. A 1985 study by the National Association of Public Hospitals found that in a two-week period 26 hospitals reported over 1,000 transfers, 70% of which needed emergency room treatment.

A study of economic transfers (or “dumping”) at Highland Hospital in Oakland, CA, found that of 458 patients transferred to the emergency department from other hospitals, 63% had no medical insurance, 21% had Medicaid, 13% had Medicare, and 3% had private insurance. Approximately 32% of the patients transferred to Highland Hospital either had life-threatening complications or required immediate therapy that was delayed by transfer.

Does patient dumping affect quality of care? In a 1986 study at a Memphis, TN, public hospital, 190 telephone requests for transfer from other institutions were examined. Almost 90% of these requests were made specifically because the patient had no money or no insurance. Of the 164 transferred patients, about one-fourth were unstable on arrival. Many of these eventually died. Furthermore, of the 70 cases refused over the telephone, eight were denied transfers because they were considered unstable. The average delay between the time of the call and the time...
of admission at the public hospital was four hours, with a range of 20 minutes to 14 hours.

In 1988 congressional testimony, several prominent directors of public hospitals affirmed the occurrence of patient dumping and reverse dumping and indicated that many of these patients were medically unstable when received. In a 1986 study of 467 patients transferred to Cook County Hospital, nearly one-tenth of the patients eventually died in the hospital. The group as a whole had a mortality rate three times that of nontransferred patients for the same hospital (13).

Impact of medical technology

High-technology medicine may be defined as the sum of all the advances in medical knowledge and techniques that have been translated into improved diagnosis, therapy, and rehabilitative procedures during the past several decades (14).

The economic issues of the country—real growth in the GNP, the relative success of deficit reduction efforts—as well as the generic issue of glasnost and perestroika will have a major impact on domestic policy, particularly in health care delivery. With the Pepper Commission report calling for development of a new national health program, and a number of bills being introduced which address needed reforms, the only real issue to confront is the question of how much our economy can afford to pay for a revamped national health strategy, assuming that we have low, moderate, and high options from which to choose.

Health care spending will continue to be an important part of the overall health plan debate. Proposals to reform the payment system or the distribution of expenditures from the government to the private sector must face the inherent tendency within the current system of health care inflation. However configured, all reforms will have to address the issues of HIV disease and AIDS, increasing costly technology, medical indigence, and the underinsured.

Health care rationing

William Schwartz of Tufts University and Henry Aaron of the Brookings Institute indicated, “No matter what else this country does to try to control costs, a significant reduction in the growth of medical spending will require the sacrifice of beneficial services.”

Ethicist Daniel Callahan (15) of the Hastings Institute argues that we must redefine our future national priorities, but he admonishes us to consider carefully that “unless we are prepared to spend an unconscionable proportion of resources on health care—letting schools, roads, housing, and manufacturing investments suffer in comparison—we cannot possibly afford every medical advance that might be of benefit.”

These are sentiments expressed by leading scholars regarding the quandary of America’s health care system. On one hand, we have a commonly held belief that health care is a right and that society is obligated to perform to the limits of its technology to save, preserve, or offer meaningful enhancements to the quality of life of the patient. In contrast, there is the realization that health care resources are finite.

Experience has demonstrated that we cannot service every patient demand or need. One fault of our financing of health care is that we have paid whatever price was demanded, irrespective of competing demands for other uses of scarce dollars. The result has been a call for greater cost control and reduced expenditure of public funds for health care. Can we continue to justify the expense for any medically effective technology irrespective of cost? Do we place limits on the class of patients for whom we are willing to provide such care?

Our challenge, perhaps the most compelling of those we will face as we move toward the year 2000, will be how to redefine the goals and objectives of the health care system to respond to the urgency of unmet minority health needs, and how to respond to exhortations for fiscal austerity in health care without sacrificing compassion for the human condition.

A chilling decision by government to confront the high cost of health care has come from the state of Oregon. In response to growing difficulties in financing Medicaid, Oregon placed limits on what Medicaid would reimburse. Their Health Services Commission established a list of priority services to be provided to all Medicaid recipients. While this policy would eliminate coverage for certain high-cost procedures such as liver, pancreas, and bone marrow transplants, many other services could be disqualified based only on the budget level established for the year. Only the aged and the disabled would be exempt from such rationing and retain their current benefits.

Under this policy, Medicaid coverage could be extended to cover some 50,000 to 70,000 new mothers and children. However, unlike the elderly and disabled who are exempt from the spending limits imposed by the legislation, mothers and children, who consume only 30% of the Medicaid dollars, would not be exempt and could have significant reductions in their access to care.

With the continued spiraling health care costs, fueled by 20 years of federal, state, and private efforts to reform the system, will the issue come down to a choice for the Oregon experience, or can we devise a more humanistic, less draconian option?

The impact of AIDS

A recent study (16) on the cost of AIDS in public hospitals reports that:

“Our results reveal a major concentration of PWAs in a relatively few institutions. These hospitals tend to be larger than the average community-based hospitals. Still, with fewer than 5 percent of hospitals involved in treating more than 50 percent of the identified AIDS cases, and with a large concentration of patients in a subset of these hospitals, any changes in financing or treatment patterns are likely to affect these hospitals most significantly. Of particular concern is that, if current trends prevail, the
inner-city hospitals where AIDS patients are concentrated may find their ability to provide health services in general severely compromised."

According to a report released by Standard and Poor, the cost of caring for AIDS patients will strain the finances of state and local governments for years to come, soon exceeding the cost of other major diseases. The Centers for Disease Control has estimated that the national cost of treating AIDS will reach $8.5 billion a year by 1991. This exceeds automobile accidents at $8 billion, lung cancer at $3.9 billion, and breast cancer at $3.1 billion. This translates into a national AIDS-related public health cost increase that will rise to 1.4% of total health care costs by 1991.

These findings, if only partially true, are almost draconian in their implications to the delivery of health care to this nation’s minority populations. These hospitals currently provide the lion’s share of care to minority populations through emergency rooms and outpatient clinics. They are already strained with indigent care, large numbers of Medicaid patients, the uninsured and marginally insured, and many chronically ill patients. What are the implications?

1. The increasing fiscal pressure on the inner-city hospitals to treat cases other than AIDS will likely increase the fiscal drain on these hospitals. Based on recent studies, 5% of the hospitals treat 50% of the AIDS cases, and most of these are inner-city public hospitals. For the hospitals already overburdened by increasing numbers of the medically uninsured and indigent, the increasing number of AIDS cases is likely to severely limit their ability to care for other patients.

2. The increase in AIDS and HIV caseloads in many inner-city hospitals has produced a trend in which an increasing proportion of medical/surgical beds in these hospitals are occupied by AIDS patients.

3. For the inner-city minority AIDS patient, the alternatives to expensive hospitalization and long-term care are limited at best. For the increasing number of intravenous drug users with AIDS as well as other conditions related to drug abuse, the average length of hospital stay is substantially longer than for AIDS patients who do not use intravenous drugs. Effective discharge planning for AIDS patients with intravenous drug addiction is almost an impossibility. The implications of this trend are ominous. Without alternatives to care for these patients, the likelihood of rationing of services, prematurely discharging patients, and other forms of system-induced reductions in the numbers receiving care is a genuine possibility.

Conclusions

As we enter the last decade of this century, the health care issues facing us today are virtually identical to those we faced at the start of the 1980s. The only real differences are in absolute levels of magnitude and severity. These issues, the unmet needs of minority populations, particularly the lack of access to and financing for health care, are not amenable to disjointed incremental efforts intended to ameliorate symptoms. Our challenge, perhaps the most compelling of those we will face as we move toward the year 2000, will be how to redefine the goals and objectives of the health care system to respond to the urgency of unmet minority health needs, and how to respond to exhortations for fiscal austerity in health care without sacrificing compassion for the human condition.

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