Is Poverty a Death Sentence?

The Human Cost of Socioeconomic Disparities

A Report from Chairman Bernie Sanders
Subcommittee on Primary Health and Aging
U.S. Senate Committee on Health, Education, Labor & Pensions

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Key Findings

- Life expectancy for women has declined over the past 20 years in 313 U.S. counties.
- People in the highest income group can expect to live, on average, at least 6.5 years longer than those in the lowest income group.
- Adult men and women who have graduated from college can expect to live at least 5 years longer than people who have not finished high school.
- Almost as many people die from poverty as from lung cancer.
- In 2009, the mortality rate for African American infants was over twice that of white infants.
- As a nation we have 6 million more people living in poverty than we did in 2004.
- Poor adults are twice as likely as affluent adults to have diabetes.

This is the first time in our history that children born in certain parts of the United States of America can expect to live shorter lives than their parents' generation.[1] Determining which underlying factors affect mortality requires researchers to consider many health and social variables such as race, gender, employment status, and housing conditions, among others. However, a growing body of recent data now show that poverty is the single biggest factor contributing to poor health outcomes, and as poverty becomes more severe, health outcomes become worse.[2] Remarkably, six million more people are living in poverty than were in 2004.[3] A study just published in the June 2011 issue of the *American Journal of Public Health* determined that in the United States in 2000, 133,000 people died due to poverty.[4] These mortality estimates are comparable to numbers associated with some leading causes of death, such as lung cancer.[5]

The Long-Term Effects of Poverty

Childhood poverty is a tremendous obstacle to the promise of the American dream. Poor health in childhood has lifelong consequences, and the importance of protecting and nurturing our future generation of citizens has never been more vital than it is today. Children are, for example, particularly susceptible to environmental toxins, such as exposure to tobacco smoke and lead. Poor children are twice as likely as non-poor children to have unhealthy levels of lead in their blood, which has been shown to affect behavioral and cognitive functioning,[6] and the effects of poverty are long-

"Those living close to the poverty level cannot afford office visits unless they are part of a federal/state program. Offices may work out payment agreements - and even discount their care. Even this may be too much. Illness causes poverty and this poverty locks some patients in a vicious cycle of decline. Physicians, to paraphrase Dr. Paul Farmer, should be defenders of the poor." - Dr. Adam Law, Practitioner, IthacaMed Community Centered Medicine, Ithaca, New York

lasting – the socioeconomic status of an individual's family at birth is associated with higher death rates in adulthood.[7]

Infant mortality and life expectancy are key indicators of a nation's overall health. According to recent data, life expectancy for women has declined over the past 20 years in 313 U.S. counties.[8] In 2009, the infant mortality rate for black infants was almost two and a half times the rate of white infants.[9] There is a growing divide between those who can afford to keep themselves healthy and those who are dying because they are poor. U.S. infant mortality rates indicate that this country is failing to protect those people who cannot afford to protect themselves.

By the time poor children "fortunate" enough to survive infancy are able to take action to improve their life circumstances, childhood poverty has already inflicted a permanent toll on their health. Among low-income children, rates of poor or fair health are seven times higher in poor families than upper

"I want to get this done and get my life back in shape so at least I can do something. The state said because of my Social Security, I'm making too much money. You're paying rent and food and you have to pay insurance for your car and clothes. After all that, you're broke. My medication is $400 a month. I make $930 a month on Social Security. The cut-off to qualify for AHCCCS is $908 a month. So, I make too much. Before, when I was working, I didn't have this problem. Now, I guess you'd call it being retired and this is the benefit?"

Yuma, AZ, resident Steven Stephenson was recently diagnosed with a serious heart condition that forced him to give up his job. He had been receiving health insurance coverage through Arizona's Medicaid system, the Arizona Health Care Cost Containment System (AHCCCS), because his income fell under the federal poverty level. Upon leaving his job, Mr. Stephenson enrolled in the Social Security program, which increased his monthly income. Consequently, he no longer qualifies for AHCCCS due to cuts (and related eligibility changes) recently made to the program. Without coverage, Mr. Stephenson cannot receive the corrective care he needs in order to return to a normal life and is at a significantly increased risk of death.

income families, and their poor health conditions persist into adulthood.[10] Individuals in the lowest-income and least-educated groups typically experience the worst health. Even Americans who are considered to be "middle-class" are less healthy than Americans with the highest incomes. People in the highest income group can expect to live, on average, at least 6.5 years longer than those in the lowest income group.[11]

Despite spending more on medical expenses per capita than any other industrialized nation, the United States fails to provide health care to all of its citizens.[12] Consequently, the U.S. ranks near the bottom of industrialized nations on key health indicators such as infant mortality and life expectancy.

"We see thousands of cases where people develop debilitating and devastating conditions as a result of having no access to preventive care. In South Los Angeles, where St. John's eleven clinics are located, the prevalence of chronic disease is epidemic. We have seen many diabetic patients who lose limbs for lack of access to preventive foot exams and patient who lose their site because they did not have access to preventive eye exams. Patients with cancer at its earliest stages often wait until they can access care in an emergency room to receive treatment, when the cancer has already advanced beyond the scope of treatment." – Jim Mangia, President & CEO St. John's Well Child & Family Centers, Los Angeles, California

Relationship between Poverty, Health Insurance & Mortality

There are close to 50 million Americans who are currently uninsured. Evidence shows that a lack of insurance increases risk of an early death in select illnesses and populations. A 2009 Harvard study estimated that nearly 45,000 annual deaths are associated with lack of health insurance.[13]

By Dr. Garrett Adams

"Being under-insured is another big problem faced by low and middle income Americans. Even if eligible for Medicaid, low-income Americans often can't get access to full care. If they do have private insurance, they can't afford the deductible or co-pay or their insurance won't cover certain preventative services." -Dr. Steffie Woolhandler, Professor of Medicine, Harvard University, Cambridge, Massachusetts

Even with continuous insurance coverage, lower-income Americans 18-64 years old are more than twice as likely to forgo needed health care.[14] And in June of 2011, a study in the *New England Journal of Medicine* reported that disparities exist in access to specialty care between children with private health insurance and children enrolled in Medicaid programs.[15]

Those without even Medicaid coverage fare worse. A recent groundbreaking study conducted in Oregon looked at a group of uninsured, low-income adults. The group was entered into a lottery to be given the chance to apply for Medicaid. This study provided the ability to look at the effects of expanding access to health insurance on utilization, health, and medical expenditures. The results showed that the people with Medicaid had higher health care utilization, lower out-of-pocket medical costs and medical debt, and also better self-reported mental and physical health than the group who did not have the opportunity to apply for Medicaid.[16]

Racial and ethnic minority populations make up over half of the uninsured, despite constituting only one-third of the total U.S. population.[17]

Impact on Health: Race & Education

Income, wealth, race, education, access to health care, lifestyle and diet all play central roles in predicting health outcomes. Approximately 245,000 deaths in the U.S. in 2000 were attributable to low education.[18] Babies born to mothers who have not completed high school are almost twice as likely to die before their first birthday. Adult men and women who have graduated from college can expect to live at least 5 years longer than people who have not finished high school.

There is a supported and growing body of evidence describing racial and ethnic disparities in health. In 2002, former U.S. Surgeon General Dr. David Satcher calculated that 229 African Americans die each day

"I had to give up on the 'platinum' part of our private insurance. The new plan only covered hospital visits, not trips to the doctor's office for regular check-ups. This left me to struggle with getting things like shots for the children until I was able to get the Medi-Cal. I want to work and am willing to do anything, but I cannot afford to lose the Medi-Cal. I need my daily cancer medication and need to continue my treatments, but I cannot afford to purchase health insurance from a private sector provider."

Mrs. Satu Immermann from Santa Ana, CA, is a mother of three young children. In early 2010, her husband died of a sudden heart attack a week after she had surgery to combat stage IV breast cancer. Her husband was a self-employed financial consultant when he passed away and did not have a life insurance policy. While she has a college degree, Mrs. Immermann has not worked outside the home in almost 10 years and has focused on raising her young family. Due to the slumping economy, they had recently given up their health insurance coverage before her husband's death and were receiving coverage through Medi-Cal, California's Medicaid program.

who would not have died if black and white mortality rates were equal. This amounts to 83,570 deaths per year. In 2008, African Americans had a four-times greater risk of pregnancy-related death than whites. Earlier this year, U.S. Department of Health and Human Services Secretary Kathleen Sebelius announced new standards for collecting data related to health disparities.

"Health Disparities have persistent and costly affects for minority communities, and the whole country…[T]he data we will eventually collect in these efforts will serve as powerful tools and help us in our fight to end health disparities," stated Sebelius.[19]

Unlike health disparities research related to race and gender, which has garnered considerable interest and funding, there is an unfortunate gap in our knowledge-base and understanding of poverty as a determinant of health disparities. Without comprehensive socioeconomic information, racial or ethnic differences are sometimes explained away as too intertwined with culture to be influenced by changes in public policy. However, we do know that social factors influence health and that factors such as income, education and wealth are likely to explain more about health differences than race or ethnicity. For example, the Centers for Disease Control and Prevention (CDC) estimate that when looking at the higher mortality rate among black adults when compared to white adults, almost 38 percent of the mortality increase is due to differences in income.[20]

Conclusion

Reducing poverty in America is a major challenge, that will require efforts on many fronts. Because disparities in health care access and utilization exist even after controlling for insurance coverage, ensuring access to health coverage for all is an important step, but will not by itself solve the problem. Addressing non-financial barriers to health, such as transportation, child care,

"The effects of poverty such as obesity can be due to the need to purchase foods and drinks that are high in carbohydrates. Those living in substandard housing may suffer increased exposure to lead, asbestos, and other environmental hazards. Migrant workers can be exposed to pesticides, and herbicides. Many of our war veterans suffer mental illnesses leading to alcohol and drug problems; homelessness, suicide etc. In summary, poverty is what puts an individual at greater risk for a decreased life expectancy." – Dr. Paul Manganiello, Professor, Physician, and a Volunteer at Good Neighbor Health Clinic, White River Junction, VT

primary school education, and safe housing, to name a few, must be considered when discussing efforts to improve health for millions of low-income Americans.[21]

At a time when the numbers of people dying in this country due to poverty rival that of those dying of preventable diseases, more attention must be paid to socioeconomic disparities. As we look for solutions to reduce the nation's debt, we must be cognizant of the effects of cutting social safety net programs. Choosing a path that impoverishes hundreds of thousands of people will result in unexpected yet largely predictable expenses in other parts of our budget. Knowing the potential impact of budgetary choices on the lives of individual Americans should help guide us to make not only the morally correct decisions, but also the more financially responsible decisions.

References

1 Mike Alberti, *Life Getting Shorter for Women in Hundreds of U.S. Counties*, Remapping Debate, June 22, 2011 (citing Sandeep C. Kulkarni, Alison Levin-Rector, Majid Ezzati, & Christopher J.L. Murray, *Falling Behind: Life Expectancy in US Counties From 2000 to 2007 in an International Context*, 9 Pop. Health Metr. 1 (2011)).

2 William H. Foege, *Social Determinants of Health and Health-Care Solutions*, 125 Pub. Health Reports 8, 9 (2010).

3 *U.S. Census, Income Earnings, and Poverty Data from the American Community Survey*. Washington: Government Printing Office, 2009 and 2004 Reports, at http://www.census.gov/hhes/www/poverty/data/acs/index.html (finding that 42.9 million Americans were living in poverty in 2009 up from 37.2 million in 2004).

4 Sandro Galea, et al., *Estimated Deaths Attributable to Social Factors in the United States*, 101 Am. J. Public Health 1456, 1462 (2011).

5 Id.

6 David Seith & Elizabeth Isakson, *Who Are America's Poor Children? Examining Health Disparities Among Children in the United States* 4-5, National Center for Children in Poverty, January 2011.

7 David M. Mirvis, Cyril Chang & Arthur Cosby, *Health as an Economic Engine: Evidence for the Importance of Health in Economic Development*, 31 J. Health And Human Services Administration 30, 32 (2008) (noting that "lower parental socioeconomic conditions at birth are associated with higher death rates during adulthood.")

8 Alberti, supra note 1.

9 *Infant Mortality and African Americans*, U.S. Department of Health and Human Services, Office of Minority Health, available at http://minorityhealth.hhs.gov/templates/content.aspx?ID=3021 (citing T.J. Mathews & Marian F. MacDorman, *Infant Mortality Statistics from the 2007 Period Linked Birth/Infant Death Data* Set, 59 National Vital Statistics Reports, June 29, 2011).

10 *Overcoming Obstacles to Health: Report from the Robert Wood Johnson Foundation to the Commission to Build a Healthier America,* p. 19, February 2008, available at http://www.rwjf.org/files/research/obstaclestohealth.pdf.

11 Id. at 16.

12 Paula A. Braveman, *Broadening the Focus, The Need to Address the Social Determinants of Health*, 40 Am. J. Prev. Med. S4, S4 (2011).

13 Andrew P. Wilper, et al., *Health Insurance and Mortality in US Adults,* 99 Am. J. Pub. Health 2289, 2294 (2009).

14 J.B. Fox & C.L. Richards, *Vital Signs: Health Insurance Coverage and Health Care Utilization – United States, 2006-2009 and January-March 2010,* 59 MMWR 1448-54, at 1450 (2010).

15 Joanna Bisgaier & Karin V. Rhodes, *Auditing Access to Specialty Care for Children with Public Insurance,* 364 N. Engl. J. Med. 2324, 2325 (2011).

16 Amy Finkelstein, et al., *The Oregon Health Insurance Experiment: Evidence from the First Year*, Working Paper p. 3, July 2011.

17 Megan Thomas & Cara James, *The Role of Health Coverage for Communities of Color,* Kaiser Family Foundation Issue Brief p. 3, November 2009.

18 Galea, et al., *supra* note 4.

19 *Affordable Care Act to Improve Data Collection, Reduce Health Disparities*, Department of Health and Human Services News Release, June 29, 2011, available at http://www.hhs.gov/news/press/2011pres/06/20110629a.html.

20 Braveman, et al., *supra* note 12, at S7.

21 Paul W. Newacheck, Yun Yi Hung, M. Jane Park, Claire D. Brindis, & Charles E. Irwin, Jr., *Disparities in Adolescent Health and Health Care: Does Socioeconomic Status Matter?* 38 Health Services Res. 1235, 1251 (2003).


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