

African American healthcare: Assessing progress and needs through Martin Luther King's perspective on social justice and equality

By: Marcus L. Martin, [Audrey E. Snyder](#), Jamela M. Martin, Taj'ullah Sky Lark, Hannah Firdyiwek, and Leslie Walker

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Abstract:

Since Dr. Martin Luther King Jr.'s death in 1968, the US population has grown substantially, with a marked increase in the percentage of people of color. It is estimated that by 2050, more than half of the American population will be people of color (US Census Bureau, 2008). The United States has the largest per capita expenditure on health care of any nation in the world (\$8,233 per capita versus \$3,268 average per capita in other developed nations), yet the United States ranks below many developed countries in health care outcomes (Kane, 2012). These statistics, as dramatically shown in Figure 4.1, sparked discussion among students and faculty involved in two University of Virginia programs.

Keywords: African Americans | health care equity | Martin Luther King Jr.

Book chapter:

*****Note: Full text of chapter below**

AFRICAN AMERICAN HEALTHCARE

Assessing Progress and Needs through Martin Luther King's Perspective on Social Justice and Equality

Marcus L. Martin, Audrey E. Snyder, Jamela M. Martin,
Taj'ullah Sky Lark, Hannah Firdyiwek, and Leslie Walker

INTRODUCTION AND BACKGROUND

Since Dr. Martin Luther King Jr.'s death in 1968, the US population has grown substantially, with a marked increase in the percentage of people of color. It is estimated that by 2050, more than half of the American population will be people of color (US Census Bureau, 2008). The United States has the largest per capita expenditure on health care of any nation in the world (\$8,233 per capita versus \$3,268 average per capita in other developed nations), yet the United States ranks below many developed countries in health care outcomes (Kane, 2012). These statistics, as dramatically shown in Figure 4.1, sparked discussion among students and faculty involved in two University of Virginia programs.

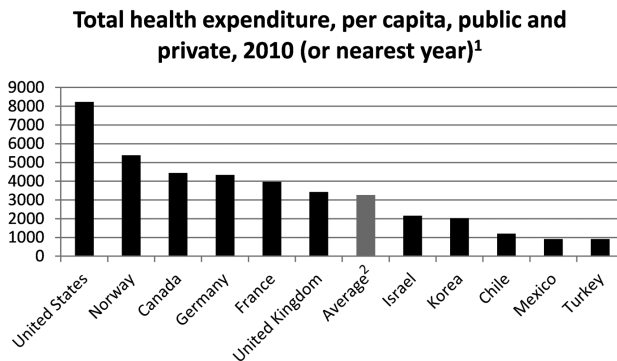


Figure 4.1 The average is based on data from the thirty-four member nations of the Organization for Economic Co-operation and Development. Sample excerpted from OECD (2012), OECD Health Data 2012: How Does the United States Compare at www.oecd.org/health/healthdata.

Students from the University of Virginia, who were either enrolled in the institution's study abroad program UVA in St. Kitts and Nevis January Term (J-Term) 2013 or who conducted research in the UVA Jefferson Public Citizens' summer 2012 research project in St. Kitts and Nevis were asked to reflect on the question, "What might Dr. King say about health care today?" Students researched Dr. King's speeches and data to develop their viewpoints and were asked to discuss their views with others in their group and with faculty and then write group reports.

The educational relationship between UVA and St. Kitts and Nevis originated with a visit from the federation's minister of health to Charlottesville during October 2007. The minister of health expressed an interest in collaborating with UVA on health care education. For the university, this partnership would become an opportunity to further diversify the cultural content of the undergraduate curriculum and to expand options for studying abroad in St. Kitts and Nevis. Of note, Marcus L. Martin and Audrey E. Snyder served as guest editors for the *Special Edition of the Journal of Race and Policy Proceedings of the UVA in St. Kitts and Nevis Program* 7(1)(Summer 2011). During the first two weeks of J-Term, UVA offers a study abroad program on disaster preparedness in St. Kitts and Nevis. Students studying in St. Kitts and Nevis during J-Term 2013 participated in this research.

The second group of students participated in the Jefferson Public Citizens (JPC) Program at UVA, which was established to provide undergraduate students the opportunity to conduct public service projects and research. The JPC Program inspires students to act as engaged citizens through active community partnerships, research service projects, and scholarly reflections and encourages them to prepare to work with local, national, and international communities to effect positive change in the world. Authors of this chapter Marcus L. Martin, Audrey E. Snyder, and Jamela M. Martin served as mentors to the JPC students who conducted research in St. Kitts and Nevis in the summer of 2012. The JPC students' research project was titled *Enhancing Primary and Preventative Care through Increased Utilization of Community Health Centers in St. Kitts and Nevis*. They studied the views of patients, health care providers, and policy makers regarding the health system through surveys and interviews. These students gained an appreciation and awareness of cultural differences and health care nuances of the developing West Indies Federation compared to those of the United States of America. A manuscript reporting the results of this study was published in the 2013 edition of the Jefferson Public Citizens' journal, *Public* (www.virginia.edu/jpc).

The Federation of St. Kitts and Nevis is a developing nation. There, unlike the United States, the health care expenditure per capita is very modest and focused on primary and preventive care. Students in the study abroad program and Jefferson Public Citizens research team made comparisons between the health care system of a small federation with much lower financial resources and the health care system in the United States while reflecting on the study question.

In his talk on January 4, 2013, to students of the UVA in St. Kitts and Nevis Program, Dr. Patrick Martin of the Ministry of Health and chief medical officer of St. Kitts and Nevis noted that comparatively, the public and private health expenditures are contradistinctive between the Federation of St. Kitts and Nevis (SKN) and the United States. Total health care expenditure in SKN is \$691 per capita versus \$8,233 in the United States, and represents 5.6 percent of the GDP versus 17.3 percent in the United States (table 4.1).

Table 4.1		
	SKN	USA
Total Health Expenditure (% GDP)	5.6 (2010)	17.3 (2009)
Total Health Expenditure (US\$)	691 (2010)	8,233 (2009)
Table 1. Total Health Care Expenditure per capita in St. Kitts and Nevis and the United States		
Source: Chief Medical Officer of St. Kitts and Nevis, Dr. Patrick Martin, of the Ministry of Health during his talk on January 4, 2013, to UVA nursing students.		

The guiding principles of health care policy in St. Kitts and Nevis are consistent with the principles espoused by the World Health Organization (WHO) as central to a primary health care-based health system. These include social justice, responsiveness to legitimate needs, quality orientation, participation, intersectionality, sustainability, and government accountability. The overall themes of service delivery incorporate prevention, health promotion, care of the family throughout the life cycle, and the health of the environment. More specifically, the core structural and functional elements of the primary health care orientation include the following: guaranteed universal coverage and access; optimal organization and management based upon sound policy and legal and institutional frameworks; high-quality programs and services that are available, accessible, affordable, acceptable, and quality-enhancing; decision making based on the well-being of families and communities; participation by families and communities in decision making; and an emphasis on health promotion, prevention, and health maintenance. The ultimate vision for population health and personal medical

service delivery is comprehensive, holistic, and integrated care rendered by coordinated teams of knowledgeable and skilled providers.

Access to health care and behavioral modifications are two important determinants of health outcomes in any health system. While in recent years the uninsured and underinsured in the United States total about 20 percent of the population (approximately 61 million US citizens) the Patient Protection and Affordable Care Act (PPACA), also known as ObamaCare, has the potential of providing health insurance to 30 million more Americans (Patient Care and Affordable Care Act, 2010).

The Affordable Care Act is perhaps the single most important governmental legislation of the past fifty years to have an impact on the health of those living in the United States. Compared to fifty years ago, the United States today has made great strides with health care access, quality of clinical care, research, and diversity within our health professions' training programs and workforce. Although the United States has made much progress, there is still much work to do, particularly with access to health care, health care insurance coverage, and representation of minorities in the health professions.

METHODS

We postulated that if Dr. King were alive his focus on health care would center on issues of access. Considering this hypothesis, we asked students and faculty engaged in study abroad in the St. Kitts and Nevis J-Term and JPC summer research programs to participate in this project on what might Dr. King say about health care today. Several steps were utilized in compiling data and opinions on this topic. Thirty-four undergraduate students with various academic majors at UVA, enrolled in the 2013 J-Term course, conducted literature reviews and participated in focus groups to condense the pertinent literature into six papers. These students also held discussions with six UVA faculty members teaching in the St. Kitts and Nevis J-Term. Five additional students, who participated in the JPC summer research, comprised a peer review group to edit and further condense the six papers into one manuscript. Finally, three of the six faculty mentors further edited the manuscript for accuracy and completion.

Students in the UVA in St. Kitts and Nevis study abroad program learned how a developing nation focuses resources on primary and preventative care in comparison with health care in the United States. UVA faculty and the St. Kitts and Nevis minister of health gave pertinent lectures to the students on

various health-related topics including the following: an overview of health care and culture in St. Kitts and Nevis; global health and global research methodologies; infant mortality as an indicator of population health; emergency and disaster management; current health disparities; and what might Dr. King think about health care today. Students were immersed in local health care culture through field experiences at St. Kitts and Nevis hospitals and community health clinics. A total of thirty-nine students and six faculty members participated in the project.

Students in the UVA in St. Kitts and Nevis J-Term course were divided into six teams of five or six students each. They conducted literature searches on Dr. King's speeches and reviewed current literature relevant to health care access. Student teams met daily over the course of the two-week January term to debate pertinent findings related to Dr. King's speeches. Daily team focus groups fostered communication, teamwork, and consensus.

The JPC group of five students interacted frequently from November 2011 during planning and implementation of summer research, through their May 2013 final presentation on access to community health centers in St. Kitts and Nevis. This group of students served as peer reviewers, critiquing the summarized opinions expressed in the six papers written by the January Term students.

RESULTS OF STUDENT LITERATURE SEARCHES

Equality and justice for all are common themes resonating from Dr. King's speeches. Although the focus of each speech was specific to a particular issue at hand, the themes are overarching in relevance to the human condition and inalienable rights. Quotations from Dr. King's speeches are applicable to the disparities and underpinnings of the state of health of minorities in both the United States and the Federation of St. Kitts and Nevis, and possible remedies thereof. Dr. King was able to see the interdependency of our human existence and how the denial of human and civil rights threatens the overall health of all mankind.

Let us march on poverty until no American parent has to skip a meal so that their children may eat. March on poverty until no starved man walks the streets of our cities and towns in search of jobs that do not exist.

"Address at the Conclusion of the Selma to Montgomery March on Alabama State Capital," Montgomery, AL, March 25, 1965

Because the goal of America is freedom, abused and scorned tho' we may be, our destiny is tied up with America's destiny.

"Letter from a Birmingham Jail," Birmingham, AL, April 16, 1963

We've come a long, long way, but we have a long, long way to go in economic equality.

"A Realistic Look at the Question of Progress in the Area of Race Relations," St. Louis, MO, April 10, 1957

Of all forms of inequity, injustice in health care is the most shocking and inhuman.

"Speech to the Medical Committee for Human Rights," Chicago, IL, March 25, 1966

All I'm saying is simply this, that all life is interrelated, that somehow we're caught in an inescapable network of mutuality tied in a single garment of destiny. Whatever affects one directly affects all indirectly. For some reason, I can never be what I ought to be until you are what you ought to be. You can never be what you ought to be until I am what I ought to be. This is the interrelated structure of reality.

"Eulogy for the Martyred Children," Birmingham, AL, September 18, 1963

How long? Not long, because the arc of the moral universe is long, but it bends toward justice.

"How Long, Not Long," also known as "Our God Is Marching On," Montgomery, AL, March 25, 1965

The good neighbor looks beyond the external accidents and discerns those inner qualities that make all men human and, therefore, brothers.

Strength to Love, 1963

Injustice anywhere is a threat to justice everywhere.

"Letter from a Birmingham Jail," Birmingham, AL, April 16, 1963

Now, I say to you today my friends, even though we face the difficulties of today and tomorrow, I still have a dream. It is a dream deeply rooted in the American dream. I have a dream that one day this nation will rise up and live out the true meaning of its creed: "We hold these truths to be self-evident, that all men are created equal."

"I Have a Dream," Washington, DC, August 28, 1963

If any of you are around when I have to meet my day, I don't want a long funeral. And if you get somebody to deliver the eulogy, tell them not to talk too long. Every now and then I wonder what I want them to say . . . I'd like somebody to mention that day, that Martin Luther King, Jr., tried to give his life serving others. I'd like for somebody to say that day, that Martin Luther King, Jr., tried to love somebody. I want you to be able to say that day that I did try to feed the hungry. I want you to say that I tried to love and serve humanity.

"The Drum Major Instinct," Atlanta, GA, February 4, 1968

In a sense we've come to our nation's capital to cash a check. When the architects of our republic wrote the magnificent words of the Constitution and the Declaration of Independence, they were signing a promissory note to which every American was to fall heir. This note was a promise that all men—yes, black men as well as white men—would be guaranteed the unalienable rights of life, liberty and the pursuit of happiness.

"I Have a Dream," Washington, DC, August 28, 1963

These quotations (Washington, 1986; King, 1965, 1957; PNHP, 2014) as examples of Dr. King's sentiment about human rights and social justice, coupled with current literature regarding health disparities and access issues, served as the basis for six brief papers written by the student teams. This chapter on what might Dr. King say about health care today was written excerpting from the following student papers:

TEAM 1: "Infant Mortality Rates in African American Women: What Would Dr. King Say?"

TEAM 2: "That Our Destinies Are One: Exploring African American Mistrust of Health Care and a Response from a Civil Rights Perspective"

TEAM 3: "Access: A Crucial Multidimensional Component of Healthcare"

TEAM 4: "Dreaming of Equality: Those Excluded by the Affordable Care Act"

TEAM 5: "The Affordable Care Act—What Would Dr. King Say?"

TEAM 6: "United States Healthcare: Accessibility and Affordability"

DISCUSSION

Health Disparities

A health disparity is an inequality in health outcomes or mortality. Disparities can also be viewed as a lack of equal opportunity or treatment within a health care system. Generally, health disparities are a measure of inequity and are typically deemed unfair, unjust, unnecessary, and often avoidable. Close to 20 percent of the US population in recent times has been either uninsured or underinsured. There is a disproportionate share of minorities enrolled in lower-end health care insurance plans. Minorities tend to be underinsured with higher deductibles, higher premiums, and likely no dental coverage, no catastrophic coverage, and no prescription plan. The most important predictor of quality of care is access to care.

While some health disparities are associated with poverty, education, and housing, some are genetically linked, and others are directly associated with implicit biases in health care. African Americans have the highest overall incidence of death rates from cancer of the lung, colon, rectum, prostate, and breast than any other ethnic/racial group. African Americans also have the highest incidence of and death rate from HIV-AIDS. Heart disease, diabetes and infant mortality rates are highest among African Americans. African Americans have the highest rates of homicide deaths. Latinos have the highest rate of cervical cancer. Asian Americans have the highest rate of gastric cancer (National Cancer Institute, 2008; Friedan, 2011).

Infant Mortality

“Infant mortality [defined as the death of a child before the age of one] is an important indicator of the health of a nation or community because it is associated with a variety of factors such as maternal health, quality and access to medical care, socioeconomic conditions, and public health practices” (MacDorman, et al., 1994). In 2010, the US infant mortality rate (IMR) was 6.14 infant deaths per 1000 live births (Miniño and Murphy, 2012). The 2010 IMR in comparison to the 1990s’ IMR has decreased, yet the rates are not practical.

Between 2006 and 2008, the IMR for non-Hispanic blacks was 13.1 per 1,000 live births and 5.6 for non-Hispanic whites, with infant mortality occurring 2.3 times more in non-Hispanic blacks in the United States (MacDorman and Mathews, 2012). In 2010, the US Department of Health and Human

Services (USDHHS) launched its Healthy People 2020 targets, which aimed to improve the health of all Americans along a decade-long initiative. Its goal of fewer than six infant deaths per 1,000 live births highlights the scope and importance of critically addressing this issue for African Americans.

According to the USDHHS, among white women with live births, 79.2 percent began care in the first trimester of pregnancy, and 4.9 percent received late or no care. Conversely, far fewer black women began early care (60.6 percent), and twice as many obtained late prenatal care (11.3 percent) (Kiely and Kogan, 1994). African American women are also more likely to give birth to low-weight babies, a factor which is closely linked to infant mortality. A focus on adequate and consistent prenatal care for African American women is essential to lowering infant mortality rates in this population.

It is well established that prenatal care is connected to birth outcomes. The American Association of Pediatrics (AAP) and the American College of Obstetrics and Gynecology (ACOG) assert that women who receive early and regular prenatal care deliver healthier infants (10). It is during prenatal care that comorbidities such as maternal hypertension and diabetes, which can lead to infant death, are prevented and/or addressed (Lockwood and Lemons, 2007; Johns, et al., 2007). The Institute of Medicine estimates that for every additional \$1.00 spent on prenatal care, \$3.37 is saved on health care spending for neonates (Lantos and Lauderdale, 2011).

Without prenatal care and surveillance, conditions such as gestational diabetes (GDM) and preeclampsia may go unrecognized in poor, uneducated, and/or vulnerable populations. Otherwise healthy women should be at lower risk of developing comorbidities such as GDM. However, income, education level, and ethnicity are significant social determinants of the development of these conditions (Goldenberg, et al., 1996). Controlling for factors such as poverty, education, housing, employment, and medical risks such as high blood pressure and diabetes mellitus, 90 percent of the difference between black and white infant mortality rates in our country cannot be accounted for.

Studies show that education level is a significant contributor to infant mortality, and women of all races tend to have higher infant mortality rates if they have less than a high school education. Unfortunately, in African American women, even with college and/or professional degrees, the infant mortality rate is still greater than that of all other races. There is also a potential familial tie between low birth weight and premature births in African American women. Mothers who were low birth weight babies give birth to low birth weight babies. There is also an association with high blood pressure

and diabetes (Jaber, Melchior, and Rutledge, 1992). According to Singh and van Dyck (2010):

The leading causes of infant death in 2007 were congenital anomalies (birth defects), short gestation and low birth weight, Sudden Infant Death Syndrome (SIDS), maternal complications of pregnancy, unintentional injuries, chord and placental complications, and [respiratory distress syndrome]. Together these causes accounted for 62.1 percent of all infant deaths in 2007 and 57.9 percent of all infant deaths in 1970.

There can never be a quality health care system, based on equality, unless all people are given resources to maintain a healthy life. Because infant health spans the breadth of a health system's services, providers, and levels of care, the African American infant mortality rate may reflect inherent and inter-related issues within our health care system. To establish the best-quality health care system and to reach Healthy People 2020 goals, an expanded and exigent focus on infant mortality in underserved populations, including African Americans, is critical.

Age-Adjusted Mortality

Age-adjusted mortality rates per 100,000 persons by race and ethnicity for three health-focused areas in the United States would indicate that African Americans have a higher mortality rate from heart disease, cancer, and stroke. The white population has a higher heart disease and cancer mortality rate than all other race ethnicities with the exception of African Americans in the United States. African American men have DNA variants that place them at increased risk for prostate cancer when these variants occur in combination (Freedman, et al., 2006). African American men are twice as likely to develop prostate cancer as white men (Jones, 2001). The age-adjusted death rate for diabetes mellitus of African Americans is 40.4 per 100,000, for American Indian-Alaska natives 34 per 100,000, and for Hispanics 25.6 per 100,000. Age adjusted death rates related to HIV/AIDS is 20.4 per 100,000 for African Americans, which is twice that of American Indian-Alaska natives, twenty times that of Asian-Pacific Islanders, ten times that of whites, and four times that of Hispanics. Age-adjusted mortality from homicide is 20 per 100,000 for African Americans compared to 3.6 per 100,000 for whites (Kochanek, et al., 2011).

Minorities, particularly African Americans, receive fewer referrals for renal transplant evaluation and fewer transplants, less adequate pain medication for cancer, fewer admissions to cardiac care units, and fewer revascularization procedures, especially coronary artery bypass grafts. Studies also show that African Americans and Latinos are less likely to receive pain medication in the emergency department for fractures compared to white patients (Betancourt, 2007). These statistics reflect the inherent disparities in health care for minority populations.

Physician Shortage

By 2015, the Association of American Medical Colleges (AAMC) approximates that the United States will have a deficit of 62,900 doctors. This lack of physicians is expected to multiply two-fold by 2025. Historically, there have been approximately 24 physicians per 100,000 people in communities where there are high numbers of African Americans and Hispanics versus other communities where there are 69 physicians per 100,000 with a low proportion of Hispanics and African Americans. The shortage is escalating as a result of numerous factors including time investment for someone to become a doctor, the aging baby boomers (which will substantially increase the need for care), and the extension of health care insurance to all US citizens (Lowrey and Pear, 2012). Similarly, there is also a significant shortage of minority physicians. AAMC found that in 2008 only 6.3 percent of practicing physicians were African American, 5.5 percent Hispanic or Latino, and 0.5 percent American Indian/Alaska Native (Castillo-Page, 2010). To increase the number of physicians overall, loan forgiveness and funding for scholarship programs could be strengthened.

Distrust

People of color, particularly African Americans, are less trusting than whites of hospitals; of reasons physicians use or withdraw life-sustaining therapies; of the organ donation system; and have a profound mistrust of medical research. The US Public Health Service conducted The Tuskegee Study of Untreated Syphilis between 1932 and 1972. Before this study, which aimed to determine the effects of untreated syphilis, men had little access to health care. Six hundred African American men from the rural community of Tuskegee, 399 with syphilis and 201 without, were told they were being evaluated for what was commonly termed “bad blood,” a blanket diagnosis referring to

syphilis, anemia, or fatigue. Patients were never told that they had syphilis, but were given free medical exams, vitamins, meals, and burial insurance. Despite the widespread introduction of penicillin as a powerful antibiotic after World War II and the subsequent 1947 discovery of its efficacy in treatment of syphilis, it was, in accordance with the purpose of the study, never used to treat the men. This unethical practice was continued for forty years, during which time the men passed syphilis on to their partners, and their children developed congenital syphilis. The study might have never come into the public light if not for the efforts of Dr. Peter Buxton, who leaked details to the press in 1972 after fruitless efforts to end the study through review by a board of physicians, all but one of whom deemed the study fit to continue (Parker, Alvarez and Thompson, 2003).

In 1974 Congress passed the National Research Act, which both created the National Commission for Protection of Human Subjects of Biomedical and Behavioral Research (NCPHSBBR) and required the establishment of institutional review boards for any institution receiving federal aid (Hoyert and Xu, 2012). Four years after its founding, the NCPHSBBR issued the Belmont Report, which focused on the distinction between research and practice and led to the establishment of three ethical principles: respect for persons, beneficence, and justice. The report also detailed guidelines for informed consent, increased assessment of risks and benefits, and appropriate subject selection in medical research (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1978).

The mistrust in the medical establishment led to fewer African Americans participating in research and seeking medical care. This mistrust has had a noted impact in public opinion in light of the AIDS epidemic of the 1990s, such as the suspicion within the African American community that the government had manufactured and introduced the disease.

While correlation of reduced participation in medical studies and a negative approach to care cannot signify direct causation, one can reason that increased research participation and greater utilization of care would be useful both to improve quality of life and to identify factors that could be utilized to lessen health disparities. Studies show more blacks than whites know about the Tuskegee syphilis study. More blacks than whites are reluctant to enter into research trials. Lack of adequate minority participation in research studies hampers progress toward understanding disease processes, the effects of medications or treatment, and ultimately a better health care system and delivery.

Access to Care

“One size fits all” health care systems cannot meet the needs of the increasingly diverse US population. Access to care issues must be addressed, culturally appropriate written materials distributed, and interpreter services provided. Convenient hours of operation, accessible clinic locations, and culturally sensitive policies, practices, and settings are important for health care delivery. Currently about 70 million low-income Americans, mostly pregnant women and children, individuals with disabilities, and the elderly who need help at home and those living in nursing homes, are recipients of Medicaid. The Affordable Care Act (ACA) now requires states to cover the very low income population within their Medicaid programs, including adults without dependent children. The government provides 100 percent of this new cost coverage with federal funds for states who elect to expand their Medicaid programs. This provision will happen over approximately three years, subsequently dropping down to around 90 percent, requiring states to pick up a portion of the cost. With the passage of the ACA, up to 17 million new Americans would be expected to gain Medicaid coverage under the new health law. Medicaid expansion is one part of the laws that changed significantly with the US Supreme Court ruling in June 2012. The justices asserted that states can refuse to expand Medicaid to all low-income adults without losing all federal funding or existing Medicaid programs. Some states have opted out, leaving some of the poorest people without Medicaid coverage. The ACA creates a national Medicaid minimum eligibility level of 133 percent of the federal poverty level (approximately \$31,000 for a family of four) approximately \$15,000 for individuals under the age of sixty-five, including adults without dependent children (Patient Care and Affordable Care Act, 2010). This change ends the longstanding coverage gap for low-income adults.

The eligibility standards now also include people who were previously ineligible, such as low-income adults with or without dependents, and low-income children who heretofore would have lost their Medicaid benefits when they were reclassified as adults at age nineteen. The ACA includes protections which outlaw some practices that have previously left people uninsured. Insurers can no longer cancel insurance policies if a person gets sick, a practice previously known as rescission. In January 2014, annual dollar limits previously set by insurance companies on how much they would pay for an individual’s medical expenses each year were eliminated. In addition,

lifetime limits have been eliminated. High medical bills resulting from major or long-term illness are no longer subject to payment limits from insurers. In 2007, 62.1 percent of all bankruptcies were due to unpaid medical expenses, a number that these measures seek to decrease (Himmelstein, et al., 2009).

The new health care law promotes free preventive care and annual check-ups which hopefully will keep people healthier through preventative health screenings and early identification and treatment of health concerns. New private health plans now must cover and eliminate cost sharing such as co-payments, co-insurance, or deductibles for proven preventive measures such as immunizations and cancer screenings, which will encourage people to seek preventative care.

Older adults with Part D drug coverage will find it less expensive to pay for their medications in the future. Americans who can afford coverage will be required to have health insurance or pay a tax penalty. As of January 2014, insurers cannot deny coverage to anyone regardless of pre-existing conditions, and they cannot charge more because of gender. More primary care doctors will be promoted and supported with a higher income from the Medicaid program. Funding for scholarships and loan-forgiveness programs for primary care physicians choosing to serve underserved and rural communities will encourage doctors to practice in these areas (Assistant Secretary of Public Affairs, 2015). Some people who are required to purchase insurance who have not done it before may qualify for subsistence through the government to help pay for the insurance. By raising the Medicaid eligibility ceiling to 133 percent of the poverty level, the ACA targets low-income families and allows nearly 17 million additional people access to health insurance (Patient Care and Affordable Care Act, 2010; Martin, 2013).

Kathleen Sebelius, secretary of Health and Human Services stated: "When the average African American child born today will live five fewer years than the average white child, with a greater likelihood of illness, we are still falling far short of Dr. King's vision" (Sebelius, 2011). Dr. King's dream was that all children would have the chance to reach their full potential, no matter the color of their skin or where they were born. The ACA, with its emphasis on providing attainable health care costs for typically underserved populations, comes close to fulfilling his dream of equality of care.

We are at the beginning of a new era in terms of health care in the United States. There are still those who will not benefit from the health care law, such as those who are undocumented or not considered legal in the United States. Unfortunately, an estimated 11 million undocumented immigrants in the United States remain unable to access health care under this act (Preston,

2008). These immigrants provide necessary services, often in farming and the service industry. Dr. King, who spoke out strongly for certain basic rights afforded to all people, would likely support the ACA but would object to the fact that it does not allow access for undocumented immigrants. Since Dr. King is quoted as saying that access to basic health care is a universal human right, we believe he would want the ACA to be revised to incorporate undocumented immigrants (Zuber, 2012).

One way of extending health care to undocumented immigrants would be to grant them access to Medicaid. While this action would add a significant financial burden to the US health care budget, it would ensure that undocumented immigrants could get necessary health services without fear of being deported. Considering the strained nature of our nation's health care budget, however, this option would almost invariably be unpopular with members of Congress and/or the general public. A more appealing and potentially cost-effective option would be to implement the Development Relief and Education for Alien Minors (DREAM) Act, allowing undocumented minors the ability to buy insurance.

In August 2010, Congress began to develop the DREAM Act. Under this act, children of illegal immigrants would be given access to higher education, citizenship, and all the benefits that American citizenship affords (Barron, 2011). Should this act pass, it would be a significant step toward both health care and education equality. By allowing the children of undocumented immigrants to gain citizenship through sustained education, the act would allow immigrant minors to acquire steady jobs, livable incomes, and necessary health care. Although this method may be less efficient than providing Medicaid for immigrants, it would create a sustainable system to provide undocumented immigrants both citizenship and health care.

There are several practical reasons to expand care to all people, regardless of citizenship status. Many individuals who do not have health coverage delay seeking care and resort to obtaining treatment in costlier emergency departments, which raises the overall cost of care. With a total annual cost of \$113 billion to provide emergency care for undocumented immigrant treatment, a government decision to treat these individuals through primary care would lower overall costs significantly (Zuber, 2012). Furthermore, undocumented immigrants who do not have access to primary health care may develop preventable life-threatening conditions that are expensive to treat. Solving this dilemma by increasing access to primary care would increase the overall health of society in the United States. In addition, these undocumented immigrants, though not US citizens, likely work, and the taxes they would

pay as citizens could apply to some level of health insurance to benefit the country's health system.

While the ACA increases the coverage of many Americans and is moving toward a concept of universal health care, there is room for improvement. Critics of the ACA believe that it will "extend a new entitlement without clear cost-control mechanisms and the result will be that spending exceeds expectations" (Trumbull, 2010). This is largely due to the fact that the act extends Medicaid to millions of families just above the poverty line and extends subsidies to help millions more comply with the mandate to buy insurance. In addition, employers have the choice to offer health insurance as a benefit or pay a penalty. Those preferring to pay the fee would force employees to purchase coverage on new insurance exchanges (Patient Care and Affordable Care Act, 2010).

An essential provision of the ACA is expanding Medicaid coverage to low-income Americans (those with incomes less than 138 percent of the federal poverty level). However, a Supreme Court decision in 2012 made Medicaid expansion optional for states, and as of February 2015, only 28 states and the District of Columbia agreed to do so. From 2014 to 2016, the federal government will cover 100 percent of expansion cost. Afterward, federal support will decline each year, reaching and remaining at 90 percent by 2020 (Barofsky, 2015). Uninsured community health center (CHC) visits have decreased, and Medicaid-covered visits have increased in states that expanded Medicaid in 2014, whereas CHCs in states opting out of the expansion have maintained a high rate of uninsured visits. This suggests that ACA-related Medicaid expansions have been successful in decreasing the number of uninsured safety net patients in the United States (Angier, et al., 2015).

Results from the Commonwealth Fund Biennial Health Insurance Survey, 2014, indicate that the ACA's subsidized insurance options and consumer protections reduced the number of uninsured working-age adults from an estimated 37 million people, or 20 percent of the population, in 2010 to 29 million, or 16 percent, by the second half of 2014. Conducted from July to December 2014, for the first time since it began in 2001, the survey found declines in the number of people who report cost-related access problems and medical-related financial difficulties. The number of adults who did not get needed health care because of cost declined from 80 million people, or 43 percent, in 2012 to 66 million, or 36 percent, in 2014. The number of adults who reported problems paying their medical bills declined from an estimated 75 million people in 2012 to 64 million people in 2014. In 2014, 6.7

million people enrolled in health plans sold through the ACA's marketplaces, with most signing up through the federal marketplace website (Collins, et al., 2014).

These new subsidized options for people who lack insurance from employers are helping to reverse national trends in health care coverage and affordability. Uninsured rates have declined to their lowest levels in more than a decade, and rates among young adults and low-income adults are at their lowest levels in fourteen years. For the first time since 2003, when the question was first introduced, there was a decline in the number of adults who reported not getting needed care because of cost. And for the first time, there was a decline in the number of people who had problems paying their medical bills or who were paying off medical debt over time (Collins, et al., 2014).

On June 25, 2015, the US Supreme Court delivered a major victory to the Obama administration and congressional Democrats, as it handed down its decision on *King v. Burwell*, the biggest legal challenge to the Affordable Care Act (ACA) since the Supreme Court upheld the constitutionality of the law in 2012. The Court ruled six to three that federal tax subsidies to help consumers purchase health insurance are permitted under the ACA regardless of whether insurance is purchased through a state-run exchange or an exchange facilitated by the federal government. After passage of the ACA, thirty-four states chose not to establish state-run exchanges and instead directed residents to so-called federally facilitated exchanges.

CONCLUSION

Dr. Martin Luther King Jr. would suggest that there be a way for all Americans, regardless of their socioeconomic status, to have equal access to health care at an affordable rate. He would be pleased with the establishment of the Affordable Care Act, which is providing coverage to millions of people who were previously uninsured. This allows for low-income families to afford health care through the expansion of Medicaid, affordable health insurance, and tax aid.

However, because health care is not simply a "citizen's" right but rather a human right, we conclude that Dr. King would be disheartened at the fact that undocumented immigrants are still denied Medicaid or subsidies (Patient Care and Affordable Care Act, 2010). He would be disheartened over the shortage of health care providers, particularly the vast underrepresentation

of minority physicians and other health care providers, and the persistence of underserved communities. He would also be disheartened by the mistrust of health care systems by minorities. Dr. King would desire a reduction in health disparities inclusive of infant and age-adjusted mortality rates among all citizens. He would advocate for health care that is community-based and culturally sensitive to the minority populations in the United States that contribute to the diversity and greatness of this country. Specifically, we believe Dr. King would advocate for the following:

- Equitable health care that is affordable, free to those without income, accessible, sustainable, and portable.
- Diverse health care providers and administration reflective of the racial demographics of the communities served.
- Health prevention through comprehensive education, beginning as early as kindergarten to completion of compulsory education, and via community information sessions and workshops.
- Increasing and expanding health centers within low-income communities.
- Employment opportunities for the unemployed/underemployed and the poor with a living wage which would position individuals with the means to pay for health care.

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REFERENCES

- Angier, H., M. Hoopes, R. Gold, S. R. Bailey, E. K. Cottrell, and J. Heintzman. 2015. An Early Look at Rates of Uninsured Safety Net Clinic Visits after the Affordable Care Act. *Annals of Family Medicine*. 13(1): 10-6.
- Assistant Secretary of Public Affairs, Digital Communications Division. 2015. *Creating Jobs by Addressing Primary Care Workforce Needs*. United States Department of Health and Human Services. <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobso6212012.html>.
- Barofsky, J. 2015. *What Are the Effects of Not Expanding Medicaid?*. Washington, DC: Brookings Institution. <http://www.brookings.edu/blogs/health360/posts/2015/02/20-effects-not-expanding-medicare-barofsky>.
- Barron, E. 2011. "The Development, Relief, and Education for Alien Minors (DREAM) ACT." *Harvard Journal on Legislation*. 48(2): 625-55. Index to Legal Periodicals and Books Full Text (H. W. Wilson), EBSCOhost.
- Betancourt, Maina A., Jr. 2007. "Barriers to Eliminating Disparities in Clinical Practice." In *Eliminating Healthcare Disparities in America: Beyond the IOM report*, ed. R. A. Williams. Totowa, NJ: Humana. 83-85.
- Castillo-Page, L. 2010. *Diversity in the Physician Workforce: Facts and Figures 2010*. Washington, DC: Association of American Medical Colleges; 2010. <https://members.aamc.org/eweb/upload/Diversity%20in%20the%20Physician%20Workforce%20Facts%20and%20Figures%202010.pdf>.
- Collins, S. R., P. W. Rasmussen, M. M. Doty, and S. Beutel. 2015. *The Rise in Health Care Coverage and Affordability since Health Reform Took Effect: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014*. *The Commonwealth Fund* 1800(2): 1-15.

- Freedman, M. L., C. A. Haiman, N. Patterson, G. J. McDonald, A. Tandon, A. Waliszewska, et al. 2006. "Admixture Mapping Identifies 8q24 as a Prostate Cancer Risk Locus in African-American Men." *Proceedings of the National Academy of Sciences of the United States of America* 103(38): 14068-73. Epub 2006 Aug 31.
- Friedan, T. R. 2011 Jan 14. CDC Health Disparities and Inequalities Report—United States." *Morbidity and Mortality Weekly Report*. 60, supp. <http://www.cdc.gov/mmwr/pdf/other/su6001.pdf>.
- Goldenberg, R. L., S. P. Cliver, F. X. Mulvihill, C. A. Hickey, H. J. Hoffman, L. V. Klerman, et al. 1996 Nov. "Medical, Psychosocial, and Behavioral Risk Factors Do Not Explain the Increased Risk for Low Birth Weight among Black Women." *American Journal of Obstetrics and Gynecology* 175(5): 1317-24.
- Himmelstein, D. U., D. Thorne, E. Warren, and S. Woolhandler. 2009 Aug. *Am J Med*. 122(8):741-46. doi: 10.1016/j.amjmed.2009.04.012.
- Hoyert, D. L., and J. Xu. 2012. "Deaths: Preliminary Data for 2011." *National Vital Statistics Reports* 61. http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf.
- Jaber, L. A., W. R. Melchior, and D. R. Rutledge. 1992 Jul–Aug. "Possible Correlation between Glycemia and Blood Pressure in Black, Diabetic, Hypertensive Patients." *Annals of Pharmacotherapy* 26(7-8): 882-86.
- Johns, B., K. Sigurbjörnsdóttir, H. Fogstad, J. Zupan, M. Mathai, and T. Tan-Torres Edejer. Apr 2007. "Estimated Global Resources Needed to Attain Universal Coverage of Maternal and Newborn Health Services." *Bulletin of the World Health Organization*. 85(4): 256–63.
- Jones, J. 2001 Mar 7. "African-Americans and Prostate Cancer: Why the Discrepancies?" *Journal of the National Cancer Institute* 93(5): 342-44.
- Kane, J. 2012 Oct 22. "Health Costs: How the US Compares with Other Countries." In PBS Newshour. The Rundown: A Blog of News and Insight. Washington, DC: NewsHour Productions, LLC. c2003-2014. [about 10 screens]. <http://www.pbs.org/newshour/run-down/2012/10/health-costs-how-the-us-compares-with-other-countries.html>.
- Kiely, J. L., and M. Kogan. 1994. "Reproductive Health of Women: Prenatal Care." In *From Data to Action: CDC's Public Health Surveillance for Women, Infants, and Children*, ed. L. S. Wilcox and J. S. Marks. Atlanta, GA: Centers for Disease Control and Prevention; 1994. 105-18. <http://stacks.cdc.gov/view/cdc/11354/>.
- King, M. L., Jr. 1965. "Address at the Conclusion of the Selma to Montgomery March." http://kingencyclopedia.stanford.edu/encyclopedia/documentsentry/doc_address_at_the_conclusion_of_selma_march/index.html.
- . King, M. L., Jr. 1957. "A Realistic Look at the Question of Progress in the Area of Race Relations." Address delivered at St. Louis freedom rally. http://kingencyclopedia.stanford.edu/primarydocuments/Vol4/10-Apr-1957_ARealisticLook.pdf.
- Kochanek, K. D., J. Xu, S. L. Murphy, A. M. Miniño, and H-S. Kung. 2011. "Deaths: Final Data for 2009." *National Vital Statistics Report* 30(3). Hyattsville, MD: National Center for Health Statistics. http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_03.pdf
- Lantos, J. D., and D. S. Lauderdale. What Is Behind the Rising Rates of Preterm Birth in the United States? *Rambam Maimonides Med J*. Oct 2011; 2(4): e0065. doi: 10.5041/RMMJ.10065.

- Lockwood, C. J., and J. A. Lemons, eds. 2007. *Guidelines for Perinatal Care*. 6th ed. Elk Grove Village, IL: American Association of Pediatrics and American College of Obstetrics and Gynecology. 83-137.
- Lowrey, A., and R. Pear. 2012 Jul 28. "Doctor Shortage Likely to Worsen with Health Law." *New York Times*. http://www.nytimes.com/2012/07/29/health/policy/too-few-doctors-in-many-us-communities.html?_r=0&.
- MacDorman, M. F., and T. J. Mathews. 2012. "Infant Mortality Statistics from the 2008 Period Linked Birth/Infant Death Data Set." *National Vital Statistics Reports* 60(5). Hyattsville, MD: National Center for Health Statistics. http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_05.pdf.
- MacDorman, M. F., D. L. Rowley, S. Iyasu, J. L. Kiely, P. G. Gardner, and M. S. Davis. 1994. "Birth Outcomes: Infant Mortality." In *From Data to Action: CDC's Public Health Surveillance for Women, Infants, and Children*, ed. L. S. Wilcox and J. S. Marks. [Internet]. Atlanta, GA: Centers for Disease Control and Prevention. 231-49. <http://stacks.cdc.gov/view/cdc/11354/>.
- Martin, M. Health disparities. 2013. Lecture during January Term. St. Kitts and Nevis Jan 2-14.
- Miniño, A. M., and S. L. Murphy. 2012. *Death in the United States, 2010*. NCHS data brief, no. 99. Hyattsville, MD: National Center for Health Statistics. <http://www.cdc.gov/nchs/data/databriefs/db99.htm>.
- National Cancer Institute at the National Institutes of Health. *Cancer Health Disparities*. Reviewed March 11, 2008. <http://www.cancer.gov/cancertopics/factsheet/disparities/cancer-health-disparities>.
- National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. 1978. The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research. DHEW Publication No.(OS) 78-0012. Bethesda, MD. http://videocast.nih.gov/pdf/ohrp_belmont_report.pdf.
- Parker L., S. H. K. Alvarez, and S. Thompson. 2003. "Module 2: The Legacy of the Tuskegee Syphilis Study." In *Ethics and Public Health: Model Curriculum*, ed. B. Jennings, J. Kahn, A. Mastroianni, and L. S. Parker. Rockville, MD: Health Resources and Services Administration. 37-73. <http://www.aspph.org/wp-content/uploads/2014/02/EthicsCurriculum.pdf>.
- Patient Care and Affordable Care Act of 2010. 2010. Pub. L. 111 Stat. 148 March 23.
- Physicians for a National Health Program (PNHP). 2014. "Dr. Martin Luther King on Healthcare Injustice." <http://www.pnhp.org/news/2014/october/dr-martin-luther-king-on-health-care-injustice>.
- Preston, J. 2008. "Decline Seen in Numbers of People Here Illegally." *The New York Times*. July 31. http://www.nytimes.com/2008/07/31/us/31immig.html?_r=0.
- Sebelius, K. 2011. *A Tribute to Dr. King*. USDHHS. January 17. <http://www.hhs.gov/healthcare/facts/blog/2011/01/drking-tribute.html>.
- Singh, G. K. van Dyck PC. 2010. *Infant Mortality in the United States, 1935-2007: Over Seven Decades of Progress and Disparities*. Rockville, MD: Health Resources and Services Administration, Maternal and Child Health Bureau. http://www.hrsa.gov/healthit/images/mchb_infantmortality_pub.pdf.

- Trumbull, M. 2010. "New Healthcare Bill Pros and Cons: Will It Cut Costs?" *Christian Science Monitor*. March 22 [cited 2015 Jul 1]. <http://www.csmonitor.com/USA/2010/0322/New-health-care-bill-pros-and-cons-Will-it-cut-costs>.
- United States Census Bureau. 2008. *An Older and More Diverse Nation by Midcentury*. Updated 2013 June. <http://www.census.gov/newsroom/releases/archives/population/cbo8-123.html>.
- Washington, J. M., ed. 1986. *A Testament of Hope: The Essential Writings of Martin Luther King, Jr.* San Francisco: Harper and Row.
- Zuber, J. 2012. "Healthcare for the Undocumented: Solving a Public Health Crisis in the US." *Journal of Contemporary Health Law and Policy* 28(2)(Spring):350-80.