

Journal of Gender, Social Policy & the Law

Volume 21 | Issue 1

Article 3

2012

My Aging Minority Rural Grandparents: Disparities in the Health and Health Care of the Rural Elderly Minority Population and the Need for Culturally Competent Health Care Providers

Camille M. Davidson

Follow this and additional works at: <http://digitalcommons.wcl.american.edu/jgspl>

 Part of the [Law Commons](#)

Recommended Citation

Davidson, Camille M. "My Aging Minority Rural Grandparents: Disparities in the Health and Health Care of the Rural Elderly Minority Population and the Need for Culturally Competent Health Care Providers." *American University Journal of Gender Social Policy and Law* 21, no. 1 (2012): 57-78.

This Article is brought to you for free and open access by the Washington College of Law Journals & Law Reviews at Digital Commons @ American University Washington College of Law. It has been accepted for inclusion in *Journal of Gender, Social Policy & the Law* by an authorized administrator of Digital Commons @ American University Washington College of Law. For more information, please contact fbrown@wcl.american.edu.

MY AGING MINORITY RURAL GRANDPARENTS: DISPARITIES IN THE HEALTH AND HEALTH CARE OF THE RURAL ELDERLY MINORITY POPULATION AND THE NEED FOR CULTURALLY COMPETENT HEALTH CARE PROVIDERS

CAMILLE M. DAVIDSON*

I. Introduction	58
II. Cultural Competency and the Rural Elderly African American Population	60
A. My Grandparents: Super-elderly, Rural, and African American	60
B. The Demise of the Patient-Provider Relationship and the Importance of Cultural Competence	63
C. Culturally Competent Medical Professionals Are Necessary to Eliminate Health and Health Care Disparities	66
1. African American Disparities	66
2. Rural Population Disparities	69
3. Elderly Population Disparities	72
4. Rural, African American, and Elderly Disparities	73
III. The ACA, Health Professionals, Cultural Competency, and the Rural Elderly Population	74
A. Increase Workforce	74
B. Diversity Training	75
C. Elderly Population	76
IV. A Call for Action	76
A. The ACA Provides the Framework	76
B. Diversity in Medical School Is Necessary	78

* Assistant Professor, Charlotte School of Law. B.B.A. *magna cum laude*, Millsaps College; J.D., Georgetown University Law Center. The author thanks Samantha Souza, Charlotte School of Law class of 2012, and her colleagues at the Charlotte School of Law.

58 JOURNAL OF GENDER, SOCIAL POLICY & THE LAW [Vol. 21:1
V. Conclusion 78

I. INTRODUCTION

This is a story about my rural elderly grandparents and how the lack of culturally competent health care providers affects their health and health care. As I write this article, they are ages ninety-two and ninety-six, and they are aging in their rural Mississippi home. As rural elderly African Americans, they beat the odds in a country where African Americans are sicker and die younger than their Caucasian counterparts, and where the health of rural Americans lags behind the population in general.¹ My grandparents embody the intersection of three of health care's most disadvantaged population characteristics: age, race, and geographic location.

As a result of their age, race, and geographic location, the quality of care they receive is inadequate and their overall health status suffers. Taken separately, each of the three population subsets—the elderly population, the rural population, and the African American population—is a disparity population. So it is no surprise that, when combined, the health of the rural elderly African American lags behind the health of the majority of the population.

Although there are a number of reasons for the inadequate health and health care of such individuals, in this Article I focus on the non-financial barrier of the limited availability of culturally competent health care providers. Most conversations about disparities focus on lack of insurance and other financial barriers to health care. For my grandparents, and other similarly-situated individuals, eliminating disparities means more than removing financial barriers such as access to health insurance.

One of the major components of the Patient Protection and Affordable Care Act (ACA) is an increase in insurance benefits to all individuals.² By 2014, the ACA will require all individuals to have health insurance coverage.³ Proponents of health insurance mandates accurately state that lack of health insurance coverage or underinsurance—coverage that does not meet all medical needs—is a major cause of health disparities. Simply

1. See U.S. DEP'T OF HEALTH AND HUMAN SERVS., CTRS. FOR DISEASE CONTROL AND PREVENTION, HEALTH, UNITED STATES, 2010, at 133-35 (2010), <http://www.cdc.gov/nchs/data/hus/hus10.pdf> (demonstrating that in 2007, Caucasian Americans had 18.7 more years of life expectancy at age 65 while African Americans had only 17.2 more years of life expectancy at age 65).

2. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 5001, 124 Stat. 119, 487 (2010) (explaining that the purpose of the ACA is to “improve access to and the delivery of health care services for all individuals, particularly low income, underserved, uninsured, minority, health disparity, and rural populations”).

3. *Id.* § 1501 (detailing that part of the individual responsibility of the act requires minimum essential health insurance coverage).

stated, when an individual does not have insurance and does not qualify for government assistance, he or she is not inclined to seek needed care. Since lack of insurance and underinsurance disproportionately affect minorities, rural populations, and often the elderly, such populations are less healthy than the general population.⁴ Simply removing financial barriers will not eliminate disparities that exist among these populations, although a reduction of disparities requires affordable health insurance coverage. Data suggest that members of disparity populations with adequate insurance coverage still have a lower quality of health and health care than the general population.⁵ Therefore, non-financial barriers must be addressed.

The patient-provider relationship is essential to quality health and health care.⁶ My grandparents do not have an effective relationship with their health care providers because they do not trust them, which, in turn, is because their health care providers are not equipped to understand their unique cultural needs. In order to eliminate such distrust, medical professionals must be trained in cultural competency. They must be able to communicate with those patients who do not look like them and who do not share their cultural background and beliefs. When health care providers are not culturally competent, the end result is inadequate health care and health disparities for certain population subsets.

As members of the super-elderly community—those over eighty years old—my grandparents are part of the fastest growing segment of our population.⁷ Like others their age, they live daily with chronic illnesses and they have a greater need for health care providers than the general population.⁸ So, while I am fascinated that they have survived to be among

4. See Angeline Bushy, *A Landscape View of Life and Health Care in Rural Settings*, in HANDBOOK FOR RURAL HEALTH CARE ETHICS: A PRACTICAL GUIDE FOR PROFESSIONALS 19-20 (William A. Nelson ed., 2009) (reporting that rural residents are far more likely to suffer from poor health than urban residents).

5. See HOLLY MEAD ET AL., THE COMMONWEALTH FUND, RACIAL AND ETHNIC DISPARITIES IN U.S. HEALTH CARE: A CHARTBOOK 8-9 (2008), available at http://www.commonwealthfund.org/usr_doc/mead_raceethnicdisparities_chartbook_111.pdf (positing that underlying dynamics may help explain why disparities still exist after taking factors such as income, education, and insurance coverage into account).

6. See Elizabeth Tobin Tyler, *Allies Not Adversaries: Teaching Collaboration to the Next Generation of Doctors and Lawyers to Address Social Inequality*, 11 J. HEALTH CARE L. & POL'Y 249, 267 (2008) (arguing that patient-centered care must be emphasized in medical school).

7. See Press Release, U.S. Census Bureau, Dramatic Changes in U.S. Aging Highlighted in New Census, NIH Report (Mar. 9, 2006), http://www.census.gov/newsroom/releases/archives/aging_population/cb06-36.html (“The age group 85 and older is now the fastest growing segment of the U.S. population.”).

8. See CTR. FOR HEALTH WORKFORCE STUDIES, THE IMPACT OF THE AGING POPULATION ON THE HEALTH WORKFORCE IN THE UNITED STATES: SUMMARY OF KEY FINDINGS 6 (2006), available at http://www.albany.edu/news/pdf_files/impact_of_aging_excerpt.pdf (stating that the super-elderly place a greater demand on the health care system due to chronic illnesses, greater physical vulnerability, and

the super-elderly who live relatively independently, I am concerned about whether they will continue to thrive as they age.

In Part II of this Article, I define “cultural competency” and discuss the need for culturally competent health care providers. In Part III, I specifically address the provisions of the ACA that address cultural competency training for health care providers. Part IV is a call for action suggesting that lawyers and policymakers will need to come up with innovative programs to make sure culturally competent health care providers are available to serve disparity populations in general and specifically the rural elderly African American population.

II. CULTURAL COMPETENCY AND THE RURAL ELDERLY AFRICAN AMERICAN POPULATION

A. My Grandparents: Super-elderly, Rural, and African American

My grandparents’ circumstances demonstrate the need for health care providers equipped to communicate with the rural elderly African American population. Their interactions with health care providers demonstrate the importance of cultural competency training and the impact such training has on the health and health care of individuals.

As I write this article, my grandparents age at their home in Shaw, Mississippi, a small, rural town of about 2100 people located in the Mississippi Delta.⁹ Shaw, Mississippi is one of several small towns located in Bolivar County.¹⁰ The town is approximately ninety-two percent African American, and the majority of the population lives near or below the poverty line.¹¹ The closest “city” is Cleveland, a small college town of about 12,000.¹² A drive to downtown Cleveland from my grandparents’ home takes approximately twenty minutes along Highway 61.

My grandfather was (and still thinks he is) a farmer, and my grandmother is a retired homemaker. Together they raised six children and sent all of them to college. While they could move near any of those children, they have chosen to grow old in their rural Mississippi home.¹³

increased consumption of prescription medications, among other factors).

9. See *City & Town Totals: Vintage 2009*, U.S. CENSUS BUREAU, <http://www.census.gov/popest/data/cities/totals/2009/index.html> (last visited May 29, 2012).

10. See *Shaw, Mississippi Profile*, CITY-DATA.COM, <http://www.city-data.com/city/Shaw-Mississippi.html> (last visited May 26, 2012).

11. See *Races in Shaw, Mississippi*, CITY-DATA.COM, <http://www.city-data.com/races/races-Shaw-Mississippi.html> (last visited May 26, 2012) (showing that of the 2110 citizens of Shaw county, 2063 are African American).

12. See *City & Town Totals: Vintage 2009*, *supra* note 9.

13. See *Bushy*, *supra* note 4, at 17-18 (“The term ‘rural’ can be defined in many

They currently rely on the assistance of their children, and, most recently, a part-time in-home aide.

Like many other rural elderly African Americans, my grandparents are deeply religious, hardworking, and self-sufficient.¹⁴ Their beliefs impact the health care that they choose to receive (or not receive) and affect their overall health. They may be inclined to rebuff suggestions by family members to see a physician because they do not instinctively trust their physicians. In their opinion, physicians do not listen to them, do not understand their frustrations and ailments, and do not respect them. Often, my grandparents are inclined to tough it out with respect to ailments or illnesses even though such an attitude may have long-term repercussions. Sometimes, when the ailment does not get better, my grandparents simply think it is “God’s will.” Their beliefs and subsequent actions often mean that more serious medical problems may surface later. My grandparents’ barriers are not financial. They have private insurance coverage and Medicare. Instead, non-financial barriers are what limit their quality of care.

As I write this article, my grandmother, a diabetic who has nursed a wound on her leg, must now make some decisions regarding surgery. A physician has made recommendations to her, but she does not readily trust the physician or those recommendations. The wound that afflicts my grandmother has been recurrent for almost two years. Although a home health nurse had, until recently, visited every two weeks, her healing has not progressed consistently.

The family encouraged my grandmother to visit her primary care physician. However, she does not connect with him and so does not freely share her health concerns with him. She would rather rely on her children to assist her than attempt to explain her issues to a health care provider, who she perceives as not caring about her.

Eventually, she visited her primary care physician and he referred her to a wound specialist. The specialist spoke “at” her rather than “to” her. He informed her that she needed surgery to remove a clot, and that the procedure would require an overnight hospital stay.

Somehow, in her ninety-plus years, my grandmother had never spent the night in a hospital, so she was understandably reluctant. But family members encouraged her and—dare I say—persuaded her to do what we thought was right for her health and well-being. The doctors told her that

ways. . . . Population is a common way to define rurality. . . . Another common definition of rural is based on the geographic size of a community relative to population density. . . .”).

14. *See id.* at 20-21 (“Members of small homogenous communities tend to be conservative politically and socially, with some exceptions. They tend to be ‘church-going’ . . .”).

she would not even have to stay overnight if the procedure was done early in the morning. At no point were any family members told this would be a two-part process.

On the day of the scheduled procedure, my grandmother arrived at the hospital before 9:00 AM. She had followed doctor's orders and had eaten nothing, so she was hungry. After spending all morning in the hospital, she was told that she would have to reschedule because something had come up. A staff person relayed the information. She did not see the physician that day. She asked for an apology but never received one.

Amazingly, my grandmother rescheduled the procedure, but again there was a breakdown in communication. After spending the day in the hospital, my grandmother (and the rest of the family) thought that she had received the necessary procedure. The physician told her everything went well. Only later, when hospital staff called to say that they needed to schedule the procedure, did she (and we) discover that the sedation was merely evaluative and she had not received the necessary treatment. The lack of communication is the primary reason why my grandmother does not readily accept the recommendations of her physician.

Although my grandfather does not hesitate to visit his primary care physician's office, he also does not trust the physician's diagnoses or recommendations, and does not always follow the recommendations. The end result for both my grandmother and grandfather is a lack of quality health care.

For years, experts studying the medical field have argued that the primary reason minorities do not seek early medical attention is because they are distrustful of the predominantly white system.¹⁵ My grandparents are no exception. Their health suffers because they distrust their health care providers. Their distrust results from the inability of the health care provider to connect and communicate with his or her rural elderly African American patient.

At a recent symposium, I spoke about this need for culturally competent health care providers. One of the audience members asked me why I suggested that there was a problem when almost all medical schools teach cultural competency. The audience member was correct in that "[c]ulture is the rage in medical schools and hospitals across the country."¹⁶ There has been an "explosion of programs designed to teach what is called

15. Barbara A. Noah, *Racial Disparities in the Delivery of Health Care*, 35 SAN DIEGO L. REV. 135, 171-72 (1998) [hereinafter Noah, *Racial Disparities*].

16. Lynn M. Morgan, "Life Begins When They Steal Your Bicycle": *Cross-Cultural Practices of Personhood at the Beginnings and Ends of Life*, 34 J.L. MED. & ETHICS 8, 8 (2006).

‘cultural competence.’”¹⁷ I maintain that the teaching in the monolithic medical school environment is inadequate.¹⁸ While medical students believe that their schools teach them cultural competency, disconnect continues to exist between the patient and the health care provider in the clinical setting. “Health care professionals, like many individuals, are reluctant to believe that they themselves engage in discriminatory behavior.”¹⁹ So, while medical schools are paying attention to the issue, more effective cross-cultural competency training is necessary.

B. The Demise of the Patient-Provider Relationship and the Importance of Cultural Competence

My grandparents often claim that physicians are not what they used to be. They maintain that when they were younger and raising their children, physicians cared about their total person. What has contributed to the apparent demise of the patient-provider relationship? What is cultural competence and why is it important?

Although African Americans have historically distrusted health care providers, my grandparents’ reactions to their health care providers most likely changed when the health care delivery model changed. The traditional Fee-for-Service model allowed “health care professionals to address the unique individuality of patients.”²⁰ In my grandparents’ rural community, they took comfort in the therapeutic relationship afforded by the Fee-for-Service model of health care.²¹ In contrast, the current model of health care delivery leaves little opportunity for such relationship-building. The disconnected delivery of health care under the managed care system has contributed to the demise of the patient-provider relationship.

17. *Id.*

18. See RICHARD J.D. PAN, COUNCIL ON MED. EDUC., DIVERSITY IN THE PHYSICIAN WORKFORCE AND ACCESS TO CARE 1 (2008), available at <http://www.ama-assn.org/resources/doc/council-on-med-ed/a-08cmerpt7.pdf> (finding that there is very little economic or ethnic diversity in medical schools. “[T]he percent of entering medical students who self-classify as African American has been 7.1-7.3%, the percent of Hispanic students has been 7.4-7.5%; the percent of Asian student has been 20-21%, and the percent of white, non-Hispanic students has been 62-63%. . . . The percent of new medical students coming from families in the top quintile of family income increased from about 51% in 2000 to 55% in 2005, and the percent of students from families in the lowest quintile has not risen above 5.5%.”).

19. Gwendolyn Roberts Majette, *Access to Health Care: What a Difference Shades of Color Make*, 12 ANNALS HEALTH L. 121, 137 (2003).

20. Jean Spann Anthony, *Self-Advocacy in Health Care Decision-Making Among Elderly African Americans*, 14 J. CULTURAL DIVERSITY 88, 89 (2007) (citing Susan Dentzer, *Modern Maturity Report: Managed Care, Part II*, MODERN MATURITY, Jan.-Feb. 1998, at 34).

21. See Charity Scott, *Doctors as Advocates, Lawyers as Healers*, 29 HAMLINE J. PUB. L. & POL’Y 331, 331 (2008) (explaining the theory of doctors as advocates and lawyers as healers).

Gone are the days of long conversations between physicians and their patients.²²

The managed care model requires physicians to see more patients in shorter periods of time.²³ Sadly, the days of the family physician that cared for all of a patient's needs—"someone who can coordinate and manage all their preventive, chronic and acute care"²⁴—no longer exist. My grandparents may remember the physician of the 1960s who knew all of their ailments and concerns, as well as those of their children, but that physician is rare under today's managed care model. Today's managed care model manages "quality care [through] efficient cost effective services."²⁵ Unfortunately, this "fast paced, impersonal[,] economically focused health care system" adversely affects the health and health care of many elderly African Americans.²⁶

Without a personal connection, physicians often make judgments about diagnoses, treatments, and medications based on stereotypes associated with the groups to which the patient belongs.²⁷ Therefore, cultural competence becomes increasingly important under a managed care health care model. A culturally competent professional is one who understands and can interpret that major culture of his or her patients, including "health beliefs, cultural practices, and folk remedies."²⁸

Cultural competence is the ability of the members of a professional system or environment to work effectively in cross-cultural situations.²⁹ "The United States Department of Health and Human Services' Office of Minority Health (OMH) defines culture as 'integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or

22. See Laura D. Hermer & William J. Winslade, *Access to Health Care in Texas: A Patient-Centered Perspective*, 35 TEX. TECH L. REV. 33, 38 (2004) ("Physicians are no longer as patient-centered as many of them once were in the care they deliver.").

23. See *id.* (rationalizing that because managed care organizations squeeze physicians' profit margins so severely, physicians are forced to increase profit by seeing as many patients as they can in the shortest amount of time).

24. Josh Freeman, *PPACA, The New Health Reform Law: How Will It Affect the Public's Health and Primary Care?*, MED. & SOC. JUST. (Apr. 22, 2010), <http://medicinesocialjustice.blogspot.com/2010/04/ppaca-new-health-reform-law-how-will-it.html>.

25. Anthony, *supra* note 20, at 89 (citing Dentzer, *supra* note 20, at 34).

26. *Id.*

27. See *id.* (opining that judgment based on stereotypes often leads to inappropriate treatment regimens).

28. Lisa Byrd, *Health Disparities Affecting Minority Elderly Populations*, MEDSCAPE EDUC., <http://www.medscape.org/viewarticle/550265> (last visited May 28, 2012).

29. TERRY CROSS ET AL., GEORGETOWN UNIV. CHILD DEV. CTR., TOWARDS A CULTURALLY COMPETENT SYSTEM OF CARE 28 (1989).

social groups.”³⁰ Although urban, rural, African American, Latino, Asian, and elderly populations constitute various cultures in the United States, cultural competency training is often limited to ethnic- and race-based stereotypes.³¹

Professor Lisa Ikemoto has written about cultural competence as follows:

The basic premise of cultural competency is that the near monoculture of the health care system interferes with the care of the growing number of patients who are not part of that culture. Cultural competence efforts aim at changing the institutional culture of health care and accompanying social services. The efforts include enabling health care and social service workers to provide effective access and care to patients with diverse values, beliefs, and practices. A primary and oft-stated goal of cultural competence is to contribute to the elimination of racial and ethnic gaps in health outcomes.³²

Cultural competence is especially important in the clinical setting. The physician-patient relationship is an integral part of effective medical care, and cultural competence affects how a health care provider communicates and delivers care to his or her patient.³³ “Research suggests that the quality of communication between physician and patient strongly influences the quality of care that the patient receives, and that social and cultural stereotypes can interfere with communication.”³⁴ Additionally, these breakdowns are further evidenced by the abundance of communication-related patient complaints.³⁵

Ineffective communication contributes to the distrust between my grandparents and their health care providers. Trust is at the crux of the physician-patient relationship.³⁶ For a patient to trust his or her health care provider, the provider must understand the patient. When patient and provider are not part of the same culture, the health care provider must work to establish trust. Part of establishing trust is to understand the

30. Darci L. Graves et al., *Legislation as Intervention: A Survey of Cultural Competence Policy in Health Care*, 10 J. HEALTH CARE L. & POL’Y 339, 345 (2007).

31. See Joseph R. Betancourt et al., *Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care*, 118 PUB. HEALTH REP. 293, 298-99 (2003), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497553/pdf/12815076.pdf> (arguing that providing a list of “dos” and “don’ts” and attempting to learn a set of “facts” for certain ethnic minorities such as Asians or Hispanics can easily lead to stereotyping).

32. Lisa C. Ikemoto, *Racial Disparities in Health Care and Cultural Competency*, 48 ST. LOUIS U. L.J. 75, 75 (2003).

33. Tyler, *supra* note 6, at 267.

34. Barbara A. Noah, *A Prescription for Racial Equality in Medicine*, 40 CONN. L. REV. 675, 678 (2008) [hereinafter Noah, *Prescription for Racial Equality*].

35. Noah, *Racial Disparities*, *supra* note 15, at 170.

36. Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 470 (2003).

culture of the patient. Therefore, cultural competency training is important.

All individuals have preconceived notions about people who do not look like them, and health care providers are no exception.³⁷ A health care provider's preconceived stereotypes affect how that provider treats his or her patients. "A physician's stereotypical or biased beliefs can interfere with his or her exercise of decision-making authority in making recommendations among different treatment alternatives."³⁸ A physician's first impressions are, in many ways, as important as his or her scientific training because that perception determines the remainder of the physician-patient communication. "How a doctor thinks can first be discerned by how he speaks and how he listens."³⁹

C. Culturally Competent Medical Professionals Are Necessary to Eliminate Health and Health Care Disparities

Congress defined a disparity population as follows: "A population is a health disparity population if . . . there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population."⁴⁰ My grandparents represent three distinct disparity populations as a result of their race, age, and geographic location. Individually and in combination, their representative populations experience health disparities. The elimination of such disparities comes from a culturally competent health care provider.

1. African American Disparities

The DNA makeup of the human race is consistent across ninety-nine percent of the population.⁴¹ Despite the almost identical human makeup, health studies show that African Americans are sicker and have shorter lives than Caucasians.⁴² African Americans have disproportionately higher

37. Noah, *Prescription for Racial Equality*, *supra* note 34, at 713.

38. *Id.* at 713-14.

39. Tyler, *supra* note 6, at 267 (citing William Grimes, *Diagnosis as Art, Not Rocket Science*, N.Y. TIMES, Mar. 23, 2007, at E1 (quoting Harvard Medical School professor Jerome Groopman)).

40. Minority Health and Health Disparities Research and Education Act of 2000, Pub. L. No. 106-525, § 101, 114 Stat. 2498 (2000).

41. Karen Williams & Veronica W. Johnson, *Eliminating African-American Health Disparity via History-based Policy*, 3 HARV. HEALTH POL'Y REV., no. 2, 2002, <http://www.hcs.harvard.edu/~epihc/currentissue/fall2002/williams-johnson.php> (last visited May 28, 2012) (arguing that race is largely psychological and sociopolitical).

42. See Dennis Thompson, *U.S. Minorities No Strangers to Health Ills*, HEALTHDAY (July 22, 2011), <http://consumer.healthday.com/Article.asp?AID=655043> (stating that African Americans are more prone to chronic illnesses and diseases such as obesity and cancer).

rates of disease, mortality, and survival than the majority population.⁴³

Research also strongly suggests that race is not a proxy for class.⁴⁴ “A significant body of evidence suggests that minority race adversely affects the quantity and quality of health care provided to minority patients.”⁴⁵ Even when socioeconomic status is the same, disparities still exist between African Americans and their Caucasian counterparts.⁴⁶ “[R]egardless of socioeconomic status,” African Americans have more difficulty accessing health care, attempt to access it less, and are more likely to express frustration when doing so.⁴⁷ There is even discrepancy in treatment and outcome among patients of racial or ethnic minorities who have the same health insurance as the majority.⁴⁸

Although several factors contribute to these outcomes, the patient-provider relationship is crucial. The Institute of Medicine (IOM) released a report titled “Unequal Treatment: Confronting Racial Disparities in Health Care in 2002.”⁴⁹ The report concluded that there is evidence suggesting that bias, prejudice, and stereotyping by health care providers may contribute to disparities in health care.⁵⁰ A study in the Archives of Internal Medicine determined African Americans to be less trusting of the medical system than Caucasians.⁵¹ Almost two-thirds of African Americans are convinced that physicians are experimenting with new prescription drugs on people without approval.⁵² The Health Care Financing Administration also conducted a study and concluded that

43. *University of Arkansas Sponsored Conference Promotes Health Equity*, THE COLLEAGUE (March 2009), <http://coehp.uark.edu/colleague/6948.php>.

44. See T.J. DeGroat, *Does Race Really Matter?*, DIVERSITYINC., May 2006, at 34 (discussing the social and biological aspects of race and how race has very little to do with biology); Won Kim, *Does Class Trump Race?*, DIVERSITYINC., May 2006, at 24, 28 (arguing that while race strongly affects disparities, low-income African Americans have more in common with low-income Caucasians regarding access to quality health care than they do with high-earning African Americans).

45. Noah, *Prescription for Racial Equality*, *supra* note 34, at 675.

46. See INST. OF MED. OF THE NAT’L ACADS., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 5 (Brian D. Smedley et al. eds., 2003).

47. Vernellia Randall, *Why DiversityInc May Issue Is Institutional Racism*, RACE, HEALTHCARE & L. (May 11, 2006), <http://academic.udayton.edu/health/11Disparities/Disparities11.htm>.

48. T.J. DeGroat, *Healthcare Solutions from the Nation’s Thought Leaders*, DIVERSITYINC., May 2006, at 48, 50.

49. INST. OF MED. OF THE NAT’L ACADS., *supra* note 46, at 3.

50. *Id.* at 12 (explaining that indirect evidence supports such an assertion, although a greater understanding of the prevalence and influence of such factors is necessary).

51. Peter A. Clark, *Prejudice and the Medical Profession: A Five-Year Update*, 37 J.L. MED. & ETHICS 118, 118 (2009).

52. *Id.* (citing Giselle Corbie-Smith, Stephen B. Thomas, and Diane Marie M. St. George, *Distrust, Race, and Research*, 162 ARCHIVES INTERNAL MED. 2458, 2459 (2002)).

identical insurance does not result in equal health care.⁵³

In Unequal Treatment, the IOM committee offered several recommendations to conquer racial and ethnic disparities. The first recommendation was for “cross-cultural education of medical professionals.”⁵⁴ The culturally competent health care provider is a necessity because the current medical system interferes with the communication and relationship-development required by adequate health care.⁵⁵ One reason African Americans resist professional medical assistance is because of the lack of culturally competent care by medical professionals.⁵⁶

Cultural competence is necessary to overcome the history of mistrust between African Americans and their health care providers. African Americans are more skeptical than other social groups, due to a history of experimentation and medical developments based on entrenched racial stereotypes. The experimentation has included the Sickle Cell Screening Initiative, involuntary sterilization in the name of family planning, racism and stereotyping within the medical system, and experimentation.⁵⁷ Vernellia Randle reminds us of the Tuskegee Syphilis Experiment:

The most well[-]known post-slavery experiment is the Tuskegee Syphilis Experiment which the United States engineered from 1932 through 1972. The Tuskegee Experiment involved four hundred African American men in a government[-]sponsored study to research the effects of untreated syphilis. While the men were not deliberately exposed to syphilis, as some rumors maintained, they were never told that they were not being treated or that effective treatment was available. Furthermore, even though the experiment was regularly reported over the course of the forty years, there was no outcry from the medical establishment. The effects of the Tuskegee Syphilis Experiment of maintaining and strengthening the distrust in the health care system cannot be underestimated. The

53. Noah, *Racial Disparities*, *supra* note 15, at 142.

54. INST. OF MED. OF THE NAT'L ACADS., *supra* note 46, at 19.

55. Ikemoto, *supra* note 32, at 82.

56. Vernellia R. Randall, *Racial Discrimination in Health Care in the United States as a Violation of the International Convention on the Elimination of All Forms of Racial Discrimination*, 14 U. FLA. J.L. & PUB. POL'Y 45, 54-65 (2002) (outlining several factors that inhibit African Americans from receiving professional medical assistance, including barriers to hospitals and healthcare institutions, barriers to physicians and other providers, discriminatory policies and practices, communication problems, lack of culturally competent care, inadequate inclusion in health care research, commercialization of health care, disintegration of traditional medicine, and disparities in treatment).

57. Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics*, 15 ST. LOUIS U. PUB. L. REV. 191, 195 (1996) (citing Annette Dula, *African American Suspicion of the Healthcare System Is Justified: What Do We Do About It?*, 3 CAMBRIDGE Q. HEALTHCARE ETHICS 347, 347-50 (1994)).

Tuskegee study served to reinforce the belief in the African American community that the distrust of the medical system was not merely an historical issue.⁵⁸

“Patients of color have expressed a continuing distrust in the health care system and in individual medical providers, and with good reason.”⁵⁹ In a recent study, focusing on “the effect of unconscious racial bias on clinical decision-making, researchers found a striking correlation between the presence of implicit negative stereotypes of African Americans and a decreased likelihood to provide appropriate medical treatment.”⁶⁰ Hence, “African American patients do not receive the same care as white patients when they seek medical treatment.”⁶¹

“Implicit racial biases are prevalent in the United States, in general, and as such it should not be surprising that they are prevalent among physicians as well.”⁶² These unconscious racial biases lead to at least some of the variations in the quality of care.⁶³

Physicians have the opportunity to improve patient health, or to offer palliative care when disease prevails, and a relationship based on respect, communication, and trust improves the odds for success in both of these undertakings. Although the influence of managed care on medicine may make this ideal difficult to attain at times, surely all patients, whatever their race or background, deserve the physician’s best efforts on their behalf. This best effort demands that physicians carefully examine their beliefs and practices and take affirmative steps to communicate effectively with their patients. Paternalistic or stereotypical assumptions about patients based on race or ethnicity have no place in modern medical care. Instead, all patients deserve the opportunity to participate in medical decision making with information about the full range of treatment options.⁶⁴

2. Rural Population Disparities

About one-fifth of the U.S. population lives in rural areas.⁶⁵

58. *Id.* at 197-98.

59. Noah, *Prescription for Racial Equality*, *supra* note 34, at 684-85.

60. *Id.* at 688 (citing Alexander R. Green et al., *Implicit Bias Among Physicians and Its Prediction of Thrombolysis Decisions for Black and White Patients*, 22 J. GEN. INTERNAL MED. 1231 (2007)).

61. *Id.* at 685 (citing INST. OF MED. OF THE NAT’L ACADS., *supra* note 46, at 6).

62. *Id.* at 688 (quoting Green, *supra* note 60, at 1236).

63. *Id.* at 688.

64. Barbara A. Noah, *The Invisible Patient*, 2002 U. ILL. L. REV. 121, 148-49 (2002) (reviewing SALLY SATEL, *HOW POLITICAL CORRECTNESS IS CORRUPTING MEDICINE* (2000)).

65. See *Rural and Urban Health*, CTR. ON AN AGING SOC’Y (Jan. 2003), <http://ihcrp.georgetown.edu/agingsociety/pubhtml/rural/rural.html> (explaining that residency in rural areas affects health disparities).

Approximately five percent of the total rural population lives in towns of 2,500 residents or less.⁶⁶ Most rural Americans are Caucasian.⁶⁷ Racial and ethnic minorities account for about seventeen percent of the rural population.⁶⁸ Most rural African Americans reside in the Southeast.⁶⁹ “[G]eographically rural areas of America are a substantial and significant component of our society.”⁷⁰ Because so much of the United States is rural, and because of the number of citizens this land supports, rural counties have been described as “the backbone of America.”⁷¹

Each rural community is unique in nature, which often makes studying the needs of the rural population difficult; however, generally speaking, there are many shared characteristics of small, rural towns, and those living in such towns have similar living experiences.⁷² For example, most rural residents experience “close social or kinship relationships” and have a “preference for informal support systems in times of need.”⁷³ Even adjusted for age, rural residents have higher mortality, disability, and chronic disease rates than urban residents.⁷⁴ “[C]ompared with urban Americans, rural residents have higher poverty rates, a larger percentage of elderly, tend to be in poorer health, have fewer doctors, hospitals, and other health care resources, and face more difficulty getting to health care services.”⁷⁵

Several factors contribute to the lack of access to quality health care for rural populations. “Financial, sociocultural, and structural features of the rural environment create barriers to health care.”⁷⁶ A common contributor

66. See Bushy, *supra* note 4, at 18 (positing that residents of rural towns with populations of 2,500 or less will have vastly different health care experiences than towns still classified as rural but with populations of 25,000).

67. U.S. DEP’T OF AGRIC., RURAL AMERICA AT A GLANCE: 2008 EDITION 1 (2008), <http://www.ers.usda.gov/media/192860/eib40.pdf> (reporting that Caucasians make up eighty-one percent of the non-metro population).

68. See Bushy, *supra* note 4, at 18 (demonstrating the increase in ethnic and racial minorities in rural areas).

69. *Id.*

70. Kathryn E. Artnak et al., *Health Care Accessibility for Chronic Illness Management and End-of-Life Care: A View from Rural America*, 39 J.L. MED. & ETHICS 140, 143 (2011).

71. Craig Thomas, *Understanding Rural Health Care Needs and Challenges: Why Access Matters to Rural Americans*, 43 HARV. J. ON LEGIS. 253, 255 (2006).

72. Bushy, *supra* note 4, at 20.

73. *Id.* at 21.

74. CAROL ADAIRE JONES ET AL., U.S. DEP’T AGRIC., HEALTH STATUS AND HEALTH CARE ACCESS OF FARM AND RURAL POPULATIONS, at i (2009), available at http://www.ers.usda.gov/media/155453/eib57_1_.pdf.

75. *Improving Health Care for Rural Populations*, AGENCY FOR HEALTHCARE RES. & QUALITY (Mar. 1996), <http://archive.ahrq.gov/research/rural.htm>.

76. Barbara Ann Graves, *Community-Based Participatory Research: Toward Eliminating Rural Health Disparities*, 9 ONLINE J. RURAL NURSING & HEALTH CARE,

to health and health care disparities of rural populations is geographic isolation and professional isolation.⁷⁷ “Rural hospitals are . . . aging, shrinking, and in short supply.”⁷⁸

Rural populations suffer because there are insufficient health care professionals to meet demand from patients.⁷⁹ Physicians who were not the product of a rural community are not inclined to work in those areas; therefore, recruiting and retaining health professionals in rural areas is difficult.⁸⁰ Newly-minted physicians shun rural practices “because of the perceived professional isolation, a lack of amenities, higher poverty rates and the many other challenges that come with providing care to rural patients.”⁸¹ Additionally, rural doctors may face cultural or educational barriers to providing medical care, such as opposition to welfare programs or lack of particular skills training in clinic staff.⁸²

Unlike people who live in urban areas, rural individuals tend to base their health care decisions on cultural beliefs.⁸³ A health care professional must understand the unique cultural needs of the rural population in which he or she serves. For example, rural residents often base their idea of health on whether or not a person is able to work.⁸⁴ This self-reliance can “undermine healing if the patient and family avoid formal health care treatment and ‘tough it out[,]’” particularly with a problem like substance abuse or domestic violence that is viewed as private.⁸⁵ However, if a health care professional is attuned to such a cultural attitude, he or she can adjust care accordingly, for instance, by maintaining secrecy to preserve family integrity. Therefore, rural populations need culturally competent health

Spring 2009, at 12.

77. See Bushy, *supra* note 4, at 16-17 (explaining that health care providers often feel isolated from their peers in rural communities and may face geographic challenges such as challenging roads, inclement weather, and difficulties with public transportation that all affect their ability to provide health care to rural communities).

78. Sidney D. Watson, *Mending the Fabric of Small Town America: Health Reform & Rural Economies*, 113 W. VA. L. REV. 1, 9 (2010).

79. Thomas, *supra* note 71, at 257 (citing COMM. ON THE FUTURE OF RURAL HEALTH CARE, INST. OF MED. OF THE NAT'L ACADS., QUALITY THROUGH COLLABORATION: THE FUTURE OF RURAL HEALTH 79 (2005)).

80. See Zina M. Daniels et al., *Factors in Recruiting and Retaining Health Professionals for Rural Practice*, 23 J. RURAL HEALTH 62, 66 (2007) (noting that returning to a rural hometown was the top factor in successfully recruiting new health care providers to a rural community).

81. Lou Ann Wilroy, *Health Care Reform: A Rural Perspective*, COLO. TR. (June 2, 2010), <http://www.coloradotrust.org/news/blog/blog-entry/health-care-reform-a-rural-perspective>.

82. Bushy, *supra* note 4, at 27.

83. *Id.* at 15.

84. Thomas, *supra* note 71, at 257 (citing K. A. Long, *The Concept of Health*, 28 RURAL NURSING 123, 123-30 (1993)).

85. Bushy, *supra* note 4, at 22.

care providers.

3. Elderly Population Disparities

America is growing old. Those over sixty-five are the most rapidly growing subset of the population, with the super-elderly (persons aged eighty-five years and older) comprising the largest increase.⁸⁶

“The population in the United States is rapidly aging, both in terms of actual numbers and percentages.”⁸⁷ Today, older Americans are living longer. According to the 2010 census, nearly two million of America’s elderly are ninety years old or older.⁸⁸ The super-elderly are the fastest growing segment of the elderly population.⁸⁹

Since “[t]he rate of population growth among the elderly is greater than that of the total population,” their health and health care is important to society.⁹⁰ “The elderly use physician, hospital, and long-term care services at higher rates and with greater frequency than younger age groups.”⁹¹ The elderly need culturally competent health care providers because a person’s living patterns determine his or her health status in old age. Health care providers must educate patients about the impact of their choices because everything from cigarette use to obesity impacts health.⁹²

86. Monique M. Williams, *Invisible, Unequal, and Forgotten: Health Disparities in the Elderly*, 21 NOTRE DAME J. L. ETHICS & PUB. POL’Y 441, 442 (2007).

87. Marshall B. Kapp, *My Parents Are Getting Older: Resources to Respond to Aging-Related Inquiries*, 29 FLA. B. NEWS (Aug. 15, 2002; rev. Feb. 9, 2012), http://www.floridabar.org/DIVCOM/JN/JNNews01_WORK.nsf/Articles/FACD2DA4E9DF244385256C0E0046CA22.

88. Hope Yen, *Living to 90 More Likely, Census Finds*, CHARLOTTE OBSERVER (Nov. 18, 2011), <http://www.charlotteobserver.com/2011/11/18/2784080/living-to-90-more-likely-census.html>.

89. Frank B. Hobbs, *The Elderly Population*, U.S. CENSUS BUREAU, <http://www.census.gov/population/www/pop-profile/elderpop.html> (last visited May 26, 2012).

90. ReNel Davis & Joan K. Magilvy, *Quiet Pride: The Experience of Chronic Illness by Rural Older Adults*, 32 J. NURSING SCHOLARSHIP 385, 386 (2000).

91. Carolyn A. Mendez & Steven P. Wallace, *Access to Health Care for the Vulnerable Elderly*, 15 NAELA Q. Fall 2002, at 3, 3.

92. See FED. INTERAGENCY FORUM ON AGING-RELATED STATISTICS, OLDER AMERICANS 2010: KEY INDICATORS OF WELL-BEING 1, 40-41 (2010), http://www.agingstats.gov/agingstatsdotnet/Main_Site/Data/2010_Documents/Docs/OA_2010.pdf (comparing the effects of obesity to those of smoking where smoking patients showed an increased likelihood of cancer, and other debilitating diseases); *A Profile of Older Americans: 2011*, ADMIN. ON AGING (Feb. 10, 2012, 7:11 AM), http://www.aoa.gov/AoARoot/Aging_Statistics/Profile/2011/14.aspx (finding that, in a study, over a quarter of patients ages 60 and over who came to receive an influenza shot were of the height and weight that placed them among the obese); NAT’L ADVISORY COMM. ON RURAL HEALTH AND HUMAN SERVS., THE 2008 REPORT TO THE SECRETARY: RURAL HEALTH AND HUMAN SERVICES ISSUES 31 (2008) <ftp://ftp.hrsa.gov/ruralhealth/committee/NACreport2008.pdf> (finding that the rural elderly have more limitations on daily activity, suggesting that they need human services more than the urban elderly).

Finally, medical educators must highlight the rural elderly because “[t]he elderly population differs from the general population in terms of its geographic distribution.”⁹³ Approximately one-fourth of the elderly live in non-metro areas and are more likely to stay in these areas than those who are younger.⁹⁴

4. Rural, African American, and Elderly Disparities

If each of the population subsets experience health and health care disparities, it is no surprise that individuals who embody all three subsets suffer health and health care disparities. The health of the minority elderly in the United States is one of the most important issues facing the nation’s health care system today. “The number of minority group elderly is expected to increase more than 500% by the middle of the next century, from 4.3 million persons in 1990 to 22.5 million by the year 2050.”⁹⁵ As a result, “minority elderly will become ‘an even larger and more important component of the aging of America.’”⁹⁶ Rural ethnic minorities suffer because of race and geographic location. We often hear the terms “minority community” and “urban area” interchanged. However, not all African Americans live in urban inner-city areas and programs designed for urban areas may not address rural needs.⁹⁷

“[T]he *combined* effects of rural residence and minority race/ethnicity can result in greater disadvantage than these characteristics alone.”⁹⁸ These problems are compounded by the increasing isolation of the rural elderly, as the extended families that used to provide their care leave rural areas with no additional services stepping in to take their place.⁹⁹

93. 1 KIMBERLEY DAYTON ET AL., ADVISING THE ELDERLY CLIENT §1:3 (2011), available at Westlaw ADVELD.

94. *Id.*

95. ANDREW E. SCHARLACH ET AL., CURRICULUM MODULE ON AGING AND ETHNICITY 4-5 (2002), <http://www.oaltc.ku.edu/gerorich/Reports/AGINGANDETHNICITY.pdf>.

96. *Id.* (quoting J.L. Angel & D.P. Hogan, *The Demography of Minority Populations*, in MINORITY ELDERS: LONGEVITY, ECONOMICS AND HEALTH, BUILDING A PUBLIC POLICY BASE (1991)).

97. See Janice C. Probst et al., *Person and Place: The Compounding Effects of Race/Ethnicity and Rurality on Health*, 94 AM. J. PUB. HEALTH 1695, 1700 (2004) (citing J.C. Thomas et al., *Rural Gonorrhea in the Southeastern United States: A Neglected Epidemic?*, 143 J. AM. EPIDEMIOLOGY 269 (1996); M.M. Hillemeier et al., *Measuring Contextual Characteristics for Community Health*, 38 HEALTH SERV. RES. 1645 (2003)).

98. *Id.* at 1695.

99. Betty Booker, *End of the Road Far from Support Services, Rural Elders Grapple with Meeting Life’s Basic Needs*, RICHMOND TIMES DISPATCH, Oct. 12, 1998, at E-1 (quoting an interview with Gordon Walker, Executive Director of the Jefferson Area Board on Aging).

To the extent that health professionals often prejudge the needs of the elderly, the African American elderly are frequently treated without being given the opportunity for input into their treatment plans[,] which sometimes results in inappropriate and inadequate care. This lack of opportunity to give input into their treatment plan, coupled with high costs of insurance, social cultural issues and what many view as an unresponsive health care system affects their ability to practice self-advocacy in health care decision-making.¹⁰⁰

The culturally competent professional can help relieve the “[f]ears of reprisal and discomfort” that result when elderly African Americans interact with physicians of the majority culture.¹⁰¹ Cultural competency training equips providers with the ability to understand their patients. Therefore, the patient should begin to trust the physician and believe that such provider has an interest in his or her well-being.¹⁰²

Rural elderly African Americans must begin to trust the system. The thought of “not being heard” should not prevent them from sharing important information with their provider.¹⁰³ Although informal networks are important, they cannot replace annual physician visits. Therefore, cultural competency is especially important to treat this population.

II. THE ACA, HEALTH PROFESSIONALS, CULTURAL COMPETENCY, AND THE RURAL ELDERLY POPULATION

Congress recognized that the federal government has some responsibility to educate health care professionals and several provisions of the ACA address the concerns raised in Part II.¹⁰⁴ The ACA attempts to increase the health care workforce in underserved areas and also addresses issues of diversity training for health care workers. Further, the new law also discusses the aging of America.

A. Increase Workforce

Several provisions of the ACA address the physician workforce.

100. Anthony, *supra* note 20, at 89 (citing James S. Jackson, *Growing Old in Black America: Research on Aging Black Populations*, in *THE BLACK AMERICAN ELDERLY: RESEARCH ON PHYSICAL AND PSYCHOLOGICAL HEALTH* 3-16 (James S. Jackson ed., 1988); NOLA J. PENDER, *HEALTH PROMOTION IN NURSING PRACTICE* (2d ed. 1987)).

101. *Id.* at 88.

102. See Betancourt et al., *supra* note 31, at 298-99 (emphasizing that communication and knowledge of multi-cultural communities leads to better relationships between physicians and patients).

103. See Anthony, *supra* note 20, at 88 (arguing that the usage of informal networks of family and friends in African American communities to inform health care providers of health issues can become seriously problematic for a patient).

104. See, e.g., Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 5402, 124 Stat. 119, 544 (2010) (providing for diversity training for health care providers).

Recognizing that numbers of primary care physicians are on the decline, the ACA not only creates new education and training programs but also expands existing programs.¹⁰⁵ Sections 5201 and 5301 encourage medical students to work as primary care physicians.¹⁰⁶ For example, the ACA amends the Public Health Service Act to require medical students who receive loan funds “to practice in primary care for 10 years . . . or until the loan is repaid, whichever comes first.”¹⁰⁷ The ACA also amends the Public Health Service Act to provide grants to entities for programs that train primary care professionals and other underserved communities, such as rural areas.¹⁰⁸

Most of the assistance provided through the ACA is through grants. For example, the ACA encourages primary residency training through teaching health center development grants.¹⁰⁹ The centers include several entities, including Rural Health Clinics.¹¹⁰ The rural physician training grants established under the ACA encourage medical schools to recruit students who will likely practice in “underserved rural communities” by providing grants and training to such students.¹¹¹

B. Diversity Training

The ACA addresses the issue of cultural competency with workforce diversity training in several sections.¹¹² These sections deal primarily with racial and ethnic diversity of health care professionals.¹¹³

The ACA enables the Secretary of Health and Human Services to facilitate cultural competency training for health professionals through provision of grants for “research, demonstration projects and model curricula.”¹¹⁴ After collaborating with select entities to develop training, the Secretary must evaluate the curricula by collaborating with “health

105. *Id.* (providing for scholarships and specialized loan repayment plans for individuals from disadvantaged backgrounds).

106. *Id.* § 5201 (supporting student loan funds federally); *id.* § 5301 (providing training in family medicine and general practices such as internal medicine and pediatrics).

107. *Id.* § 5201.

108. *Id.* § 5301 (giving grant priority to those training to work in a rural area).

109. *Id.* § 5508 (aiming to increase teaching capacity to facilitate such programs).

110. *Id.* (including also community mental health services and health centers operated by Indian Health Services).

111. *Id.* (providing that half of training should be in a non-hospital community based setting).

112. *See, e.g., id.* § 5307 (discussing cultural competency and diversity training to reduce health disparities).

113. *See id.* (declaring that such programs are to increase the aptitudes for working with diverse people).

114. *Id.*

professional societies, licensing and accreditation entities, health professions schools, and experts in minority health and cultural competency, prevention and public health and disability groups, [and] community-based organizations”¹¹⁵ An internet clearinghouse will be used to disseminate any model curricula.¹¹⁶

Section 5402 supports diversity training for health professionals when it authorizes appropriations for educational assistance and increases the annual limit on the loan repayment amount to \$30,000.¹¹⁷ Diversity training will help ensure culturally competent health professionals. The section also authorizes appropriations for educational loan repayments for disadvantaged individuals who serve as medical school faculty, scholarships for disadvantaged students, reauthorization for loan repayments and fellowships regarding faculty positions, and reauthorization for education assistance in the health professions regarding individuals from a disadvantaged background.¹¹⁸

C. Elderly Population

Provisions of the ACA also address the issue of geriatric services.¹¹⁹ As the population ages, the workforce must be trained to care for the needs of the population. The ACA amends the Public Health Service Act to provide two new sections with respect to the geriatric workforce. First, grants are available to entities that “operate a Geriatric Education Center.”¹²⁰ Incentives are also available to certain health care professionals who are “entering the field of geriatrics, long-term care, and chronic care management.”¹²¹

III. A CALL FOR ACTION

A. The ACA Provides the Framework

The ACA provides a framework for recruiting physicians, especially primary care physicians, and training them in the area of cultural

115. *Id.*

116. *Id.*

117. *Id.* § 5402 (specifying grants for disadvantaged students).

118. *Id.* § 5404 (allowing for stipends and additional support for students entering bridge programs in the medical profession).

119. *See, e.g., id.* §§ 3021, 3501, 4001, 5101, 5302, 5305, 5501, 5508, 6703, 10501 (establishing, among other things, a Center for Medicare and Medicaid Innovation).

120. *Id.* § 5305 (requiring that such centers provide at least eighteen hours of voluntary instructional training to students in a clinical setting to maintain such fellowship funds).

121. *Id.* (opening up training additionally to volunteer faculty and practitioners who do not have formal training in geriatrics).

competency. With the enactment of the ACA, our administration recognized many of the issues addressed in Part II. Our health care system is fractured. The system of managed care does not encourage relationship-building between physicians and health care providers in general, and especially between physicians and their rural elderly African American patients.

The provisions of the ACA discussed in Part III may assist with recruiting and training a workforce that is able to address the needs of the rural elderly African American population. However, questions certainly remain. To begin with, are the incentives outlined in the ACA enough of an incentive for a younger generation of physicians to move into primary practice in general, and specifically into a rural area? Pipeline programs must be put in place to recruit and train those who are likely to serve the rural elderly populations.

Data suggest that children who grow up in rural areas are more likely to practice in those areas.¹²² Also, “[m]inority physicians are more likely to practice in some of the communities hardest hit by the health disparities.”¹²³ Unfortunately, these individuals are not attending medical school in large numbers. Medical schools are homogenous, with very little economic or ethnic diversity. As of 2008, 7.1-7.3% of entering medical students identified as African American, 7.4-7.5% as Hispanic, 20-21% as Asian, and 62-63% as Caucasian, non-Hispanic.¹²⁴ An increasing percentage—55%, up from 51%—of new medical students have come from the top quintile of family income, while the percentage of new medical students who come from families in the lowest quintile has remained below 5.5%.¹²⁵ This homogeneity has created a health care system that is unable to properly care for the increasing number of patients who are not part of the system’s dominant culture.¹²⁶ It affects “(1) the manner in which patients understand and seek health care; (2) the attitudes of health care providers; (3) the way providers approach offering health

122. Daniels et al., *supra* note 80, at 66 (acknowledging that students who are aware of the realities of rural living and of the needs of their hometowns are more likely to return to them).

123. Christopher Snowbeck, *Role Models Needed in Health Care*, PITTSBURGH POST-GAZETTE (Aug. 20, 2002), <http://old.post-gazette.com/healthscience/20020820hminority0820p3.asp>.

124. PAN, *supra* note 18, at 1.

125. *Id.*

126. Ikemoto, *supra* note 32, at 75; see also Cindy Brach & Irene Fraser, *Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model*, 57 MED. CARE. RES. & REV. 181, 183 (Supp. 1 2000) (suggesting that diversity of language and culture affect choices in health care, which precludes the idea that a one-size fits all approach is untenable).

care services; and (4) the organizational system.”¹²⁷ Although health care providers may determine what health care their patients need, they do not always give the same care to all patients.¹²⁸

B. Diversity in Medical School Is Necessary

If we wait until students reach medical school to address issues of cultural competency and practicing in remote areas, we have waited too long. To attempt to teach cultural competency to a homogenous group of medical students may be a fruitless endeavor. When medical schools are homogeneous, both ethnically and economically, the training and incentives that the ACA offers may be useless.

Effective cultural competency training requires a diverse population of students. Effective training requires an audience with various racial, cultural, economic and religious backgrounds. The interaction with such diverse individuals is the smartest way to eliminate assumptions, biases, and stereotypes that may impede a physician’s ability to make sound medical recommendations or diminish the patient’s trust in the physician. “[T]he benefits of classroom diversity in medical schools extend far beyond the classroom. Ideally, the physician workforce will mirror the increasingly diverse society in which it practices.”¹²⁹ To accomplish this, we must develop “a pipeline of . . . youth interested in both health care careers and returning to or remaining in rural communities.”¹³⁰

IV. CONCLUSION

I am cautiously optimistic. The ACA provides a framework for ensuring a culturally competent health care workforce. What happens next depends on how much the general population recognizes the seriousness of the problem. Many of the provisions of the ACA only give Congress authorization to appropriate funds. That means that the provisions must face the annual appropriations process if they are ever to take effect.

The ACA is a start, not a solution to the problem. We cannot rely solely on legislation to remove years of distrust between patients and health care providers. Because the solutions are long-term, in the interim work is to be done by lawyers and policymakers to ensure access to care for all individuals.

127. Lisa Byrd, *Disparities in Health Care: Minority Elders at Risk*, 18 ABNF J. 51, 52 (2007).

128. *Id.*

129. Noah, *A Prescription for Racial Equality*, *supra* note 34, at 707.

130. JON M. BAILEY, CTR. FOR RURAL AFFAIRS, NO. 9, HEALTH CARE REFORM: WHAT’S IN IT?: RURAL COMMUNITIES AND RURAL MEDICAL CARE 5 (2010), <http://files.cfra.org/pdf/Rural-Communities-and-Medical-Care-brief.pdf>.