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## **CALENDAR**

**\* North Carolina Black  
Leadership Caucus Regular  
Meeting, Saturday, Aug. 21  
State Baptist Bldg. 603  
South Wilmington St.  
Raleigh. Executive  
Committee 10:00 a.m.  
General Body 11:00 a.m.**

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## **CONGRATULATIONS:**

**\*Senator Larry Shaw\***

**Matthew "Rick" Watts**  
*Chairman, NC Real Estate Commission*

**Joshua & L'Tanya Haire**  
*2004 National Parents*

## **Questions of the Month**

**Will Governor Easley assist  
in the election of Black  
statewide candidates or will  
it be Election 2002 again?**

**How many black democrats  
won run-off elections?**

**A. None**

**What are the top ten reasons  
Blacks should vote for Mike  
Easley? Pat Ballantine?**

## MESSAGE FROM THE CHAIRMAN

### **HEALTH CARE! "WHO CARES"?**

by Larry D. Hall

In this era of organizational repudiation who is going to require support of health care. Yes the Republicans have repudiated the action of House Speaker Richard Morgan and banned him from state party organization leadership. Some Catholic Church Bishops have said they will refuse communion to pro-choice politicians or voters who support them. But there is no religious or political organization, network or hierarchy to enforce the efforts of universal healthcare and health insurance. Obviously there is a HEALTH crisis in North Carolina. It is not just a healthcare crisis, but a health crisis. You see, health has consequences from worker productivity to student academic performance; from increased emergency room utilization to more expensive treatment. Minorities, low income families, and children are disproportionately represented in those without healthcare. This situation requires immediate attention by the legislature. Some call the disparity between the healthcare of Black and non-Blacks a gap, but is more of a canyon, the Grand Canyon that is.

Unfortunately, 16% of North Carolinians are uninsured. That would be in excess of one Million of our fellow citizens. In spite of all the hospitals, research facilities, new cancer centers (UNC & Duke), heart centers (ECU, Duke), medical schools (UNC, ECU, Duke, Wake Forest), too many have no access. One-Fifth of all Black North Carolinians are without health coverage compared to One-Tenth of White North Carolinians and this disparity manifests itself across all indicators from mortality, infant mortality, aids rates, tuberculosis and the list goes on. With the loss of so many textile and manufacturing jobs this uninsured crisis has worsened. Eighty Five percent of all people who become unemployed have family members who lose their health insurance as a result.

Enter Orange County House of Representatives Member Verla C. Insko. Insko entering her fourth term and a member of the House Health Committee has promised to put forward a bill. Her bill would propose to amend Article 1 of the North Carolina Constitution to obligate the state to provide health care as a fundamental right. This would put a responsibility on the government to solve this long running problem. Insko reports she does not think that she even has the votes to get the bill out of committee. Opponents say they are opposed because it will cost more than we presently pay and may require increased tax revenues.

It is amazing that these same cost prohibitive excuses are not made for the death penalty, incarceration of non-violent offenders, Business Relocation Incentives, etc. We do what we have the will to do, whether it is going to the moon or creating astro-turf. Achievement follows leadership, courage and commitment. Unfortunately our elected officials are lacking in the courage necessary to put this and other issues ahead of their own individual political fortunes. May be we should have longer terms with prohibitions against successive terms.

**The North Carolina Black Leadership Caucus adopted its Health Care Position in July 2004. We ask that you read it in this edition and ask your elected representation to "Stand and Deliver".**

**Health Care Policy Position  
2004 Drafted by Gwendolyn S. Hailey, Esquire**

The North Carolina Black Leadership Caucus believes that every candidate for state or federal office should make a commitment to the following health care goals:

1. Universal health care coverage for every citizen of North Carolina and the United States.
2. Comprehensive health benefits including health maintenance, preventive, diagnostic, therapeutic, and rehabilitative services for all types of illnesses and health conditions.
3. Elimination of financial barriers to basic health care.
4. Health care cost financing based on ability to pay. The ability to pay for health care cost on a "sliding fee" basis.
5. Organization and administration of health care through publicly-accountable mechanisms to assure maximum responsiveness to public needs, with a major role for federal, state, and local government health agencies. The insistence that health data is reported by ethnicity to insure that the health issues of African Americans receive their fair share of public dollars.
6. Health outcome results to be included in all city, county, state and federally funded health care projects because we can no longer accept minimal results from projects that are funded by our own tax dollars. No more "pork barrel" spending on so called health initiatives with no accountability of whether the tax dollars accomplished the stated health care objectives.
7. Incentives and safeguards to assure effective and efficient organization of services and high-quality care. Adopt programs that insure that tax payer money only funds health care that falls within accepted "standards of care."
8. New African-American health care businesses are created to solve the access and transportation barriers, in order to improve health care in the African-American community
9. Fair payment to providers using mechanisms, which encourage appropriate treatment by providers and appropriate utilization by consumers. Institute health care programs and physician payment systems that encourage preventative care.
10. Ongoing evaluation and planning to improve the delivery of health services with consumer and provider participation.
11. Inclusion of disease prevention and health promotion programs.
12. Support of education and training programs for all health workers.
13. Affirmative action programs in the training, employment, and promotion of health workers. The location of health related professional schools in historically African-American schools and universities.
14. Non-discrimination in the delivery of health services.
15. Education of consumers about their health rights and responsibilities.

16. Attention in the organization, staffing, delivery, and payment of health care to the needs of all populations including those confronting geographic, physical, cultural, and other non-financial barriers to service.
  17. Elected officials commit to help improve and or design health care delivery systems tailored for the African-American community.
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### **Health Profile of North Carolina African Americans**

African Americans are the second largest racial group in North Carolina. One out of every five of the state's 7.3 million residents is Black, or about 9 out of every 10 minority residents. According to the U.S. Bureau of the Census, approximately 1.6 million African Americans lived in North Carolina in 1996, compared to 1.5 million in 1990. Overall, according to Census information, African Americans in North Carolina have lower income, education and employment levels than White North Carolinians and are less likely to have health insurance, factors which can adversely affect health status.

African Americans suffer higher death rates than Whites. Although the health status of the Black population in North Carolina has been improving in some areas, research shows a widening gap between Black people and White people in illness from asthma, diabetes, major infectious diseases and several forms of cancer. African Americans often receive less and poorer quality health care than Whites, and thus they tend to become sicker and die earlier than Whites. In addition to factors such as economic status and educational levels, researchers are finding growing evidence that race, discrimination, and social and cultural factors influence the care people receive and, consequently, their health.

African Americans born today have a life expectancy of about 70, typically dying six or seven years earlier than White Americans. The age-adjusted death rate for North Carolina's African Americans was slightly lower in 1996 than in 1990, but was still more than 1½ times the 1996 death rate for White North Carolinians. This means that, in general, African Americans in each age group are dying at higher rates than Whites in the same age groups.

Many rural places in North Carolina have limited access to health care. There are 8 counties in North Carolina that have fewer than 5 active physicians. In Hyde County, which has a population of nearly 6,000, there is only one active physician. Of the nearly 16,000 physicians in North Carolina only 5,400 are located in rural counties. In addition, there are four counties in the state, all of them are rural, that do not have a practicing dentist. The limited number of physicians and dentists in an area result in either traveling long distances to visit a health care provider or putting off needed exams and procedures.

Source: N.C. Rural Economic Development Center 2002.

Office of Minority Health and State Center for Health Statistics, July 1998.

### **Health Care Crisis Areas in the African American Community**

- African American women are more than twice as likely to die of cervical cancer as are white women and are more likely to die of breast cancer than are women of any other racial or ethnic group.
- Heart disease and stroke are the leading causes of death for all racial and ethnic groups in the United States. In 2000, rates of death from diseases of the heart were 29 percent higher among African American adults than among white adults, and death rates from stroke were 40 percent higher.
- In 2000, American Indians and Alaska Natives were 2.6 times more likely to have diagnosed diabetes compared with non-Hispanic Whites, African Americans were 2.0 times more likely, and Hispanics were 1.9 times more likely. Diabetes is a serious health risk to all people of color.

## Health Care Position Cont'd

- Although African Americans and Hispanics represented only 26 percent of the U.S. population in 2001, they accounted for 66 percent of adult AIDS cases and 82 percent of pediatric AIDS cases reported in the first half of that year.
- In 2001, Hispanics and African Americans aged 65 and older were less likely than Non-Hispanic Whites to report having received influenza and pneumococcal vaccines.
- Some fundamental societal problems, such as poverty, inadequate access to health care, and lack of education are associated with disproportionately high levels of syphilis in certain populations. Cases of primary and secondary syphilis in 1999 had the following race or ethnicity distribution: African Americans 75 percent, whites 16 percent, Hispanics eight percent, and others one percent. Syphilis reflects one of the most glaring examples of racial disparity in health status, with the rate for African Americans nearly 30 times the rate for whites.

Source: *Disease Burden and Risk Factors* a report published by the Centers for Disease Control. Office of Minority Health.

## Tackling the Uninsured Population Crisis

In the United States there are **41.2 million** uninsured:

- 19.4 million are non-Hispanic White
- 12.4 million are Hispanic
- 6.8 million are Black
- 2.3 million are Asian and Pacific Islander

(Source: Census Bureau, September 2002)

North Carolina is one of 10 states with the greatest number of people under age 65 without health insurance. Seventeen percent or 1.1 million North Carolina residents in 2001 were uninsured for the entire year and 2.3 million were uninsured for all or part of the year. The situation is worse in many rural counties where it was estimated that in 1999 there were 608,000 people under age 65 who were uninsured. In 22 counties, 20 percent or more of the population was uninsured. They are all rural.

There are better alternatives for achieving economies in health care than shifting costs to patients. Costs are higher in the United States than in other countries because we pay higher prices for the same services; our administrative costs are higher; and physicians prescribe specialized services that are not clinically justified. If we as a nation were to adopt fundamental reforms—such as an integrated public-private strategy to purchase health services efficiently, demand quality performance, and streamline administrative costs—substantial savings could be achieved.

A significant amount of care for the uninsured is provided each year by hospitals, clinics and physicians. In total, this care for 2001 was valued at nearly \$99 billion: \$40.6 billion for those uninsured the entire year and \$58.3 billion for those uninsured for a portion of the year. Of that \$99 billion, approximately 62% was compensated directly, and 38% was uncompensated.

So what does this mean? It means that money is flowing into the system to care for the uninsured; it's just not going to help them buy insurance. As the Kaiser Commission stated, "In 2001, governments spent \$30.6 billion covering, perhaps, 85% of the cost of uncompensated care. Although this is a substantial public expenditure, it represents less than 6% of total government spending for personal healthcare in 2001." For example, in 2001 government spending on Medicare was \$247 billion, on Medicaid, \$226 billion, on tax code subsidies to buy insurance, \$138 billion, and on uncompensated care \$31 billion. Or, viewed another way, uninsured patients in need got less care as reflected in per capita costs. The per capita cost for a privately insured patient in the US was \$2,484; for a publicly insured patient it was \$2,435; and for an uninsured patient it was \$1,335.

Extending coverage to the uninsured, then, is not as impossible as it sounds. That's because we are not starting from scratch. In fact, we are providing considerable tax funds, in a after the fact way. Rather than providing insurance more broadly to those in need, and making prevention a priority, we reactively reimburse those who assume the responsibility of caring for a population of the disadvantaged and disempowered. Extending coverage to those currently uninsured could be accomplished without new government funding. Once again, from the Kaiser Commission, "If a substantial part of the financing of care received by the uninsured is already in the public sector, then some share of these funds is potentially available for transfer to new government efforts to extend coverage to those currently uninsured. Much of the \$23.6 billion in payments to hospitals...would be a reasonable candidate for reallocation...since hospitals would be the primary beneficiaries."

#### References:

Kaiser Family Foundation website: [www.kff.org](http://www.kff.org)

Barman, LE; Uccello, C; and Kobes D. Tax Incentives for Health Insurance. Tax Policy Discussion paper. The Urban Institute, Washington DC.

Hadley J and Holahan J. The Kaiser Commission on Medicaid and the Uninsured. Who pays and how much? The cost of caring for the uninsured. The Urban Institute, February 2003.

N.C. Rural Economic Development Center 2002.

### **Casualties of Redistricting: Senator Shaw was Right!**

Earlier this year, Senator Larry Shaw joined the North Carolina Black Leadership Caucus and Republican legislators in opposing the Democratic Legislative leadership's redistricting plan. At that time Senator Shaw stated that reductions in minority majority districts would result in the loss of black legislative representation. For voting against the redistricting plan, Senator Shaw was targeted for defeat in the July 20<sup>th</sup> Democratic Primary for the District 21 senate seat. Members of the Democratic leadership shopped for a candidate. They found Fayetteville Councilmember Haire and financed a losing campaign against the incumbent Senator, Larry Shaw.

Last week, Shaw was vindicated when three black candidates in minority majority districts were defeated by white democrats. Richard M. Henderson lost with 49% of the vote to Michael Wray. Shelly Willingham lost with 46% of the vote to Clark Jenkins. Darryl D. Moss lost with 49% of the vote to Doug Berger. Guess who didn't show up at the polls and guess who white democrats voted for on Tuesday.

On the other hand, Vernon L. Robinson, a black Republican, got 45% of the vote in his run-off with Virginia Fox. Last time I looked, the District 5 congressional district was a republican district and majority white. **Are white Republicans more supportive of black candidates than white Democrats?**

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