View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by IssueLab

The Opportunity Agenda

FACT SHEETS

The State of Opportunity in America

Health Care and Opportunity

Tens of millions of Americans experience barriers to accessing appropriate health care, and many more face inequitable, lower-quality care that carries a heavy human and economic toll. Inequality in health care affects all Americans, both directly and indirectly, as inadequate health care limits opportunity for those who face health challenges and weakens their ability to participate in the economic and social life of the nation.

Access to Health Insurance

A growing number of people in the United States—including those in working families—lack access to health care, a problem which presents significant consequences for the nation:

- More than 45 million Americans lack health insurance, and more than 80 million Americans lacked health insurance for all or part of the last two years.[1]
- 52% of workers do not enroll in employer insurance plans because they are too costly.[2]
- Insurance premiums have increased at a higher rate than overall inflation and workers' earnings for most of the last 15 years.[3]
- Since 2000, premiums for family coverage have increased by 59%, compared with a 9.7% increase in inflation and 12.3% increase in workers' earnings.[4]
- People who lack health insurance are less likely to receive preventive health services, thereby increasing their risk for preventable chronic and infectious diseases. Fewer hospitals and health systems can afford to provide indigent care, and the health care that the uninsured may receive is often of poor quality. The Institute of Medicine estimates that the aggregate annual cost of poorer health and shortened life spans attributable to uninsurance is between $65 billion and $130 billion.[5]
- Nearly 80 million insured and uninsured Americans have experienced difficulty paying medical bills and/or have accrued debt related to medical care costs.
- Two-thirds of people who experience problems with medical bills or debt go without needed care because of cost—a rate three times that for people without medical care-related financial problems.[6]
- A report by Families USA finds that in 2005 premium costs for private employer-provided family health insurance coverage rose by $922 due to the cost of caring for the uninsured, while premiums for individual coverage cost an extra $341 for the same reason.[7]

Racial and ethnic minority and immigrant communities are disproportionately uninsured. For example:

- While about 21% of white Americans were uninsured at any point in 2002, communities of color were more likely to be uninsured at any point (including 28% of African Americans, 44% of Hispanic Americans, 24% of Asian Americans and Pacific Islanders, and 33% of American Indians and Alaska Natives), and are more likely to be dependant upon public sources of health insurance.[8]
- While Hispanic children constitute less than one-fifth of children in the United States, they

New York
568 Broadway
Suite 302
New York, NY 10012
Tel: 212.334.4202
Fax: 212.334.2656

Washington, DC
2000 Florida Avenue NW
Suite 210
Washington, DC 20009
Tel: 202.387.2829 ext. 101
Fax: 301.576.5780

THE OPPORTUNITY AGENDA IS A PROJECT OF THE TIDES CENTER. All content Copyright 2005 The Opportunity Agenda.

represent over one-third of uninsured children.[9] And among children in fair or poor health who lack insurance (nearly 570,000 children in 2002), over two-thirds are Hispanic.[10]

- More than 11 million immigrants were uninsured in 2003, contributing to one-quarter of the U.S. uninsured. The uninsurance rate among immigrants increased dramatically in the late 1990s, following the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which imposed a five-year limit on most new immigrants' ability to participate in public health insurance programs. Prior to and shortly following passage of the Act (between 1994 and 1998), immigrants accounted for about one-third of the increase in the number of uninsured individuals. Between 1998 and 2003 they accounted for 86% of that growth.[11]
- Foreign-born people are 2.5 times more likely than the native-born to lack health insurance, a gap that remains unchanged since 1993.[12]

Regular Source of Health Care

Patients who lack a regular source of health care often report miscommunication, misdiagnoses, and greater frustration about their ability to receive needed care.[13] The uninsured and underinsured, many racial and ethnic minorities, people who are not proficient in English, those who live in rural communities, and those who have low incomes are more likely to report not having a regular source of health care.[14] This problem poses serious risks for personal health security, as well as for the health of communities as a whole. Yet the regular-source-of-health-care gap among racial/ethnic and income groups is growing:

- African Americans, Hispanics, and the poor and near poor (of all racial and ethnic groups) are more likely than white non-poor groups to face barriers to having a regular source of health care. These gaps have increased since 2000. Over 42% of Hispanic poor and 37% of Hispanic non-poor people lacked a regular source of health care in 2001 and 2002, an increase of more than 30% and 18%, respectively, since 1995 and 1996.[15]
- During this same period, the percentage of poor and near-poor African Americans and whites without a regular source of health care went largely unchanged. But these groups were up to 75% more likely than non-poor African Americans and whites to lack a regular source of health care in 2001 and 2002.[16]

Reproductive Health Care

Publicly funded family planning clinics are an important means of expanding access to affordable sexual and reproductive health care in the United States. But despite growing demand, access to publicly-funded reproductive healthcare is threatened:

- The Alan Guttmacher Institute estimates that more than 34 million U.S. women needed contraceptive services in 2002, nearly half of whom needed public services because of low income and/or other barriers to receipt of contraceptive care. Of these, only about 6.7 million women, or four in ten, were served in publicly funded clinics.[17]
- Publicly-funded clinics have experienced only a 2% increase in clients since 1994, despite modest growth in the number of publicly funded family planning clinics providing contraceptive services to eligible women.[18]
- Funding for public family planning services is severely threatened by pending state and federal cuts in Medicaid programs; more than eight in ten family planning agencies receive Medicaid funding for contraceptive services. Since 1980, thirty states have reduced their spending on contraceptive services.[19] In the last decade, a large number of states experienced a decline in met need or an increase in women in need living in counties without a publicly funded clinic.[20]

THE OPPORTUNITY AGENDA IS A PROJECT OF THE TIDES CENTER. All content Copyright 2005 The Opportunity Agenda.

New York
568 Broadway
Suite 302
New York, NY 10012
Tel: 212.334.4202
Fax: 212.334.2656

Washington, DC
2000 Florida Avenue NW
Suite 210
Washington, DC 20009
Tel: 202.387.2829 ext. 101
Fax: 301.576.5780

Language Barriers

More than 46 million people in the United States do not speak English as their primary language.[21] Individuals with limited English proficiency are less likely than those with strong English language skills to have a regular source of primary care, are less likely to receive preventive care, are less satisfied with the care they receive, are more likely to report overall problems with care, and may be at increased risk of experiencing medical errors.[22] The quality of health care—and the community's overall health—depends on the ability of medical professionals to effectively communicate with these patients. But many health care organizations do not provide adequate interpretation services:

- Nearly half of Latinos who are primary speakers of Spanish report having difficulty communicating with doctors or other health care providers because of language barriers.[23]
- Over one in five non-English speaking patients avoid seeking medical help altogether because of language barriers.[24]

Healthcare Disparities. A substantial body of evidence demonstrates that racial and ethnic minorities receive a lower quality and intensity of healthcare than white patients, even when they are insured at the same levels and present with the same types of health problems:

- Minorities are less likely to receive necessary procedures than whites but more likely to receive undesirable treatment than whites, such as limb amputation for diabetes.[25]
- African-American heart patients are less likely than white patients to receive certain kinds of care, such as diagnostic procedures, revascularization procedures, and thrombolytic therapy, even if they have similar patient characteristics.[26]
- Minorities are less likely to be put on waiting lists for kidney transplants or to receive dialysis.[27]

---

[1] Families USA, "One in Three: Non-Elderly Americans Without Health Insurance, 2002-2003," (Washington, D.C.: Families USA, June 2004).
[2] Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, "Key Facts: Uninsured Workers in America," July 2004 (http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=44470).
[3] Henry J. Kaiser Family Foundation, "Trends and Indicators in the Changing Health Care Marketplace," 2004 Update.
[4] Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2004 Summary of Findings" (http://www.kff.org/insurance/7148/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46287)
[5] Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* (Washington, D.C.: The National Academies Press, 2003).
[6] M.M. Doty, J.N. Edwards, and A.L. Holmgren. *Seeing Red: Americans Driven into Debt by Medical Bills* (New York: The Commonwealth Fund, August 2005).
[7] Families USA, "*Paying a Premium: The Added Cost of Care for the Uninsured*" (Washington, D.C.: Families USA, 2005).
[8] U.S. Department of Health and Human Services, *The National Healthcare Disparities Report*, January 2006, http://www.ahrq.gov/qual/nhdr05/nhdr05.htm (18 January 2006).
[9] Robert Wood Johnson Foundation, *Going Without: America's Uninsured Children*, www.rwjf.org (August 2005).
[10] The Urban Institute, "Fast Facts on Welfare Policy," www.urban.org 19 July 2005.
[11] Employee Benefit Research Institute, "The Impact of Immigration on Health Insurance Coverage in the United States," *Employee Benefit Research Institute Notes*, 26, no. 6 (2005).
[12] U.S. Bureau of the Census, Historical Health Insurance Tables, Table HI-8, 2005.
[13] Henry J. Kaiser Family Foundation, *Key Facts: Race, Ethnicity, and Health Care* (Menlo Park, CA: Henry J. Kaiser Family Foundation, June 2003).
[14] Ibid.
[15] Ibid.

THE OPPORTUNITY AGENDA IS A PROJECT OF THE TIDES CENTER. All content Copyright 2005 The Opportunity Agenda.

New York
568 Broadway
Suite 302
New York, NY 10012
Tel: 212.334.4202
Fax: 212.334.2656

Washington, DC
2000 Florida Avenue NW
Suite 210
Washington, DC 20009
Tel: 202.387.2829 ext. 101
Fax: 301.576.5780

[16] Ibid.
[17] Alan Guttmacher Institute, *Contraceptive Needs and Services, 2001-2002*, 2004, www.agi-usa.org/pubs/win/summary.pdf (19 August 2005).
[18] J.J. Frost, L. Frohworth, and A. Purcell, "The Availability and Use of Publicly Funded Family Planning Clinics: U.S. Trends, 1994-2001," *Perspectives on Sexual and Reproductive Health*, September/October 2004, www.agi-usa.org (30 August 2005).
[19] Ibid.
[20] Ibid.
[21] U.S. Bureau of the Census, *2004 American Community Survey*, http://factfinder.census.gov/servlet/ADPTable?_bm=y&-geo_id=01000US&-qr_name=ACS_2004_EST_G00_DP2&-ds_name=&-redoLog=false&-format= (20 August 2005)
[22] Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, DC: National Academies Press, 2003).
[23] Pew Hispanic Center and the Henry J. Kaiser Family Foundation, "Survey Brief About the 2002 National Survey of Latinos," March 2004, www.kff.org (23 January 2006).
[24] Ibid.
[25] IOM, *Unequal Treatment*, 2003.
[26] Henry J. Kaiser Family Foundation and the American College of Cardiology, "Racial/Ethnic Differences in Cardiac Care: The Weight of the Evidence," October 2002.
[27] IOM, *Unequal Treatment*, 2003.

THE OPPORTUNITY AGENDA IS A PROJECT OF THE TIDES CENTER. All content Copyright 2005 The Opportunity Agenda.

New York
568 Broadway
Suite 302
New York, NY 10012
Tel: 212.334.4202
Fax: 212.334.2656

Washington, DC
2000 Florida Avenue NW
Suite 210
Washington, DC 20009
Tel: 202.387.2829 ext. 101
Fax: 301.576.5780