



Innovating to End Urban Poverty

IMPROVING ACCESS TO HEALTH CARE FOR THE URBAN POOR

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The fact that people with low incomes, on average, have poorer health than those with moderate and high incomes is well-known. For every age group and across most indicators, the health of the poor is worse than that of the more advantaged, negatively influencing their quality of life. Though many factors likely contribute to suboptimal health among the disadvantaged, among the most visible is the disparity in access to medical care.

DISPARITIES IN ACCESS AND HEALTH

Access to health insurance goes hand in hand with access to care. Between 1987 and 2012, poor children age 18 and under were far less likely than nonpoor children to have health coverage. Expanding Medicaid to children and creating the Children's Health Insurance Program (CHIP) reduced the proportion of low-income children without coverage, but a gap remains.

The disparity is still greater for nonelderly adults. National Health Survey data suggests that 24 percent of the poor had no access to medical care over a 12-month period and that 30 percent had no access to dental care. Insurance reduced those percentages to 11 percent and 19 percent, respectively.

Predictably, measures of health by poverty status show significant differences. Calculations using National Health Interview Survey data

show that poor children under 18 and adults up to age 59 are 4.5 times more likely than their more affluent counterparts to be in only fair or poor health.

EXISTING PUBLIC PROGRAMS THAT INFLUENCE ACCESS TO CARE

The first large expansion of public support for access to care came from tax subsidies for private insurance and the financing of public hospitals, military health care, public medical research, and school health programs.

The biggest demand-side program was Medicaid, launched in 1965 primarily to cover pregnant women and children in low-income families. A joint federal-state program, Medicaid by 2012 covered around 60 million people. Since

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expansion of Medicaid under the Affordable Care Act (ACA), an estimated 6.3 million people have been added to the Medicaid and CHIP rolls. CHIP is designed to meet the needs of low-income children without access to private insurance and whose family income does not qualify them for Medicaid.

Community Health Centers (CHCs) and the National Health Service Corps also increase access to health care for the underserved. CHC's provide family-oriented primary and preventive health care in neighborhoods, as well as translation and health education. In 2010 CHC's were able to serve 19.5 million patients and the program received \$11 billion for expansion by the ACA. Staffing the centers remains a primary challenge. The National Health Service Corps (NHSC) offers financial assistance to medical students who agree to practice in underserved areas. The program received \$1.5 billion in ACA funding and the 2009 federal stimulus bill. It expanded from 3,600 clinicians in 2008 to more than 10,000 in 2010, with 40 percent serving urban areas.

PROPOSED WAYS TO IMPROVE ACCESS FOR THE URBAN POOR

- **Add "Medical Extenders."** Even if everyone were insured, access to health care would be limited by the supply of providers. Therefore, the number of Nurse Practitioners (NPs) and Physician Assistants (PAs) should be expanded, and NPs should be allowed to practice independently. In a 2013 review of quality of care, NPs were rated as good or better than doctors in delivering primary care. As of 2010 there were about 106,000 NPs and 70,000 PAs. Training new NPs and PAs can be done more quickly than adding physicians. The federal government should finance additional training programs and the educations of those who
- agree to provide primary care in underserved areas. Also, the 28 states not allowing NPs to practice independently should do so, and states should allow NPs and PAs to be paid directly rather than through physicians.
- States should also facilitate a new category of provider with less training than NPs and PAs: Primary Care Technicians (PCTs). An idea promoted by Arthur Kellermann, MD, PCTs would follow the model of training provided to Emergency Medical Technicians. PCTs would be trained to care for people with specific chronic diseases and to provide basic preventive care. They would work, among other places, out of community storefronts and could be recruited from the neighborhoods they serve to maximize communication and lower cultural barriers to care.
- **Expand Community Health Centers.** Go further than the ACA in expanding CHCs. One should be available in every high-population urban area that is poor and underserved. Ideally a center should be within walking distance of the majority of the poor population. Centers should offer child care, a pharmacy, and specialist services, and nurses or other assistants should be trained to do basic dental screenings.
- **Provide Primary Care in Child Care Settings.** Children and their families can access care more easily and less expensively in places where they already spend time. An NP, a nurse, or even a PCT could serve at a child care or community center. CHCs offering child care could serve the same purpose. Where facilities are inadequate, a visiting primary provider program should be considered. Combining health and child care under one roof could offer many opportunities for education and positive interactions between disadvantaged parents and their children.

- Restructure Emergency Room Triage. Patients appearing to require only limited care could be sent to primary care clinics connected to emergency rooms. These would be similar to immediate care clinics. Clinics should be open during normal working hours, including evening hours. Medicaid, Medicare, and private insurers would have to agree not to penalize providers for giving nonemergency care to patients presenting themselves for emergency care.

CONCLUSION

Costs must be addressed, even as programs to remedy medical disparities are introduced or

expanded. These suggestions could increase efficient access to care for the urban poor while discouraging more expensive, less coordinated care. Such initiatives could be funded by discontinuing unsuccessful efforts to enroll individuals in existing insurance, modifying—or federalizing—existing “scope of practice” laws, and reducing Medicare support for training certain specialists, which might also increase the number of primary care doctors.

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