Poor Families in America's Health Care Crisis

Poor Families in America's Health Care Crisis examines the implications of the fragmented and two-tiered health insurance system in the United States for the health care access of low-income families. For a large fraction of Americans, their jobs do not provide health insurance or other benefits, and although government programs are available for children, adults without private health care coverage have few options. Detailed ethnographic and survey data from selected low-income neighborhoods in Boston, Chicago, and San Antonio document the lapses in medical coverage that poor families experience and reveal the extent of untreated medical conditions, delayed treatment, medical indebtedness, and irregular health care that women and children suffer as a result. Extensive poverty, the increasing proportion of minority households, and the growing dependence on insecure service-sector work all influence access to health care for families at the economic margin.

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Contents

Preface

The United States stands alone among developed nations in not providing publicly funded health care coverage to all citizens as a basic right. Rather than a universal and comprehensive tax-based system of care, our health care financing system consists of three main components: private insurance, consisting mostly of group plans sponsored by employers; Medicare for those over sixty-five; and a means-tested system of public coverage for poor children, the disabled, and low-income elderly individuals. Unfortunately, these three components are far from comprehensive. More than forty-five million Americans have no health care coverage of any sort, and millions more have episodic and inadequate coverage. As a consequence, the health care they receive is often inadequate, and their health is placed at risk. Although many of those without coverage receive charitable care or are seen at emergency rooms, they enjoy neither the continuity of care nor the high-quality care that fully insured Americans expect. As we demonstrate in this book, the lack of adequate health care coverage is part of a vicious cycle in which the poor face more serious risks to their health and receive less adequate preventive and acute care. Because minority Americans are more likely than majority Americans to be poor, this health and productivity penalty takes on an aspect of color. African Americans live shorter lives on average than white Americans do, and they suffer disproportionately from the preventable consequences of the diseases of poverty.

Because of the universally recognized fact that good health represents the foundation of a productive and happy life, in recent years the U.S. Congress has extended the health care safety net for poor children. Medicaid and the new State Children's Health Insurance Program (SCHIP) have extended medical coverage to nearly all children and teenagers in low-income families. Unfortunately, as we document in the following chapters, not all children who qualify on the basis of low family income are enrolled. For nondisabled adults under the age of sixty-five, no such programs exist. Pregnant women and those with serious disabilities, including HIV/AIDS, qualify for publicly funded health care, but adults who are not disabled or pregnant or those in families not receiving cash assistance have few options. Those who work in service-sector jobs are unlikely to be offered employer-sponsored group coverage that they can afford, and in the absence of universal health care they have no choice but to go into debt in the case of serious illness or simply do without care.

Conservatives and liberals approach health care financing and any potential reform of the current system from different perspectives. As is the case with other aspects of the welfare state, those approaches are based on different philosophies concerning individual responsibility and the role of the state in providing citizens with the necessities of a dignified and productive life. Health care, however, is different from other aspects of the welfare state, including cash assistance for the poor. Since the 1980s and 1990s, public disenchantment with cash assistance has led to a demand that the poor be forced to take more responsibility for their own welfare and not become wards of the state. As part of welfare reform, the entire apparatus of time limits, sanctions, and work requirements with which the states had experimented for a decade before the federal government made it the law of the land was put in place.

Even in this changed climate, with its rejection of long-term cash assistance, health care for the poor was recognized to be different. Welfare reform was intended to reduce the cash assistance rolls but not the Medicaid rolls. Medicaid use was, in fact, expected to increase, even though the unintended consequence of welfare reform was to reduce the Medicaid rolls at least in the short term. The expansion of public coverage for poor children represents a response to the new reality of

medical care, one that increasingly affects working Americans. Since the 1970s, the cost of health care has grown at a rate far in excess of general inflation, and both employers and workers find that they must pay ever more for less coverage. Many employers have responded by requiring that their employees pay a larger part of the cost or by dropping their health plans altogether. Others have resorted to contingent and contract employment. As a result, a growing number of workers are not regular salaried employees and receive no retirement or health benefits from the enterprises to which they provide services. Today, a growing number of working Americans find themselves with no or inadequate health coverage. One can be a highly responsible working adult and find that one cannot obtain health care for one's family.

Health care coverage is not really an issue that belongs to the political right or left. Because a healthy population translates directly into a productive workforce, adequate health care directly serves the purposes of business in producing profits. Businesses that must compete globally with competitors in nations in which the workforce is covered by government-sponsored plans face a disadvantage if they must provide even tax-subsidized care to their workers. Universal access to adequate preventive and acute health care therefore benefits business interests as much as it does labor interests. Management and stockholders benefit as profits rise, and citizens in general benefit as healthy workers are able to pay taxes for Social Security and the rest of the middle-class welfare state.

In this book, we draw on newly collected survey and ethnographic data from three cities – Boston, Chicago, and San Antonio – to characterize the nature of the health care system and its consequences for low-income families. Given the reality of poverty and minority-group disadvantage in the United States, most of our sample is African American or Hispanic. Although the purpose of the study was to investigate the consequences of welfare reform for families and children in poverty, we learned much more about their lives, including how central issues of health are to the challenges they face. Much of what we document relates to the despair and humiliation, as well as the inadequate health care, that many families suffer because of their dependence on the means-tested and often stigmatizing system of health care financing for the poor.

We are clearly in favor of universal health care coverage in which all citizens, regardless of their ability to pay, receive basic preventive and acute care. As more working and even middle-class Americans find themselves without coverage that they can afford, the demand for a more equitable, rational, and comprehensive system will grow. Such a system will be expensive, and current debates revolve around the issue of how best to provide the best coverage to the greatest number of citizens at a sustainable cost. Whatever the ultimate route to universal coverage, however, we believe that it is eventually inevitable, both because of the indefensibility of the current highly inequitable and incomplete system and because of the unique and essentially public nature of health care.

The study that forms the basis of our analysis was multidisciplinary and included the following Principal Investigators: Ronald Angel, University of Texas at Austin; Linda Burton, Pennsylvania State University; P. Lindsay Chase-Lansdale, Northwestern University; Andrew Cherlin, Johns Hopkins University; Robert Moffitt, Johns Hopkins University; and William Julius Wilson, Harvard University. The following Lead Ethnographers were responsible for collecting the ethnographic data: Laura Lein, University of Texas at Austin; Debra Skinner, University of North Carolina at Chapel Hill; and Constance Willard Williams, Brandeis University. Many other ethnographers, coders, and transcribers assisted in these efforts. A full list of those who participated can be found at the study Web site: http://www.jhu.edu/~welfare/.

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