

POOR HEALTH AND POVERTY ARE CLOSELY LINKED. It is well known that those with moderate and high incomes are healthier on average than those with low incomes. For every age group and on most health indicators, the poor are less healthy than the near poor and nonpoor. Many factors influence health, including access to medical care. The first page of this brief summarizes survey data concerning disparities in health care access and health in the United States. The second page proposes my evidence-based solution that could be funded by shifting existing public funds from less-effective programs to those proven to improve the health of the poor.

Disparities in Health Insurance Coverage

The 2015 Current Population Survey revealed that 8.6% of poor children had no health insurance coverage during the entire year of 2014, compared to 3.5% of children with a household income at or above \$100,000 who lacked health insurance for the same time period.

Uninsured rates by race were 4.9% for non-Hispanic white children, 5.1% for black children, 6.3% for Asian children, and 9.6% for Hispanic children.

Among adults, the uninsured rate was about twice as large for non-Hispanic whites and about three times as large for blacks and Hispanics, compared with their younger counterparts.

Disparities in Access to Care

Recent National Health Interview Survey (NHIS) data indicated that poor individuals were more than four times more likely to delay or forgo needed medical care due to cost than those with middle or high incomes (21.8% vs. 5.1%).

The National Center for Health Statistics (NCHS) report *Health, United States, 2014* indicated that having health insurance appears to reduce the avoiding-care ratio from about 8.9% to 3.4%. Larger differences exist for dental care.

The poor were also more than nine times more likely than those in middle and high income ranges to forgo needed prescription drugs due to cost (18.3% vs. 2.8%). Further, almost 30% of respondents below poverty did not get needed dental care due to cost, six times the rate of those at or above 400% of poverty (5.2%).

In addition to cost, proximity of a health care facility to their neighborhood is another challenge for the poor. Among children under age 18, the poor were three and a half times more likely than those above 400% of poverty to lack a usual source of health care (6.1% vs. 1.8%).

A limited supply of health care providers presents further impediments to access for many low-income urban and rural poor persons. (Page 2 suggests cost-effective ways to address the shortage of care providers.)

2015 Current
Population Survey
revealed

8.6%

of poor children
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insurance

2015 Current
Population Survey
indicated

19.3%

of poor Americans
were uninsured

2014 National Health
Interview Survey
showed the poor were

4.2 times

more likely to forgo or
delay needed medical
care than those at or
above 400% of poverty

2012 National Health
Interview Survey data
indicated that

10.9%

of poor children had
health limitations

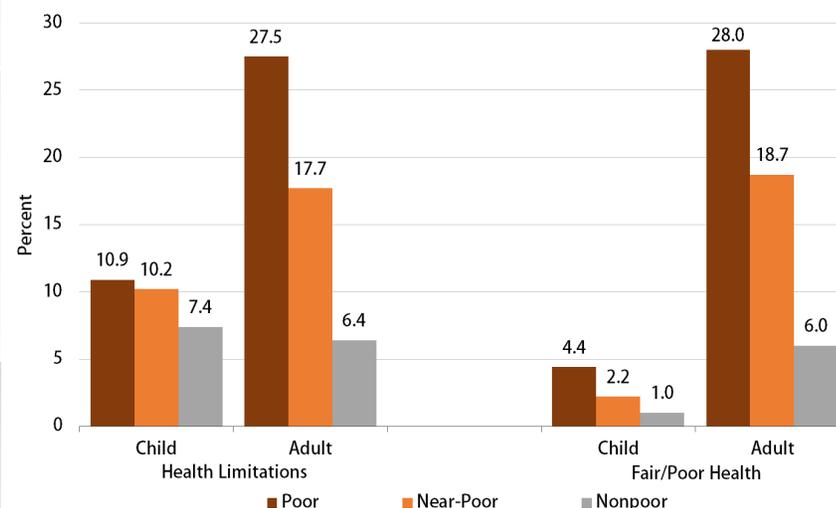
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Disparities in Health

Given the disparities in health insurance coverage, resources to pay for care, and ready access to a clinic, perhaps it is not surprising that there are differentials in health by poverty status. The graph below shows that children up to age 18 and adults ages 18 to 59 show significant differences in health status by income. With the exception of health limitations for children, there are large differences in all ratios comparing the rate for those in poverty to those with income above 200% of poverty.

Health disparities by poverty status are substantial.



Notes: Poor = below FPL (FPL = federal poverty level); Near-Poor = 100-199% FPL; Nonpoor = 200+% FPL. Health limitations include any condition that limits the ability to engage in usual age-appropriate activities.

Source: Author's calculations using 2012 National Health Interview Survey data.

“Health influences the ability to engage in everyday functions such as school and work, as well as the enjoyment of life, which lends urgency to the need to improve the health of poor individuals and families.” – Barbara Wolfe

Health Care Programs for the Poor

MEDICAID

Medicaid provides health coverage to about 60 million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities. The Medicaid expansions under the 2010 Affordable Care Act (ACA) have added an estimated 6.3 million people to the rolls. The 2015 CPS indicated that 19.5% of people in the U.S. were covered by Medicaid in 2014.

CHILDREN’S HEALTH INSURANCE PROGRAM

The Children’s Health Insurance Program (CHIP) seeks to provide health care access to low-income children who cannot obtain affordable private insurance and whose family income does not qualify them for Medicaid.

COMMUNITY HEALTH CENTERS

Community Health Centers (CHCs) provide family-oriented primary and preventive care and serve the poor and other populations with limited access to care. In 2014 CHCs served 23 million patients, 92% of whom had incomes below 200% of poverty.

NATIONAL HEALTH SERVICES CORPS

The National Health Service Corps (NHSC) was established to provide medical personnel to medically underserved areas. It offers financial aid to medical students and others in exchange for service in those areas. The NHSC received funding boosts in the 2009 stimulus bill and the ACA, enabling it to expand from 3,600 clinicians in 2008 to more than 9,200 in 2014.

Cost-Effective Ways to Improve Health Care Access

In spite of the existing programs for the poor, major health disparities remain. My suggestions to improve access to care are outlined below.

TRAIN MORE NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

Increase the supply of “medical extenders” such as nurse practitioners (NPs) and physician assistants (PAs) and work to allow them to practice independently. These providers receive extensive training, including substantial on-site practice under supervision. Their education is the equivalent of a master’s degree. A literature review on the quality, safety, and effectiveness of NPs’ care found that their quality

(cont.)

of care in primary care settings is actually better than the care of MDs. Other ways to increase NPs and PAs include providing federal aid for those who agree to work in underserved areas; allowing NPs and PAs to practice independently (28 states currently do not permit it); and allowing PAs to be paid directly rather than by the current practice of payment through MDs.

TRAIN PRIMARY CARE TECHNICIANS

States should facilitate the training and use of a new category of provider, with less training than NPs and PAs, the primary care technician (PCT). PCTs are similar to Emergency Medical Technicians that treat patients while they are being transported to the hospital. PCTs would be trained to care for patients with specific chronic diseases and to provide basic preventive care, practicing under the guidance of medical doctors or nurse practitioners.

EXPAND COMMUNITY HEALTH CENTERS

Significantly expand CHCs, even beyond ACA recommendations, to have a facility within walking distance of most people living in densely populated poor urban areas. Have services fit the community, including offering translation and other assistance that reflects the culture of the local community. Such service delivery should aim to foster improved communication with medical providers and increase patient compliance. Offering child care, a pharmacy, specialist services, and basic dental checkups at CHCs would also improve access, and ultimately health.

ESTABLISH PRESCHOOL FAMILY CLINICS

Tie preschool centers (e.g., Head Start) to a primary health care provider during certain hours, and offer services to the children and their family members. This would have the advantage of providing care at a known location and thus not requiring extra time to access care.

RESTRUCTURE EMERGENCY ROOM TRIAGING AND CARE

Restructure emergency rooms so that instead of just triaging on immediacy of need, providers send patients who appear to require limited care to hospital-based primary care clinics for services. These clinics would be like the urgent care facilities now in existence except that they would be tied to the ER. Such a shift would likely save money while maintaining access to care.

Funding

To pay for these programs that have a proven successful track record, we could discontinue outreach efforts to enroll individuals in existing insurance and other programs that are not successful; discourage Scope of Practice laws that constrain delivery of medical services (e.g., dictate which medical professionals may prescribe medications), perhaps shifting to national regulation; and increase the supply of primary care doctors by tying student loan repayments to physician earnings.