Nurses: Leading to Reduce Health Disparities in an Era of Healthcare Reform

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Abstract

Persistent disparities in health status and outcomes for racial/ethnic minority populations are well documented. African-Americans are disproportionately impacted by a number of conditions including cancer, cardiovascular disease, diabetes, HIV/AIDS, and inadequate mental healthcare. The 2010 Affordable Care Act (ACA) contains provisions to reduce health disparities. These provisions aim to improve the quality of care, reduce costs, increase access to care, strengthen the healthcare workforce, and make health coverage more obtainable. Thus, the objectives of this paper are to describe key elements outlined in the ACA aimed at reducing health disparities and identify implications for nurses to lead in the reduction of health-care disparities through practice, education, research, and advocacy. Nurses at all levels of practice and education are encouraged to intensify their advocacy and legislative efforts to help ensure that key ACA provisions are funded and implemented to improve the overall well-being of underserved communities.

Key Words: Affordable Care Act, healthcare reform, health disparities

Introduction

Disparities in health status and health outcomes are well documented for racial/ethnic minority populations. The Minority Health and Health Disparities Research and Education Act of 2000 legally defined health disparities as a significant disparity in the overall rate of disease incidence, prevalence, morbidity, and mortality or survival rates in the population as compared to the health status of the general population (Minority Health and Health Disparities Research and Education Act, 2000). For African-Americans, these disparities are more pronounced when compared with their White counterparts and other minority populations. The purposes of this paper are to: (a) provide an overview on health disparities among African-Americans; (b) highlight key provisions in the Patient Protection and Affordable Care Act focused on eliminating health disparities; and (c) identify implications for reducing health disparities through education, research, and patient advocacy.

Prevalence and Incidence of Chronic Disorders

According to the Office of Minority Health (2014), African-American adults are 40% more likely to have high blood pressure than their non-Hispanic White counterparts; however, they are half as likely to have their blood pressure under control. In addition, African-American males and females are 30% more likely than non-Hispanic Whites to die from heart disease. African-Americans are twice as likely to have a stroke compared to Whites; and, in addition, African-American males are 60% more likely to die from strokes than White males. In 2009, African-American men were 1.6 times more likely to be diagnosed with prostate cancer than non-Hispanic White males and 2.5 times more likely to die from prostate cancer in comparison to non-Hispanic White men. African-American women are 40% more likely to die from breast cancer than non-Hispanic White women, although reports show that breast cancer deaths are decreasing. Factors contributing to this discrepancy include lack of quality of care and fewer social/economic resources (Office of Minority Health, 2013).

These inconsistencies in African-American death rates persisted when chronic health disorders such as diabetes, HIV/AIDS, and mental health were examined. African-Americans are twice as likely to be diagnosed with diabetes as non-Hispanic Whites. Also, African-Americans are more likely to have diabetic complications, such as end-stage renal disease and lower extremity amputations. The Office of Minority Health (2014) further reports that African-Americans were 2.2 times more likely to die from diabetes than non-Hispanic Whites. In 2010, although African-Americans comprised 12% of the population, 44% of newly diagnosed HIV/AIDS cases were in the African-American population (CDC, 2015). According to the 2013 Centers for Disease Control HIV Surveillance Report, in 2011, African-Americans were 8.6 times more likely to be diagnosed with HIV when compared to non-Hispanic Whites. This epidemic is responsible for 7 times more deaths of African-American men than non-Hispanic White men and
In examining mental illness, socioeconomic status greatly impacts the mental health status of populations. Populations that are below the poverty level generally have more psychological stress than those above the poverty level. In addition, some minorities underutilize mental health resources, in part, due to lack of knowledge and the stigma associated with having a mental illness. The Office of Minority Health (2014) reports that African-Americans are 20% more likely to report having mental distress than non-Hispanic Whites. The suicide death rate of African-American men was approximately four times the rate of African-American women in 2009. However, according to the American Psychiatric Association (2014), the true disparity in mental health is not the prevalence rate or the severity of disease but the lack of culturally competent care and the reception of less or poor quality care.

Eliminating health disparities is complex and requires a comprehensive and sustainable approach involving a number of stakeholders. Nurses in particular are well positioned to assume leadership in addressing health disparities by virtue of their proximity to and engagement with patients, families, and communities. The ultimate goal of our actions to eliminate health disparities should be to achieve health equity among diverse underserved and minority populations.

The Patient Protection and Affordable Care Act

On March 21, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act into law with the goal of making health insurance coverage more affordable and accessible. Through the reconciliation process, the Health Care and Education Reconciliation Act was passed by Congress to amend the Patient Protection and Affordable Care Act. The Health Care Reconciliation Act became law on March 30, 2010. Together, the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act are known as the 2010 Affordable Care Act (ACA). Provisions of the law are designated to be implemented between 2010 and 2018.

The PPACA was designed to ensure that most U.S. citizens and legal residents have access to healthcare. This goal was accomplished by creating state-based Health Benefit Exchanges or Health Insurance Marketplaces that allow individuals to purchase coverage. Individuals/families with income between 133-400% of the federal poverty level would receive tax credits allowing for a reduced cost. In addition, Medicaid would expand to 133% of the federal poverty level (the poverty level for a family of three was $19,530 in 2013) to all Non-Medicare eligible persons under the age of 65. A more detailed discussion of this historic legislation is located at http://www.healthcare.gov. Table 1 provides an overview of specific provisions aimed at eliminating health disparities (See Table 1).

A significant feature of the ACA is the establishment of the Health Insurance Marketplace or Exchange. On October 1, 2013, the health-care reform website, http://healthcare.gov, provided an opportunity for consumers to purchase health insurance plans in a competitive market and based on the individual’s family income. Through the level of the plan chosen, the person could possibly receive a tax credit (Burke, Misra, & Sheingold, 2014). The Health Insurance Marketplace also facilitates comparison shopping so the consumer has a better chance of finding affordable health plans that are more accommodating regarding coverage type and price. Over 19,000 qualified health plans are offered in the Marketplace within the four metal levels (bronze, silver, gold, and platinum). Coverage through the Marketplaces began in every state on January 1, 2014, with enrollment opening on October 1, 2013. As of December 2015, 13 states, including Washington, D.C., chose to build State-based Marketplaces, 4 states have established Federally-supported Marketplaces, 7 states entered into State-Partnership Marketplaces, and 27 states entered into Federally-facilitated Marketplaces (State Health Insurance Marketplace Types, 2016). On June 30, 2015, about 9.9 million Americans had selected a private health insurance through the Exchange (HHS Marketplace Effectuated Enrollment Snapshot, 9/8/2015).

Implications for African-Americans

The Affordable Care Act provides new opportunities for affordable health insurance coverage impacting approximately 6.8 million uninsured African-Americans. The majority, 4.2 million out of 6.8 million, of uninsured African-Americans may qualify for Medicaid, the Children’s Health Insurance Program (CHIP), or lower costs on monthly premiums through the Marketplace. Furthermore, 7.3 million African-Americans with private insurance now have access to expanded preventive services with services such as colonoscopy screening for colon cancer, pap smears and mammograms for women, well-child visits, and flu shots for all children and adults. Over 390,000 African-American women in the individual market alone are projected to gain maternity coverage, which is attributable to the Affordable Care Act. An estimated 5.1 million African-American women with private health insurance now have guaranteed access to women’s preventive services and 4.5 million elderly and disabled African-Americans will receive health coverage for diabetes and colorectal cancer screening, bone mass measurement, and mammograms. More than 500,000 African-American young adults between ages 19 and 25, who would have been uninsured, including 230,000 African-American women, now have coverage under their parents’ employer-sponsored or individually purchased health plan (U.S. Department of Health and Human Services, 2014).

Implications for Nursing Education

Nurses are well positioned to take leadership roles in addressing health disparities. However, the underrepresentation of racial/ethnic minority nurses in the nursing workforce persists and represents a substantial challenge for colleges of nursing. According to the U.S. Census Bureau (2014), more than one third (37.4%) of the U.S. population in 2013 belonged to racial/ethnic minority groups.
This figure is non-reflective of the 16.8% of registered nurses (RNs) from all racial/ethnic minority groups (HRSA, 2010). The slow resolution of this unbalanced condition has negatively affected the U.S. health-care system. One of the challenges in nursing education is the meager increase of the percentage of minority nurse faculty from 9.1% in 2003 to 12.3% in 2013 (ACN, 2013). Pipeline problems and racism in academia (Hassouneh & Lutz, 2013) are

Table 1. Selected Provisions of the Patient Protection and Affordable Care Act and Health Disparities

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<tr>
<th>Provision</th>
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<tr>
<td>Federal Infrastructure to Reduce Health Disparities</td>
<td>Establishes the Office of Minority Health within the Department of Health and Human Services (HHS). Elevates the National Center of Minority Health and Health Disparities to institute status. Establishes six individual Offices of Minority Health throughout other agencies.</td>
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<td>Data Quality, Quality Improvement, and Research</td>
<td>Enhances data collection and reporting to include data on race, ethnicity, gender, language, disability status, and other demographics of those living in rural and frontier areas. Provides insight into the causes of health disparities and develops effective programs to eliminate them.</td>
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<td>Expanded Access to Care</td>
<td>Effective January 2014, individuals living at 133% of the federal poverty level ($14,404 for an individual in 2009) are eligible for Medicaid. Provides premium credits and cost sharing subsidies to qualified individuals to assist with health-care costs.</td>
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<td>Insurance Regulation</td>
<td>Expands coverage for young adults to remain on their parents’ insurance until the age of 26. Prohibits denial of insurance coverage to people who have a pre-existing condition.</td>
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<td>Healthcare Workforce and Cultural Competency</td>
<td>Requires workforce diversity data; expands workforce diversity grants to nurses; provides support for cultural competency training. Funding devoted to increasing the providers in underserved areas. Establishes new programs to support school-based health centers and nurse-managed health clinics.</td>
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<td>Community Health Centers</td>
<td>Provides $11 billion over the next 5 years to expand access to racial and ethnic minorities. Seeks to double the number of patients at CHC to 40 million by 2019.</td>
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<td>Prevention</td>
<td>Prohibits copayments and deductibles for select preventive services. Strengthens preventative efforts to improve the nation’s health through the National Prevention Strategy. Authorizes a 5-year national oral health campaign with focus on disparities.</td>
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identified as the two main barriers to the unequal representation of minority faculty in academia. The ACA addresses the pipeline issue by providing nursing education funding through loan repayment programs and grants to nurses who wish to pursue advanced degrees (a Masters or a Doctorate) to become nurse educators, researchers, or advanced practice nurses and work in underserved areas (ACA, 2010 Title V, Sections 5202, 5308, 5310, 5311). In addition, the ACA includes provisions for investing in Historically Black Colleges and Universities (HBCUs) and Hispanic Serving Institutions (HSIs) and for establishing new programs to support nurse-managed health clinics where a large percentage of minority and underserved populations receive healthcare (Health Education and Reconciliation Act, 2010, Sections 2104 and 2303).

The 2013 National League for Nursing NLN Data Review, showed a 2.1% decline in the enrollment of racial/ethnic minority nursing students (from 28.2% in 2009 to 26.1% in 2012). This drop is alarming as it counteracts any previous diversity gains in the RN workforce. The ACA also includes the Nursing Workforce Diversity Program (Title V, Sec. 5404), which “supports projects that assist underrepresented students throughout the educational pipeline to become registered nurses.” The latter provision will improve quality and equity of access to healthcare and reduce health disparities in minority populations.

These provisions are synergistic with recommendations outlined in the 2010 Institute of Medicine (IOM) report: The Future of Nursing: Leading Change, Advancing Health, which affirms that: “Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression” (IOM, 2010). Nurse educators and clinicians have an enormous obligation to support and partake in the preparation, integration, transition, and growth of racial/ethnic minority registered nurses. Nursing programs must take advantage of the new provisions in the ACA and apply for funding to increase enrollment, retention, and graduation rates of racial/ethnic minority students in order to compensate for the persistent underrepresentation. Consequently, “ensuring equal representation of racial/ethnic minority in the RN workforce is not simply a matter of ‘equal opportunity’ but one of responsiveness to a fundamental responsibility to reduce healthcare disparities among racial/ethnic minority groups, and subsequently improve the healthcare of the nation” (Aurelien, 2011).

Implications for Nursing Research

Nurses have made substantial contributions to advancing our knowledge about health disparities through their independent and collaborative research activities. While these findings have provided invaluable answers, there remains a plethora of questions that necessitate further exploration. Now, nursing has an unprecedented opportunity to continue to advance this body of knowledge by creating a research agenda that addresses key concerns during this era of health reform. African-American nurses, in particular, must seize the opportunity to conduct independent and collaborative research that addresses provisions of the ACA aimed at eliminating health disparities. Examples of potential research questions can include:

1. What are the lived experiences of African-Americans enrolled in health insurance exchanges?
2. What are the facilitators and barriers of minority populations seeking expanded access to healthcare services?
3. What is the impact of nurse managed clinics in addressing health disparities?

Nurse researchers are encouraged to tap into the research opportunities provided by the Patient Centered Outcomes Research Institute referred to as PCORI. PCORI was established as part of the ACA to fund research that will aid patients, caregivers, clinicians, and others in making informed health decisions. PCORI encourages input from a number of stakeholders, including nurses, when shaping their research agenda (Barksdale, Newhouse, & Miller, 2014). Specific to health disparities, PCORI has established an advisory panel to help shape, implement, and evaluate its research agenda for eliminating health disparities. In addition, periodically, PCORI will issue a call for panel applications, research funding opportunities, and stakeholder input on a number of PCORI initiatives (Patient-Centered Outcomes Research Institute, 2014)

Implications for Advocacy and Political Activism

Disparities in health and healthcare for minority populations have been perpetuated for centuries. Numerous provisions in the ACA promise to reduce if not eliminate these burdens by improving access to healthcare. It may take decades for minority populations in the United States to experience health parity. Persistent advocacy and political activism by African-American nurses is necessary to promote and revise health policies so as to gradually achieve positive health outcomes for minority populations. Although the ACA is an intricate piece of legislation, it is imperative that nurses take on a proactive attitude and become very familiar with it, especially the provisions that have greater impact on their scope of practice and delivery of care. The undertaking of advocacy and legislative efforts requires certain essential skills such as excellent communication, problem solving, persuasion, and teamwork, especially in relation to the controversy to fund ACA programs. Therefore, nurses must join forces and remain vigilant in advocating for funding to ensure full-scale implementation of the ACA that will aid in closing the health disparity gaps for minority populations.

Funding allocations for certain initiatives have been very limited. For example, Nurse Managed Health Clinics (NMHCs) (HRSA, 2010) received a total of $15 million dollars from September 2010 to September 2013 and the grantees were to self-sustain in subsequent years. Likewise, the 2010 IOM’s report (2010) on The Future of Nursing states: “Nurse managed health clinics offer opportunities to expand access; provide quality, evidence based care; and improve outcomes for individuals who may not otherwise receive needed care. These clinics also provide the necessary support to engage individuals in wellness and
prevention activities.” Engaging in collective actions and armed with data to educate legislators on the benefits of certain programs and the impact of health disparities on the nation, may hopefully influence their decisions on funding appropriations. African-American nurses must enter into discussions regarding the financial impact on underserved populations who reside in states where legislators have opted not to accept federal funding for Medicaid expansion. Although the effects of such decisions are not yet fully understood, constant monitoring of such decisions and related consequences may provide evidence in the future for reconsideration.

Conclusions
This paper has provided an overview of the Patient Protection and Affordable Care Act with a specific emphasis on implications for eliminating health disparities among African-Americans. African-American nurses, in concert with other stakeholders, must continue to advocate for access to high quality healthcare for all minority and underserved populations. Advocacy efforts devoted to ensuring appropriate funding to support a culturally diverse nursing workforce that is uniquely qualified to meet the needs of minority populations cannot be overemphasized. Akin to the need for a culturally diverse nursing workforce is the need for culturally aligned independent and collaborative research that will address the unanswered questions about health disparities, and ultimately, health equity. The African proverb, “When spider webs unite, they can tie up a lion,” is quite appropriate, as it will take the collective efforts of many to achieve our dream of better healthcare and health outcomes for all. As African-American nurses, we must continue to assume our rightful place and build the necessary partnerships to do so.

References


from https://www.nln.org/researchgrants/slides/viewall_1112.htm


