Changes in Patterns of Health Care: Plus Forty Years

Alan J. Sofalvi

POVERTY, INSURANCE, AND ACCESS TO MEDICAL CARE FOR ADULTS

Herman[1] described components of health care as he viewed them in 1969. Whereas his discussion of "hippies" may be dated, his point concerning utilization of the health care system is definitely relevant, raising "the whole question of the availability to and utilization of the medical care system by those who need it most, namely, the poor."[1(p. 10)]

The established federal poverty guidelines for 2009 state that for a family of four, the poverty level is $22 050[2] (this is for the 48 continental states and Washington, D.C. For Alaska, the figure is $27 570; for Hawaii, the figure is $25 360[2]). In 2007 the United States poverty rate was 12.5%.[3]

A major issue related to health care access and the poor is availability of insurance. Dorn[4] estimates that 22,000 deaths in 2006 could be connected to lack of health insurance. Kronick[5] however, questions this connection between lack of insurance and increased mortality claimed by Dorn and by others. In 2007, 45.7 million Americans lacked health insurance.[6] In June 2009, U.S. Health and Human Services Secretary Kathleen Sebelius announced that 40% of Americans classified as low-income did not have health insurance, compared to 6% of high-income Americans.[7] McCormack and colleagues[8] found that individuals at lower income levels had less knowledge about health insurance than did people at higher levels of income.

QUALITY OF MEDICAL CARE FOR ADULTS

Herman also suggested that the services provided to people of lower socioeconomic status and members of racial or ethnic minorities in clinical settings were lacking, with excessive waits and abrupt visits.[1] Washington and colleagues[9] report that members of these groups still receive lesser care than do whites and offer suggestions to practitioners to improve the care that's provided. These recommendations include hiring staff to represent the clientele: this diversity should be publicized. Also mentioned are educating the staff about the cultures of the groups that are served and surveying the patients to get their views of the services provided.[9]

Lower health literacy has also been said to be more of an issue for members of minorities.[10] Recommendations for clinicians trying to improve health literacy of their clientele include making a variety of items available in clinical settings, "such as picture books, videotapes, audiotapes or multimedia presentations and written materials using plain language."[11(p. 220)] These materials should be translated as needed.[10] This type of material would make the setting more hospitable, improving health literacy and reducing health problems.[11]

POVERTY, INSURANCE AND ACCESS TO MEDICAL CARE FOR MINORS

Herman stated that minors generally could not receive treatment without parental approval and that minors were not eligible for welfare, so they would have had difficulty paying for care.[1] More recently, Cunningham and Kirby[12] reported that insurance coverage for children decreased from 1977 to 1987, then began to increase and had just about returned to 1977 levels by 2003. In 2004, however, the number of children without insurance increased by 1 million.[13] This figure again changed in 2007, when the number of children without insurance dropped by more than half a million: The Kaiser Commission on Medicaid and the uninsured reported that as of 2007, 8.9 million children in the United States did not have health insurance.[13] The poverty rate for minors in 2007 was 18%.[3]

On February 4, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 was signed by President Obama. It went into effect April 1, 2009.[14] This program is conducted by the Centers for Medicare & Medicaid Services[14] and was instituted in 1997.[15,16]

One of the major changes from 1977 to 2001 was that the percentage of children covered by nongovernment programs dropped, accompanied by an increase in coverage by

Alan J. Sofalvi is an assistant professor in the Health Department, State University of New York – Cortland, Cortland, NY; E-mail: asofalvi@twcny.rr.com. Dr. Sofalvi is a past chairperson of the AAHE History and Philosophy Committee. He is one of the individuals who inspired the Health Education – Our Heritage set of historical papers.

government programs; the largest percentage of uninsured children were Hispanic.[16] Gresenz et al.[17] found that uninsured children in both urban and rural areas underutilized medical care. Increasing access to available preventive services, including services for dental care[18] is suggested for improving the health of young people. Regularly tracking the percentage of children without medical insurance is also needed[12] as we have more information about access to medical care by adults than by youth.[19-21]

QUALITY OF MEDICAL CARE FOR MINORS

We also know less about the quality of care young people receive.[19-21] In 2009 it was reported that while discussion of risk factors varied, adolescents receiving a physical exam in California did not receive adequate information about lifestyle risks they faced.[22]

Bright Futures[21] spells out an approach and techniques for visits to health care providers. The guidelines are for people up to age 21 and cover these topics:[21(p. 11)]

- Promoting Family Support
- Promoting Child Development
- Promoting Mental Health
- Promoting Healthy Weight
- Promoting Healthy Nutrition
- Promoting Physical Activity
- Promoting Oral Health
- Promoting Healthy Sexual Development and Sexuality
- Promoting Safety and Injury Prevention
- Promoting Community Relationships and Resources

Two of these topics were "identified as *Significant Challenges to Child and Adolescent Health: Promoting Healthy Weight and Promoting Mental Health*"[21(p. 11)] (emphasis in original).

WHAT LIES AHEAD REGARDING PROVISION OF HEALTH CARE

In 1998 Marmor wrote that "health care is an ever-changing state … and the task of anticipating the future of American medical care will become even harder than it was in past decades."[23(p. 570)] Since the 1990s nothing has changed to make this kind of forecasting less difficult. In this section, however, some possibilities regarding the future of medical care services will be discussed.

In early 2008 several presidential candidates wrote articles about health care that appeared in the *American Journal of Health* Education.[24] President Barack Obama (a United States Senator at the time the article was written) wrote "by the end of my first term in office, I will sign legislation providing universal health care."[25(p. 10)]

In the plan proposed by President Obama, steps would be taken to reduce health care costs. These steps would include "focusing on preventive care, increasing health care quality, reducing medical errors, and stopping price-gouging by drug and insurance companies."[25(p. 10)]

As of now, of course, whether and how these things could be done remains to be seen. There are, however, other ideas being discussed that relate to health care access and affordability.

Rozga[26(p. 205)] details the issues surrounding the rise of "in-store retail health clinics" typically run by nurse practitioners and found in places such as pharmacies, supermarkets and Walmart. Advantages of these clinics are said to be greater access to care and less expensive care because of greater competition. Disadvantages are said to be no supervision by physicians, a lack of continuity of care (with a person seeing different health care providers at different times) and the potential for conflict of interest when a clinic is based in a pharmacy (that there might be a greater tendency to promote prescription use in a pharmacy).[26]

Norenberg[27] expresses a concern about the decline in the number of primary care providers. Several reasons are suggested for this decline, including the salary for these positions and the stress of having to treat a wide variety of conditions in many patients with very limited time.[27]

Hawn[28] describes the incorporation of social media into a clinical practice, *Hello Health* (based in Brooklyn, New York). The practice is described as largely paper-free, relying on e-mail, blogging and sites such as *Facebook* and *Twitter*. It is believed that social media can alter the relationship between health care providers and patients, allowing for a more substantial relationship between them.[28]

Gawande[29] details the complexities of the health care issue, using McAllen, Texas as an example. McAllen ranks second per capita in health care costs, using Medicare payments as the measure.[29]

Gawande[29] mentions several points worth considering. First, is whether the priority in delivering health care is to serve the patient or to make as much as money as possible. Making the system more efficient and cost-effective could be done by encouraging providers to cooperate in meeting patient needs and to decide who should manage the delivery of care: "we have to choose someone–because in much of the country, no one is in charge. And the result is the most wasteful and the least sustainable health care system in the world."[29(p. 8)]

A second point[29] worth considering is that we should be less concerned about whether insurers, the government or patients will pay for treatment. Using an analogy of building a home, Gawande states "when it comes to making care better and cheaper, changing who pays the doctor will make no more difference than changing who pays the electrician."[29(p. 7)] Gawande also suggests that funding be given to researchers to evaluate which systems of care are most effective and efficient: "these are empirical, not ideological questions."[29(p. 8)]

LIFE EXPECTANCY COMPARISONS

Herman wrote that the United States residents ranked behind residents of seven other countries in life expectancy.[1] Based on that, the United States has regressed; ranking 49th with a 2009 estimate of 78.11 years.[30] According to Herman, the U.S. ranking in 1969 was partially due to "our collective neglect of the poorer sections of our underprivileged."[1(p. 14)] Based on an early 21st century review of the health care system, the Committee on Quality of Health Care in

America concluded that this inequity still exists: "we must build a 21st century health care system that is more equitable and meets the needs of all Americans without regard to race, ethnicity, place of residence, or socio-economic status, including … people who currently lack health insurance."[31(p. 35)]

CONCLUSION

Whatever legislative decisions are made regarding health care access and costs, seeing beneficial systematic changes in the availability and cost of care that could increase the average lifespan of Americans will be time-consuming, likely taking 10 years or more.[29] I conclude this update of Herman's article by quoting something he wrote in 1969 that is just as true now: "We are living in a time of changes at all levels, federal, state and local; in demands by people; and in changes thrust upon us by the march of technology. The more populous this country and the world become the more complex the organization of society becomes."[1(p. 14)]

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