

REDUCING DISPARITIES

by Targeting

Mothers & Children

In the United States, it's a pretty good bet that the richer you are, the healthier you are. People with enough money can afford health insurance. They are less likely to have chronic health problems or to be in poor to fair health. They can buy nutritious food and give birth to healthy babies. And they typically have running cars that allow them to easily take themselves or their children to the doctor. Money may not always buy happiness, but it does typically buy good health.

BY BARBARA L. WOLFE



A health disparity exists when a member of a racial or ethnic minority or a low-income person is in poorer health than he or she should be, given the individual's genetic makeup. Measurable health disparities are avoidable differences in health resulting from cumulative economic or social disadvantages.

Should we care about health disparities? It is obvious that disparities impose a cost on the individuals whose health falls short of what their genetic makeup would allow. For such individuals, suffering from chronic ailments or poor general health is not just an inconvenience; it additionally limits their ability to take advantage of economic opportunities and achieve some measure of mobility for themselves and their families.

It is perhaps less obvious that health disparities also harm those who are in good health by reducing the population's overall economic productivity and by creating societal burdens that are borne by all, such as excessive medical use for treatable conditions, including avoidable hospital stays. It follows that health disparities weaken economic productivity for both individuals and society as a whole. They lead to lower productivity in the home and the labor market, to less personal well-being, and to the continuance of health and income disparities in future generations. For the long-term economic health of our nation, we need a public policy that advances the physical and mental health of all our people, regardless of income, race, or ethnicity. As the United States turns again to health care reform, we would do well to review the sources of these disparities, to identify how policy might best reduce them, and to shape reform accordingly.

In the remainder of this article, I lay out some preliminary arguments for how we might accomplish this. But first I discuss in more detail how poverty impacts childhood health, as the payoff to reducing disparities in childhood health is especially large. An investment in childhood health can reap substantial benefits over an individual's entire life. Although one might alternatively make the same-sized investment in the health of an 80-year-old, such an investment will extend that person's life by less, increase her or his economic productivity by less, and reduce pain and suffering for a shorter period of time.

Disparities and Childhood Poverty

Almost one-third of children ages 2 to 17 living in poor families have a chronic health condition, compared with 26.5 percent of children in nonpoor families, according to a recent national study by Janet Currie and Wanchuan Lin. Poor children are

more likely to be diagnosed with mental conditions such as learning disabilities, developmental delays, Down syndrome, and autism. Seventy percent of poor children's mothers report that their children are in very good or excellent health, while 86.9 percent of wealthier children's mothers report such good or excellent health.

Health disparities are also evident in life expectancy and mortality rates. Angus Deaton, using the National Longitudinal Mortality Study, shows that people in families with yearly incomes (in 1980 dollars) lower than \$5,000 had a life expectancy about 25 percent lower than that of people with family incomes greater than \$50,000.

Poor health has important implications for children's futures. Poor health at birth, coupled with limited family income and health insurance, "can interfere with cognitive development and health capital in childhood, reduce educational attainment, and lead to worse labor market and health outcomes in adulthood," according to a recent study by Rucker Johnson and Robert Schoeni. The same study also finds that "low birth weight ages people in their 30s and 40s by 12 years, increases the probability of dropping out of high school by one-third, lowers labor force participation by 5 percentage points, and reduces labor market earnings by roughly 15 percent."

While somewhat controversial, research by Anne Case, Darren Lubotsky, and Chris Paxton provides evidence that, as children age, the negative effects of poverty on health only increase. Janet Currie and Mark Stabile ask whether this is because children in poor homes are more exposed to health risks or because they do not have adequate access to medical care. If it is the latter, then expanding coverage should reduce the observed gradient. Using data from Canada, a country with universal health insurance, Currie and Stabile find a similar pattern of steeper health gradients as children age, which suggests that the problem is one of greater exposure to health shocks among low-income children. These disparities are unlikely to be significantly reduced through universal coverage focused narrowly on access to medical care.

A Broader View

I propose a five-pronged approach to reducing disparities that is informed by two principles: (1) it is cost-effective to concentrate our scarce resources on reducing disparities in the health of children, and (2) it will not prove possible to make substantial headway in reducing disparities among children and their parents by simply equalizing access to medical care. The resulting broad-based reform should focus on five tactics: improving

the nutrition of pregnant women, expanding visiting nurse programs, subsidizing transportation costs to help poor people get to doctors, creating incentives for health care providers to practice in low-income areas, and improving communication between health care professionals and their patients. These specific reforms, coupled with universal health insurance, would go a long way toward reducing health disparities.

Early Intervention

President Barack Obama's health reform agenda has not been brought fully into correspondence with his antipoverty agenda. Whereas his antipoverty initiatives are built explicitly around the increasing consensus that early intervention programs create a high payoff, his health reform policies have not embraced the equally compelling argument on behalf of early-intervention health care programs. The following two early-intervention programs promise substantial benefits at a very reasonable cost.

Prenatal nutrition: Evidence increasingly shows that pregnancy is the time when health-related investments can yield large payoffs, both in the near and long term. One major problem is low birth weight. A 1991 study by Barbara Starfield and colleagues finds widespread prevalence of low birth weight among the poor, especially the chronically poor. Using national data, Sanders Korenman and Jane Miller have also shown that children are more likely to be stunted, or have low height for their age, if they grow up in poor homes. According to David Barker, pregnant women lacking good nutrition have children that are especially vulnerable to these poor outcomes. Lack of nutrition, especially late in the pregnancy, is linked to kidney malfunction and type 2 diabetes. Low birth weight, especially for those born full term, is associated with increased risks of adult hypertension. Although subsequent evidence is mixed, Barker argues that lack of nutrition in utero correlates to a greater incidence of disease among humans. And evidence from the Dutch famine (Ravelli, et al 1998) is fully consistent with the importance of in utero nutrition for adult health outcomes.

Poor prenatal nutrition (in addition to other factors like stress and pollution) is also a leading factor behind America's still alarmingly high infant mortality rate. The United States ranks 41st in the world in infant mortality, behind such countries as Sweden, Spain, the Czech Republic, Israel, and Cuba. Moreover, infant mortality differs substantially by race. Among non-Hispanic black women in 2008, the mortality rate was 2.4 times that of non-Hispanic white women, according to the U.S. Centers for Disease Control and Prevention. The Kaiser Foundation finds that America's infant mortality rate continues to be high even though Medicaid finances a large percentage of births. Given that many of these women were uninsured prior to learning of their pregnancies, providing medical insurance to women only when they become pregnant does not seem to sufficiently reduce our infant mortality rate. Reform must also seek ways to increase women's access to health care and try to influence the behavior of pregnant women, including improving nutrition, in order to improve infants' life chances. Opening more community centers that offer information on healthy lifestyles, family planning information, and access to medical providers in low-income areas could help influence the health-related choices of women of child-bearing age.

Visiting nurse programs: Visiting nurse programs have consistently shown promise in improving health outcomes for vulnerable populations who suffer from health deficits. The Nurse Family Partnership, for example, has systematically improved prenatal care and infants' health and caretaking. This program, underway in several U.S. cities, assigns nurses to visit the homes of disadvantaged women who are new mothers or pregnant. When program evaluators followed up with families 15 years after they began the program, they found that children whose families received visiting nurses reported fewer arrests, convictions, and violations of probation. Moreover, children whose families received visiting nurses reported fewer sexual partners, lower rates of cigarette smoking, and fewer days of alcohol consumption. The poorest families showed the

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greatest benefits across most outcomes. These results suggest that including visiting nurses as a component of public health care coverage for low-income mothers not only improves health but also has spinoff benefits.

Improving Access

If access to health insurance were broadened, health disparities would undoubtedly be reduced. For example, Jack Hadley's extensive 2003 review finds that low-income persons with hypertension did not fare well when they lost their insurance or faced extensive cost sharing (e.g., were required to pay 20 to 35 percent of all charges or had to pay a \$1,000 deductible). Similarly, people lacking health insurance who have acute myocardial infarctions are more likely to die than those who have insurance. And uninsured people with cancer are more likely to be diagnosed at a later stage in the disease and have higher relative mortality rates.

But simply having insurance is not enough. If poor people cannot get to their doctors, do not have doctors willing to work with them in their communities, do not receive cost-effective preventive care, or have difficulties communicating with their health professionals, then their health will continue to suffer relative to their more advantaged peers. The following three reforms, all simple and cost-effective, would address these problems.

Bringing poor people to doctors: One major problem perpetuating health disparities is transportation costs. Low-income people with treatable health problems are less likely to acquire useful medical care because of problems getting to physicians and medical centers. This is also likely to be true for preventive care. If low-income people are reluctant to get care because transportation is costly or cumbersome, they are far more likely to delay or avoid acquiring such care. It would therefore be good policy to simply cover the costs of transportation for certain low-income persons, especially those with special transportation needs. Otherwise, these individuals may not seek care as they find that the cost of transportation is higher than their willingness to pay, given their other basic needs. This is very much the case of a cheap, simple, and obvious reform yielding large dividends.

Bringing doctors to poor people: It would be helpful to improve incentives for providers to practice in distressed areas. Research shows that medical providers continue to eschew practicing in low-income areas because of more lucrative opportunities in specialist fields and higher-income areas. If providers prefer practicing in higher-income areas, then low-income and low-income minority areas will continue to face provider shortages



and continue to be underserved. By shortages, I mean situations where effective demand cannot be met or where there are long delays in obtaining care, not simply a shortage defined by a ratio of providers to population. It would be good policy to simply pay providers more to practice in low-income or less desirable areas. If providers could be lured into practicing in areas where they are needed most, this would go a long way toward ameliorating disparities tied to race and income.

Improving provider-patient communication:

Even if low-income people can find easy and affordable transportation to providers, or have more providers in their communities, there remains the problem of provider-patient communication. This problem is seemingly difficult to solve: Doctors may have difficulty fully

understanding the dietary constraints, cultural mores, language, and symptoms of our country's most vulnerable people. A straightforward solution is to supplement the work of doctors with trained and competent providers who would follow up with patients and encourage better compliance with prescribed care. Considering the success of visiting nurse programs, as well as other programs that use community support personnel, tapping pools of people with suitable communication skills could help fill the communication gap. Critics might well argue that spending resources on addressing communication gaps might be too costly. Such investments, however, pale in comparison with the short- and long-term costs of inappropriate or ineffective care, not to mention the resulting loss of productivity.

The Next Agenda

The health reform agenda of the 21st century should be based on two principles: a recognition of the payoff of early intervention, and a recognition that universal coverage alone is not adequate to the task of reducing disparities. These are, to be sure, simple principles, but they are ones that will nonetheless serve us well. We need results, not just more insurance.

This is not to gainsay the equally important point that universal coverage is desperately needed. It would go some way toward improving medical care and reducing health disparities. But we would be naïve to think that universal coverage, in and of itself, will solve the pervasive and persistent health disparities that are weighing down American productivity and equality of opportunity.

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