

Improving Access to Health Care for the Urban Poor

A framing paper

Barbara Wolfe
University of Wisconsin–Madison

The basic fact that individuals with low incomes on average have poorer health than those with moderate and high incomes is well known: poor health status and poverty are closely linked. For every age group and the majority of health indicators, the health of the poor is worse than that of the near-poor or nonpoor. Health influences most other activities of life, from the ability to engage in everyday functions such as school and work to the enjoyment of life. It is, therefore, not surprising that many are concerned about disparities in health tied to income and about the allocation of the most visible means by which health is thought to be influenced -- medical care. Many factors likely influence health among the poor, not just medical care, but this paper focuses on improving access to health care, among the urban poor.

I begin by highlighting some basic facts about health and access to health care in the United States. I then briefly discuss the major programs that have been in place to provide medical care to the poor, including Medicaid and community health centers. Then I turn to the main focus of the paper, a discussion of approaches to improve the health of the poor through improved access, and how I might reallocate dollars to improve the public investment in increased access of the poor to health care.

Health and Access to Health Care

Differentials in Health Insurance Coverage

Figure 1 below shows the proportion of those age 18 and under without health care coverage by poverty status over the years 1987 to 2012. The difference in coverage by whether a child is living in poverty or near poverty versus higher income is clear, yet children are a targeted group in terms of coverage. The expansion of Medicaid to children and creation of the Children's Health Insurance Program (CHIP) reduced the proportion of low-income children without coverage, yet a differential remains. The differences are greater for nonelderly adults.¹

Differentials in Access to Medical and Dental Care

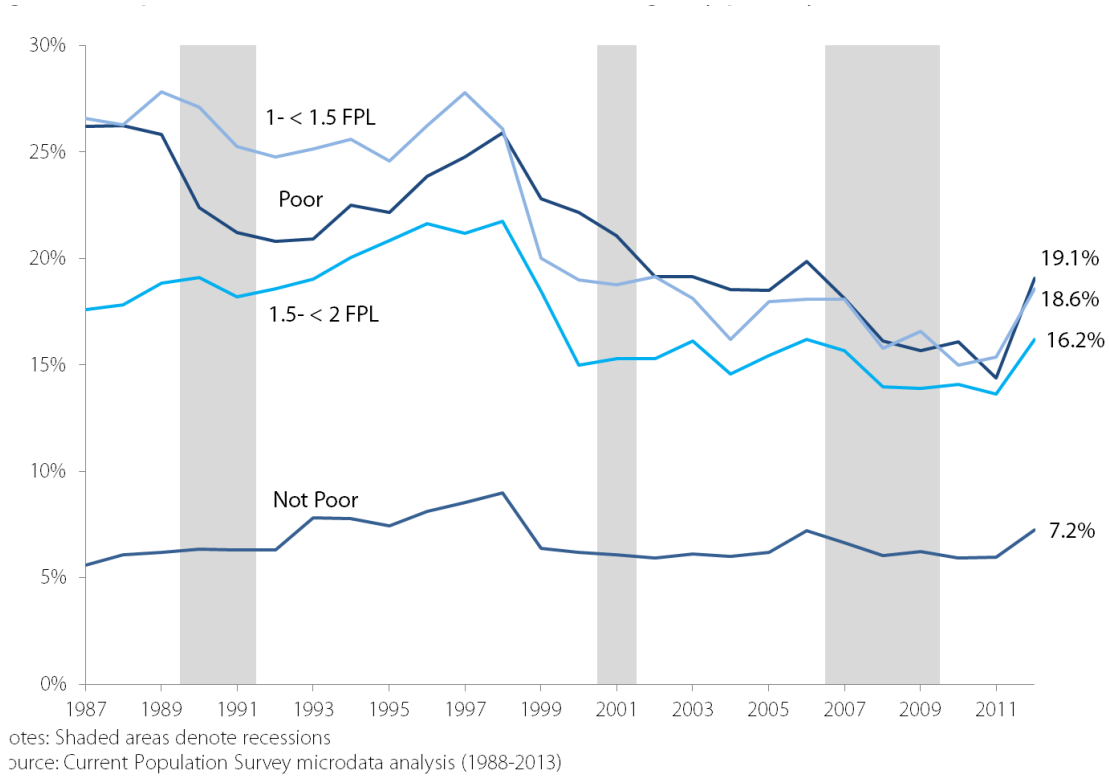
Reports of limited access to medical care due to costs² in National Health Survey data suggest a nearly 4.5 times greater constraint among the poor than those with incomes greater than 400 percent of the Federal Poverty Level (FPL); more than 24 percent vs. 5.5 percent. Insurance appears to play an important role in reducing that ratio to less than 3 (2.9) or about 11 percent vs. 3.7 percent.³ A similar pattern exists for access to dental care. Among the poor, nearly 30 percent had no access over the previous 12 months compared to about 6 percent for those with incomes greater than 400 percent of the FPL. Once again, insurance played a large role in reducing this disparity: “only” 19 percent of the poor who reported they had coverage, reported no access to dental care due to cost.

¹ As of 2011, among those between the ages of 19 and 64, 40.4 percent of the poor did not have coverage compared to 6.1 percent of nonpoor (400 percent+ FPL).

² The question is, “did not get or delayed medical care due to cost during the past 12 months.”

³ See *Health, United States, 2012*, Table 73. Available at <http://www.cdc.gov/nchs/data/hus/hus12.pdf#073>.

Figure 1 Percentage of Youth Ages 0-18 Without Coverage by Income, 1987-2012



Differentials in Health

Differentials in health can be examined using the National Health Interview Survey (NHIS). Some results from the 2012 NHIS are shown in Table 1, which reports results for two indicators of health, health limitations and a combination of poor and fair health from the five-reply general health question. Here, I report results for children up to age 18 and adults to age 59. This table shows continuing differentials by poverty status. With the exception of health limitations for children, all ratios comparing the rate for children and adults living in poverty to those living in families with incomes 200 percent or more

of the FPL are about 4.5 or four and a half times the rate of “poor” health. Among children, the ratio is under two for limitations (1.5).

Table 1: Health by Poverty Status, 2012

		Health Limitations	
	% < Poverty	100-199% FPL	200+% FPL
Child	10.9	10.2	7.4
Adult	27.5	17.7	6.4
		Fair/Poor Health	
Child	4.4	2.2	1.0
Adult	28.0	18.7	6.0

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

See Gould, Smeeding, and Wolfe, 2014.

Public Policy to Provide Access to Health Care

Tax Subsidies to Private Sector for Health Insurance

In terms of public policy directed at influencing access to care, the first large expansion of public support for health insurance came in the form of tax subsidies to the private sector. Just prior to the mid-1960s, or the War on Poverty, an estimated 70 percent of the population had hospital insurance and nearly as many had surgical insurance, but the rates varied substantially by income and race, with 34 percent of those in the lowest income group (less than \$2,000 per family) having coverage compared to 88 percent for those in the highest income group (over \$10,000) (National Center for Health Statistics [NCHS], 1964). For fiscal year 2012, the tax expenditure for the exclusion of employer provided health insurance from federal income taxes was \$184.3 billion dollars, by far the largest income tax expenditure. Since this provision excludes the value of health

insurance provided by the firm from an employee's compensation for tax purposes, it is of greatest value to those with the highest marginal tax rates. The Affordable Care Act contains a provision to go into effect in 2018 to modestly cap these expenditures. It does so via a 40 percent excise tax on employer-sponsored plans that exceed a cap termed a Cadillac plan.

Public Facilities and Medical Research

In terms of providing access to medical care, the public sector intervened on the supply side by financing public hospitals, military health care, public medical research, school health programs, and other medical facilities.

Medicaid

The biggest demand side program to increase access for the poor was the Medicaid program, signed into law on July 30, 1965. Medicaid was initially designed to cover only children in low-income families, pregnant women, and parents of authorized children. Essentially, it began as hospital coverage for these categories of poor Americans. Medicaid is a joint federal-state program where certain standards are set federally, including a minimum package of benefits and certain eligibility requirements. States have had freedom to set other standards, including eligibility, beyond federal minimums.

In 2012, Medicaid covered around 60 million people, and was the largest source of financing for nursing home and community-based long-term care. Medicaid targets the neediest and most vulnerable individuals: children, pregnant women, people with disabilities and chronic health problems, and low-income seniors. Since the launch of the Medicaid expansions under the ACA, an estimated 6.3 million have been added to the

Medicaid (and CHIP) rolls. Low-income adults are covered to various degrees in some states. Medicaid is currently the third-largest domestic federal program in the budget, and in most states it is the second largest. Medicaid outlays are largely spent on a small percentage of the beneficiaries. Medicaid spending per beneficiary has grown more slowly than premiums for employer-based coverage and national health expenditures (Kaiser Family Foundation [KFF] 2011). Problems with Medicaid include the differing eligibility across states;⁴ low reimbursement rates, which limit provider participation and hence limit access; and possible reduction of participation in private, employer-based plans by offering a public alternative to certain lower-income individuals.

Children's Health Insurance Program

A second public program that attempts to increase access to care is the State Children's Health Insurance Program (SCHIP), now the Children's Health Insurance Program (CHIP), which began in 1997 and has been reauthorized through 2019. CHIP is designed to meet the needs of low-income children who do not have a means of accessing affordable private insurance and whose family income does not qualify them for Medicaid.

Community Health Centers

A third public program designed to increase access to care for the poor is the community health center (CHC). CHCs provide family-oriented primary and preventative health care and serve populations with limited access to health care, including low-income populations, the uninsured, those with limited English proficiency, migrant and seasonal

⁴ Under the ACA as initially passed this would have been reduced substantially by the expansion of coverage across states to a minimum of 138 percent of the FPL, but the Supreme Court found this provision unconstitutional.

farmworkers, the homeless, and those living in public housing. It is a supply-oriented approach that increases access to those in the areas served rather than to the poor more generally. CHCs are unique among primary care providers for the array of enabling services they offer, including case management, translation, outreach, eligibility assistance, and health education.

In 2010, health centers served 19.5 million patients. CHC patients are primarily low income, with 92.8 percent of patients at or below 200 percent of FPL and 71.8 percent at or below the FPL; 37.5 percent of patients were uninsured; 38.5 percent were Medicaid recipients; and 7.5 percent were Medicare recipients. Health center patients tend to be relatively young, which leads to a high demand for obstetric/gynecologic, family practice, and pediatric services. The 2010 Affordable Care Act (ACA) included a number of provisions that will affect community health centers. The ACA allocated \$11 billion for broad health center expansion, with the ultimate goal of doubling the number of patients served. Critical to the success of this plan is successful recruitment and retention of health professionals, since CHCs are finding it increasingly difficult to keep up with growth in demand (National Association of Community Health Centers [NACHC], 2008). Funded-staff vacancies are common in CHCs, although less of a problem in urban centers than rural ones.

National Health Service Corps

The last program I will include here is the National Health Service Corps (NHSC), which was established in 1970 to increase the availability of medical personnel to “medically underserved areas.” It offers financial assistance to medical school students and others in

exchange for service in underserved areas. There are now two types of programs: one in which a student gets a full scholarship and for each year of scholarship must serve a year in an approved underserved site or two; and a program that reduces student loans, again tied to years of service in an underserved area. The Corps received \$1.5 billion in funding from the 2010 health care reform law and the 2009 stimulus bill and was able to expand from 3,600 clinicians in 2008 to more than 10,000 in 2010. The expansion of the student loan program helps meet the new demands for medical care under the ACA. Currently, about 40 percent of those sponsored under the NHSC serve in urban areas.

Suggestions to Increase Access to Health Care

Given that we have this extensive array of programs and yet major disparities in health and access to health care remain, what might we do? I categorize my suggestions, which focus on increasing access for the urban poor, as those that are supply versus those that are demand oriented.

Supply: Increase Medical Extenders

Even if everyone were to be insured, access would still be limited by the supply of health care providers and especially the supply of providers in low-income urban (and rural) areas. The NHSC should be expanded, but my first suggestion here is to increase the supply of “medical extenders” and to work to allow them to practice independently.⁵

⁵ The legal constraints on practice such as required education and training, licensure, and required supervision are set by the states and are known as *legal scope of practice*. State legislatures pass so-called practice acts, which grant professionals authority to provide care to patients including diagnosing disease, treating illness, or prescribing medications, which would otherwise be against the law.

Medical extenders include Nurse Practitioners (NPs) and Physician Assistants (PAs). These individuals receive extensive training including on-site hours of actual practice under supervision. Currently their education is the equivalent of a master's degree. NPs are nurses who receive additional (master's level) training; their association is lobbying to increase their education degree to a doctorate believing their supervised training hours are already sufficient for this higher degree.

As of 2010, the Agency for Health Care Research Quality estimated there were about 106,000 NPs and about 70,000 PAs.⁶ Of these, this same source estimates that 52 percent of NPs and 43 percent of PAs are in primary care practice. In 22 states and the District of Columbia, NPs are authorized to practice independently without physician oversight but in the rest of the states an MD must supervise them. PAs are under the supervision of an MD but the MD does not have to be on site.⁷

A recent (2013) review of the literature on the quality, safety, and effectiveness of care of NPs finds that, compared to MDs, NPs' quality of care is actually higher in primary care settings.⁸ Measures used in the meta analysis included patient satisfaction with care, patient self-assessment of health status, functional status, unexpected ER visits, hospitalizations, patient blood pressure, blood glucose, serum lipid levels, and mortality (for safety). On virtually all measures, there was either no difference or NPs did better

⁶ See www.AHRQ.gov/research/findings/factsheets/primary/pcwork2/index.html.

⁷ See www.practicingclinicians.com/cms/wb/pages/nursepractioner_and_physicianassistant.php.

⁸ See www.medscape.com/viewarticle/810692.

than doctors when focusing on primary care.

Training more NPs and PAs is considerably quicker than adding medical doctors. If the federal government were to set up a financing program to expand these programs, to finance the education of those who promise to work in urban (or rural) underserved areas and who provide primary care, then access would be increased. Along with this, the remaining 28 states that currently do not should allow NPs to practice independently. The final component is that states should allow the NPs and PAs to be paid directly rather than the current practice of requiring payment be made through medical doctors. This may simultaneously increase compensation to NPs and PAs and reduce costs to patients.

Create Primary Care Technicians

Going one step further, I would encourage states to facilitate the training and use of another category of provider, one with even less training than NPs and PAs. This is an idea associated with Arthur Kellermann, an Emergency Medicine MD (2013). He and his coauthors suggest a new category of medical provider, the *primary care technician (PCT)*. This is modeled after the way emergency care services are provided in ambulances by Emergency Medical Technicians (EMTs), who stabilize patients and treat victims of accidents while they are being transported to the hospital. These EMTs are individuals with a high school or associate degree that are trained to care for patients in particular circumstances such as accidents or stroke and are under the direct guidance of medical doctors.

Primary care technicians would be trained to care for persons with specific chronic

diseases and to provide basic preventive care. They would practice under the guidance of medical doctors or NPs. They would use the Internet to connect to their supervisor, use the computer to check on basic steps for providing a given type of care, and could be in charge of routine care for those with chronic illnesses. Their activities with patients would be tied to accepted protocols and decision rules. They would be located in a storefront in the community or for those with certain chronic conditions, they would visit the patient's home. Their equipment would be minimal, such as a stethoscope, blood pressure cuff, and video-equipped otoscope (for ears). The most "ideal" arrangement would be to recruit PCTs from the low-income area so that communication and understanding of culture would be maximized. PCTs represent a low-cost way of providing care. PCTs may improve communication with patients, particularly those in immigrant communities, and are inexpensive to train.

Supply: Expand Community Health Centers

My second suggestion for increasing health care access, and one also on the supply side, is to significantly expand community health centers (CHCs). This is part of the plan in the ACA to increase access but I would go further. I would encourage the formation of more CHCs in an attempt to provide one in all underserved poor urban areas with a sufficiently large population. These can be part of a larger organization of a CHC but it is important that the facility be located in the urban community so that it is easily accessible, preferably within walking distance of the majority of the local poverty population. The services offered should be appropriate to the community: translation, if English is not the spoken language, including translation that understands the culture of the local community and can work to foster communication with medical providers and

compliance among patients. The center will be more successful if it offers child care, a pharmacy, and specialist services. And finally, as part of my design, I would have the nurses or other assistants trained to do basic dental checkups so that oral disease can be treated along with physical and mental illness.

A recent paper by Martha Bailey and Andrew Goodman-Bacon (2013) documents the effectiveness of CHCs in reducing mortality among U.S. elderly. Their empirical analysis suggests that the establishment of CHCs led to a decrease of about 25 percent in the poor to nonpoor mortality gap for those age 50 and up. The authors conclude that this is evidence that it is increased access to primary care that accounts for this positive health effect.

It is true that I am cheating a bit by including both an expansion of CHCs and an expansion of their services as one suggestion. But I would argue that the two go hand-in-hand and thus are really part of one approach to increase access to care and the health of the urban poor.

Pilot Program to Provide Health Care to Young Children

There is a good deal of research suggesting the importance of resources, especially health care, for very young children. Much of the research focuses on preschool and other approaches to stimulating young children in poor families. Current programs of Head Start and pre-Head Start are two of these. One common thread is a finding that poor children do better by the age of 2.5 years in child care centers than other forms of care, which are often transitory. My suggestion for improving access to health care is to tie

these centers to a primary health care provider for certain hours. This service would be offered not just to the young children but also to their family members. This would have the advantage of providing care at a known location, thus not requiring extra time to access care.

A set of related programs run for parents and younger children is also worth considering. These would be offered in the same facility as childcare in low-income neighborhoods. The first idea is fashioned after the Infant Program in Australia. Parents and infants attend a 1.5 to 2 hour session with other parents and babies at 3, 6, 9, 12, 15 and 18 months. An experienced pediatric dietician runs the sessions and provides instruction on healthy eating, active play and reduced sedentary behavior.⁹ The idea is to focus on eating and active play at very young ages in an attempt to establish good habits. First time mothers and their babies are the target group.

A broader and longer standing program is “Playgroup Australia”. The idea for this program is to provide a place for parents and babies to meet others and to learn about support in the community. Groups that are in areas with “at risk” babies (those with a disability, those born to a single young mother, those cared for by grandparents) receive support from the federal government including staff assistance. This inexpensive program is designed to avoid isolation, to provide a place where babies and toddlers can play together and a place where at risk parents or caretakers can learn about the community and where they can receive support. (www.playgroupaustralia.org.au)

⁹ Results from the Melbourne InFANT program, which compared mothers and babies randomly assigned to attend 6 sessions compared to those only offered online materials found that those in the program had healthier diets (mothers and babies), watched less TV, ate less sweet foods and consumed more fruit and water. Longer run gains are still being evaluated. (www.infantprogram.org/files/about.htm).

Community centers could host these health care providers and offer playgroups; if the facility of a CHC could be used for childcare, this tie would be relatively easy to create. If there is not a center where both health care and childcare can be offered in related, though separate facilities, then setting up a “visiting primary provider program” should be considered. The provider could be a nurse or an NP, or even a PCT for follow-up care. They could do basic screening of the children in the child care center for a fixed salary, but offer a special “visiting hour” for parents and others at a time close to pick-up time or drop-off time of the young children. These services would be covered by the individual’s insurance (Medicaid or private), or a sliding fee to be set up with subsidies from the public sector.¹⁰ The basic idea is simple: provide care in a location where the family already spends time, reduce the costs of accessing care, and ensure that these families know where care is available.

Restructure Emergency Room Triage

Restructure emergency rooms so that instead of just triaging on immediacy of need, providers send patients who appear to require limited care instead to hospital-based primary care clinics for services. These clinics would be similar to so-called immediate care facilities now in existence except that they would be tied to the ER. A difficulty with this approach is the hours of care offered, but at least for “normal working hours including evening hours,” clinics could be available. Such a shift would likely save dollars while maintaining access. It makes use of the fact that for many urban poor their

¹⁰ Since many families of the children would already receive subsidies for child care, figuring out the sliding scale for other family members should be relatively simple.

usual source of care is an ER.¹¹ An extension of this idea is to set up protocols so that EMS services could transport patients that do not need emergency care to a health center or physician office instead of to the ER. This too would reduce costs and likely improve care. An issue here is reimbursement. Thus for these changes to be adopted, Medicaid, Medicare, and other insurers would have to reimburse the EMS or the hospital in a way that did not overly penalize them for providing non-emergency care to patients not needing emergency care but who present themselves for emergency care. (A risk of this approach could be that more patients will initially seek care from an ER believing that will immediately be evaluated on the needed level of care and treated in a timely manner.)

Funding

The key idea behind all of my suggestions is to make access local, make it in places already traveled, and increase the supply of primary care providers so that the poor do not have long delays in obtaining care, which discourages use of effective primary care. It is also to reduce the use of more expensive and less coordinated care.

What programs or characteristics of programs already in place might be reduced to help fund new initiatives? We should explore and discontinue outreach efforts to enroll individuals in existing insurance and other programs that are not successful (e.g., see

¹¹ A recent article reported on interviews with a poor population addressing why they used ERs. Two main factors were reported: they perceived the quality of care was better in ERs (hospitals) than in clinics, but more importantly, they could get care when they wanted or needed it including immediate referrals to specialists. In contrast, respondents claimed that if they saw a primary doctor, they would get a referral that required another day off work and another co-payment. See Kangovi et al., 2013.

Scrivner and Wolfe, 2005, for an example of ineffective outreach efforts for CHIP). We should discourage constraining Scope of Practice laws, perhaps shifting to national regulation. And, we should reduce Medicare support for the training of specialists. This should have the effect of increasing the supply of primary doctors. This should not be done across the board for all specialists, but done with consideration for the likely needs of the U.S. population, including the aging of baby boomers. But far larger savings could be obtained by placing a more restrictive cap on the value of employer provided health insurance. This could be done by setting a cap at a particular percentile in the distribution or by setting the cap at a particular level as of 2014 (or any other designated year) and only allowing increases at the rate of increase of the CPI.

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