Michigan League FOR Human Services

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Looming Cuts in Michigan's Budget Threaten to Widen the Gulf in Health Disparities

Health disparities are the persistent gaps that exist between the health status of racial and ethnic minorities and whites, and they are growing. Despite continued advances in health care, technology and overall health status, minorities continue to have more disease and premature death than whites. These disparities extend to some of our most vulnerable—infants and children.

Projected demographic changes in Michigan over the next decade point to the need to address health disparities. The fastest growing racial and ethnic groups in the state also experience the poorest health status. Nationally, it is estimated by the year 2050, racial and ethnic minorities will make up more than 50 percent of the U.S. population.[1] The problem of health disparities stands to get much worse without action to reduce the disparities.

Poverty continues to be a key determinant contributing to disparate health outcomes.

Distribution of Michigan's Population by Race/Ancestry

Race/Ancestry	1980	1990	2000	2005	% Change
White	85.8	84.2	80.2	80.0	-6.8
Black	13.0	14.0	14.2	14.0	+7.7
American Indian	0.5	0.6	0.6	0.6	+20.0
Asian/Pacific Islander/Other	0.7	1.2	3.1	3.8	+442.9
Multi-Racial	NA	NA	1.9	1.7	NA
Hispanic	1.7	2.2	3.3	3.8	+123.5

Source: Color Me Healthy Profile of Michigan's Racial and Ethnic Populations, May 2008. www.michigan.gov/minorityhealth

As health disparities and the populations most affected by them grow in Michigan, state policymakers are making budget decisions that do not reflect health disparity reduction as a priority. Cuts in the Executive Order issued in May and proposed cuts to the fiscal year 2010 budget slash programs aimed at reducing health disparities in our state. To understand the widespread implications of this, we must first understand the scope and magnitude of the health disparities problem in Michigan.

Contributing Factors

We now know many factors contribute to a person's health status. An examination of some of these factors and how they affect minority populations is important in understanding health disparities.

Numerous studies show that those with lower levels of income and education are at much higher risk for disease and premature death. Poverty continues to be a key determinant contributing to disparate health outcomes. Those in poverty have less access to good medical care, healthy food and resources for a healthy lifestyle. Those in poverty are more likely to live with stress and uncertainty, contributing factors to a number of health conditions and diseases.

In 2006, the percentage of African Americans in Michigan below the poverty level

[1] U.S. Census Bureau, American Community Survey, 2005.

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was more than double that of whites—24.3 percent compared with 10.3 percent. The average net worth of whites ($88,651) is more than ten times greater than that of African Americans ($5,998) and Latinos ($7,932). Nationally, African Americans make up 13 percent of the U.S. population, but they own only 3 percent of the assets and had the lowest median income in 2004 among all racial groups.[2]

Higher education levels are associated with higher income levels and also with better health outcomes. But as is the case with low income levels, minorities make up a greater percentage of those with lower education levels. In 2003, 71 percent of African American students attended public schools that were considered "high-poverty," compared to 28 percent of their white counterparts.[3]

Here in Michigan, education levels and proficiencies for white males are significantly higher than those for African American males. This is reflected in graduation rates. In 2005-2006, the graduation rate was 74 percent for white males and 33 percent for African American males. During that same year, 61 percent of African American males in 8th grade were below the basic reading level for their grade, while only 25 percent of white males were below grade level.

Education Rates for Males in Michigan 2005-2006

	Black Males Percent	White Males Percent
Graduation	33%	75%
Below basic reading level grade 8	61%	25%
Below basic math level grade 8	72%	23%

Source: The Schott 50 State Report: Black Male Data Portal. http://blackboyrsreport.org/node/80, Retrived June 22, 2009.

Minorities are more likely to be without health insurance than whites.

Likewise, 72 percent of African American males in 8th grade were below the basic math level for 8th grade, compared to only 23 percent of white males.[4]

With the exception of the Asian population, minorities in Michigan are less likely to have a bachelor's degree or higher than the overall population. Of Michigan's overall population, 24.5 percent have a bachelor's degree or higher, while only 12.7 percent of African Americans, 12.8 percent of Latinos and 10.3 percent of American Indians have a bachelor's degree or higher.[5]

Lack of health insurance is another key factor influencing a person's health status. Those without insurance are far less likely to get timely health care for themselves and in some cases their children. They are even less likely to get preventative care that could help avoid many conditions and diseases. Women over 40 without insurance are more than twice as likely not to have had a mammogram. Compared with those who have insurance, the uninsured are approximately six times more likely to be without a usual source for health care. Uninsured individuals are nearly three times as likely to delay getting care for an illness or injury.

Minorities are more likely to be without health insurance than whites. In 2005, 15.7 percent of the U.S. population lacked health insurance.

Racial/Ethnic Breakdown of Uninsured in 2005

Hispanics	32.7%
Native Americans/Alaska Natives	29.9%
African Americans	19.6%
Asians	17.9%
White Non-Hispanics	11.3%

Source: U.S. Census Bureau, 2005

[2] Michigan Department of Human Services, Poverty Summit Presentation, November 13, 2008.
[3] Greene, Jay P. and Winters, Marcus A. Leaving Boys Behind: Public High School Graduation Rates, Center for Civic Innovation at the Manhattan Institute, April 2006.
[4] The Schott Foundation for Public Education. Given Half a Chance: The Schott 50 State Report on Public Education and Black Males, 2008.
[5] Michigan Department of Human Services. Poverty Summit Presentation, November 13, 2008.

Even when insurance status, patient income and other access-related factors are comparable, minorities are less likely than whites to receive needed health services, including clinically necessary procedures.[6] Research shows that African Americans are less likely to receive diagnostic procedures and life-saving therapies for a heart attack. Despite the fact that African Americans suffer strokes at a rate as much as 35 percent higher than whites, they are less likely to receive diagnostic tests and therapeutic interventions for stroke. The list is extensive. Minorities are less likely to get appropriate cancer diagnostic tests and treatments; be placed on waiting lists for kidney transplants; receive kidney dialysis or transplants; receive certain cutting-edge therapies and treatments for HIV; and receive appropriate medications to manage asthma.[7]

Disparities exist in government-sponsored health care and children's health care also. In the Medicare program, African Americans receive proportionately fewer office visits, preventive mammograms and colonoscopies than whites. Minority patients are less likely to receive childhood immunizations and the recommended immunizations for influenza and pneumonia.[8]

Minority patients' perspectives of the health care system and health care providers play an important role in health status. African Americans are more likely to perceive bias and have a lack of trust in the health care system overall than whites. If ethnic or racial minority patients sense racism or are unable to find a health care provider that understands their culture, they are less likely to get preventive and medical care. This can impact on children, as well, if the parent is uncomfortable with the available health care.

Research indicates that there are grounds for the concern by minorities that they are treated differently in the health care system. An Institute of Medicine report concluded that prejudice or biases, overt or otherwise, contribute to disparities in health care quality and service delivery. The report also indicated that health care providers are influenced in decisions about diagnostic tests and treatment by the patient's race or ethnicity.[9] Another study found that physicians rated minority patients more negatively than white patients and that they viewed minorities as noncompliant and more likely to engage in risky health behaviors.[10]

Prejudice or biases, overt or otherwise, contribute to disparities in health care quality and service delivery.

Disparities in Death and Disease

All of these contributing factors, and more, result in the health disparities that exist in Michigan. The overall health of the state's population has improved, but not all racial and ethnic groups have seen the same level of improvement. For example, the health status of African American males has not improved at the same rate as white males. One indicator of health status is life expectancy. Life expectancy has increased for African Americans and whites in Michigan over the last 50 years, but significant disparities continue. The life expectancy for African American males in 2005 was very similar to the life expectancy for white males fifty years ago in 1950.[11]

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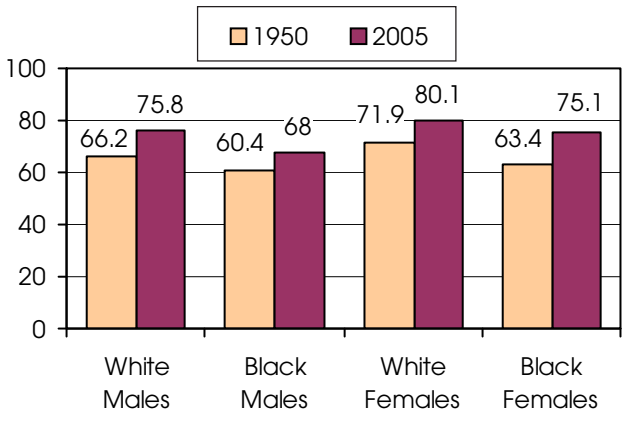
[6] Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. 2002.
[7] Addressing Racial and Ethic Disparities in Health Care Delivery: The Purchaser's Role. Health Care Cost Containment Council. www.phc4.org/reports/fyi/fyi20.htm Retrieved on June 3, 2009
[8] Steel Fisher, Gillian K. *Addressing Unequal Treatment: Disparities in Healthcare.* The Commonwealth Fund, November 2004.
[9] Steel Fisher, ibid.
[10] Van R., M. & Burke, J. (2000) The Effect of Patient Race and Socio-Economic Status on Physicians' Perceptions of Patients. *Social Sciences and Medicine.*
[11] Michigan Department of Community Health, Vital Records & Health Data Development.

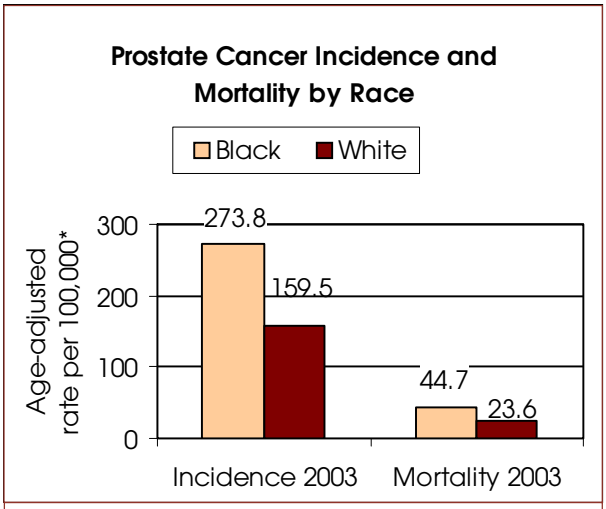


Source: Vital Records and Health Data Development Section, Michigan Department of Community Health

Large disparities exist in the three leading causes of death—heart disease, cancer and stroke. African Americans in Michigan account for 20 percent of deaths due to heart disease, but make up only 14 percent of the state population.[12] They also suffer the highest cancer mortality rate, followed by American Indians/ Alaskan Natives. Michigan's American Indians/ Alaskan Natives have the highest stroke mortality rate, followed closely by African Americans.[13]

Given their higher mortality rates, it is not surprising that African Americans have risk factors for chronic diseases at a higher rate than whites. Thirty-six percent of African American males have high blood pressure, compared with 27 percent of white males in Michigan. Twenty-eight percent of Michigan's African American males smoke, while only 22 percent of white males smoke. Almost 33 percent of African American males in Michigan are obese, compared with 27 percent of white males.[14]

Cancer incidence and death rates in Michigan also vividly reflect the disparities between whites and African Americans. White women are diagnosed with breast cancer at a higher rate (123 per 100,000) than African American women (113 per 100,000). However, African American women are more likely to die from breast cancer (33 per 100,000) than white women (23 per 100,000). African American women are diagnosed with cervical cancer almost twice as often as white women, with a mortality rate that is almost double that for white women. African American males in Michigan get prostate cancer at a much higher rate than white males—274 per 100,000 compared to 160 per 100,000. The African American mortality rate for prostate cancer is almost double the rate for whites.[15]



* Adjusted to 2000 U.S. standard population
Source: Vital Records and Health Data Development Section, Michigan Department of Community Health

Overall, the AIDS death rate is declining, but HIV/ AIDS affects African Americans at a much higher rate than other racial and ethnic groups in Michigan. The death rate for African Americans is eight times higher than the death rate for whites in the state.[16] HIV/AIDS is the fifth leading cause of death for African American men and women in Michigan among the 25-44 year old age group.[17]

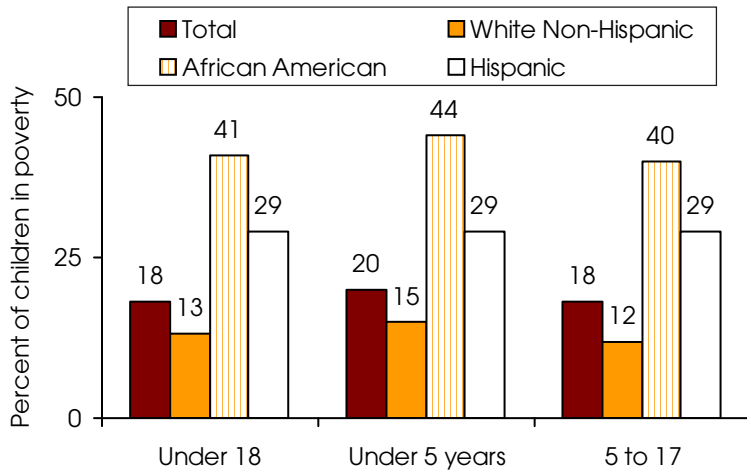
[12] U.S. Census Bureau, American Community Survey, 2005.
[13] Michigan Department of Community Health, Vital Records & Health Data Development.
[14] Michigan Department of Community Health, Michigan Behavior Risk Factor Surveillance System.
[15] Michigan Department of Community Health, Vital Records & Health Data Development.
[16] Ibid.
[17] Michigan Department of Community Health, Quarterly HIV/AIDS Report, Michigan, January 2009.

The rate at which African Americans are getting HIV is also disproportionate. Although African Americans make up 14 percent of Michigan's population, they make up 59 percent of the state's HIV/AIDS cases, with a rate of 582 HIV/AIDS cases per 100,000. On the other hand, whites make up 78 percent of the state's population and only 35 percent of those with HIV/AIDS, with a rate of 63 cases per 100,000 people.[18]

Disparities in Infant and Children Health

There are a number of risk factors that influence the health status of infants and children in our state. These risk factors are more prevalent in some racial and ethnic minority populations in Michigan, resulting in the disparities that exist related to infant and children's health.

Minority children experience double and triple the risk of poverty compared with white children.



Source: American Community Survey 2006

There are many long-term effects for children raised in poverty, including poorer health status. Child poverty has steadily worsened in Michigan. Between 2000 and 2007 child poverty rose an astounding 40 percent. The risk of childhood poverty disproportionately affects those in Michigan's minority populations. In 2006, young African American children (0-4 years of age) were three times more likely to live in families with income below the federal poverty level compared to young white children. According to Kids Count in Michigan, almost half (44%) of the state's young African American children and 29 percent of Hispanic children lived in poverty in 2006, compared with 15 percent of white non-Hispanic children.[19]

Prenatal care is an essential part of a healthy start for infants and is particularly important for women who have not had access to regular primary care. Some improvements have been made in the area of prenatal care in Michigan. However, African American mothers and infants continue to suffer from the highest rates of less than adequate prenatal care—38 percent compared with 31 percent for Hispanics and 19 percent for whites in 2006.[20]

Birthweight has been found to be the best predictor of infant mortality and childhood morbidity. Low-birthweight babies are at increased risk for serious health problems, lasting disabilities and even death. African American infants continue to suffer from low-birthweight at far greater rates than other racial and ethnic populations. In 2006, 14 percent of African American infants were born weighing less than five and one-half pounds (considered low birthweight)—double the rate of white and Hispanic infants. This continues a pattern that persisted from 1997 through 2006.[21]

Healthy Michigan 2010 reports that the rates of teen pregnancy and birth, which impact infant health,

[18] Michigan Department of Community Health, Quarterly HIV/AIDS Report, Michigan, January 2009.
[19] Zehnder-Merrell, Jane. *Kids Count in Michigan Data Book 2008: County Profiles of Child and Family Well-Being*-A Focus on Young Children, Lansing, MI. Michigan League for Human Services. 2008.
[20] Ibid.
[21] Ibid.

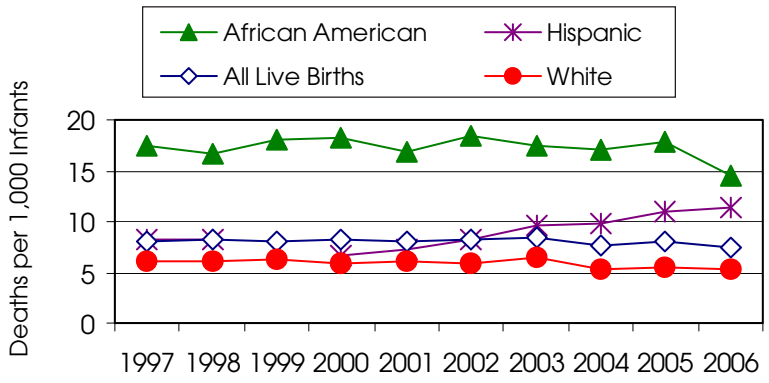
have declined steadily since 1990.[22] Teen birth rates, however, vary widely by race and ethnicity. In 2006, 19 percent of births to African American women were to teens, compared with 15 percent for Hispanics and 7 percent for whites.[23] In 2001, the birth rate for African Americans females in the 10- to 14-year-old range was eight times higher than the rate for white females in that age range.[24]

The education level of mothers of newborns also varies greatly by race and ethnicity, and impacts on child health and well-being. In 2006, almost half (47%) of Hispanic mothers who gave birth had less than 12 years of education, as did well over one-quarter (28%) of African American mothers, compared to 12 percent of white mothers. Equally troubling is the fact that between 1997 and 2006, these education rates improved by only 8 percent for whites and African Americans and actually worsened for Hispanics.[25]

Michigan's infant mortality rate has consistently been higher than the U.S. rate. This is due to a larger racial disparity in our state, according to Healthy Michigan 2010. The infant mortality rate for African Americans in Michigan in 2006 was nearly triple the rate for white babies, 14.5 deaths per 1,000 compared with 5.7 deaths per 1,000. The Hispanic infant mortality rate (11.3 deaths per 1,000) is essentially double the rate for whites. Between 1997 and 2006, infant mortality rates for African Americans and whites reflected some decline, but the rate for Hispanics rose dramatically from 8.3 to 11.3 deaths per thousand.[26]

One cause of infant mortality is Sudden Infant Death Syndrome (SIDS). From 1999 through 2004, infant deaths attributed to SIDS have decreased almost 70 percent.[27] Although the overall SIDS rate has fallen, the rate for African American and American Indians was two to three times greater than whites, as reported in Healthy Michigan 2010.[28]

Rates and trends in infant mortality differ dramatically by racial ethnic group in Michigan.



Source: Vital Records and Health Data Development Section, Michigan Department of Community Health

Budget Decisions Affecting Health Disparities

Fiscal year 2009, which began October 1, 2008, marks the 9th consecutive year that Michigan's revenues have not been adequate to fund state services and programs. The current year's deficit is being addressed with $1.4 billion in federal stimulus dollars and $300 million in cuts. The fiscal year 2010 budget deficit is projected to be almost $3 billion.

Work on fiscal year 2010's budget began in February when Gov. Jennifer Granholm presented her proposed budget for the next year. In her proposed budget, the governor recommended cuts that will negatively impact on the state's ability to reduce health

[22] Healthy Michigan 2010, Michigan Surgeon General's Health Status Report, 2004.
[23] Zehnder-Merrell, op cit.
[24] Healthy Michigan 2010, op cit.
[25] Zehnder-Merrell, op cit.
[26] Zehnder-Merrell, op cit.
[27] Tomorrow's Child. www.tomorrowschild.org. Retrieved June 22, 2009.
[28] Healthy Michigan 2010, op cit.

Targeted for Cuts. The Nurse Family Partnership focuses on vulnerable first-time mothers and is designed to improve pregnancy outcomes leading to healthier babies and healthier mothers. Visits by specially trained nurses are provided from the prenatal period until the child's second birthday. Michigan sites are in communities with a high number of racial and ethnic minorities and with high infant mortality rates-Detroit, Benton Harbor, Grand Rapids, Pontiac and Kalamazoo.

disparities. Most of Michigan's health prevention programs are housed in the Healthy Michigan Fund (HMF), which was cut by over 13 percent in the governor's budget. Almost all of the HMF programs play a role in health disparity reduction.

Included in her cuts was the Nurse Family Partnership, which provides intensive services for at-risk mothers and babies, many of which are from racial and ethnic minorities. Funding for prenatal care outreach and support services for low-income women was reduced by more than half.

The governor's budget also proposed the elimination of multicultural services for community mental health. This funding was used to provide mental health services in communities of color through local agencies.

Three months later, in May, with state revenues falling even more than expected, Gov. Granholm issued an Executive Order, which cut over $300 million from the state budget for the remainder of this fiscal year. Cuts to health disparity-related programs will lead to the total elimination of some programs, while others will suffer greatly.

Included in the Executive Order cuts is decreased funding for programs designed to reduce chronic disease (cancer, heart disease and stroke) and risk factors for these chronic diseases (tobacco use, obesity and lack of physical activity). Ethnic and racial minorities are most greatly affected by chronic disease and will be impacted by these cuts. AIDS Risk Reduction and the AIDS Media Line were also cut.

The Executive Order cuts directly affect initiatives related to maternal and child health, and infant mortality, including the Nurse Family Partnership. Michigan's immunization registry, which helps to assure that all children are up to date on their immunizations, was cut as well.

Perhaps most damaging are the cuts to the Health Disparities line in the Healthy Michigan Fund. This funding is used by the Michigan Department of Community Health in its health disparities reduction work. In 2008, the Department implemented 55 services to address health disparities and to reach over 2.6 million people. There is great concern that these cuts and program eliminations for this fiscal year will continue on into fiscal year 2010 with devastating effects on efforts to reduce health disparities in Michigan.

While the House has restored many of the cuts recommended in the governor's budget for fiscal year 2010, the Senate has passed budget recommendations which make deeper cuts than those in the governor's budget. The Senate eliminated all but $5 million of the Healthy Michigan Fund; the current fiscal year funding was $37 million before the Executive Order cuts.

Also slated for elimination in the Senate recommendation is funding for child and adolescent health centers. It is estimated that without this funding more than 200,000 children and adolescents will lose access to health care in underserved communities, including many in communities of color.

During challenging budget times, difficult decisions need to be made about the funding of state programs. However, cuts to disparity reduction initiatives are very

Targeted for Cuts. Child and Adolescent School-Based Health Centers are located in areas serving low-income children and families and are primarily in medically underserved communities with racial disparities. These centers are powerful tools in meeting the health care needs of vulnerable populations and have demonstrated the ability to serve hard-to-reach populations, especially racial and ethnic minorities.

short-sighted. While they may save money in the short run, they will cost money in the long run and they will cost lives, including the lives of our most vulnerable. The reality is that people in Michigan are getting sick and dying prematurely because of racial disparities. Michigan cannot afford to turn its back on the great need that exists to address health disparities, which continue to grow.

Even during these difficult budget times, state policymakers must fund initiatives that will reduce health disparities and will lead to a much healthier population across all racial and ethnic populations in our state. Funding of state programs, alone, will not end health disparities, but it is an essential piece of the puzzle. The goal must be a state in which racial and ethnic minorities have an equal opportunity to live long, healthy and productive lives.

Targeted for Cuts. A number of Healthy Michigan Fund programs are designed to reduce chronic disease and risk factors associated with them, particularly important for racial and ethnic minorities. Some of these programs include:

- Cancer prevention and control;
- Heart disease and stroke prevention;
- Diabetes prevention;
- Asthma prevention;
- Smoking prevention; and
- Obesity prevention and physical activity promotion.