An exploratory research to reduce barriers of the uninsured and underserved populations for quality health care in Mississippi

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Abstract

There is a critical need for change in health care system to meet the needs and the medical costs of the uninsured and underserved population in the United States. People in poverty are most likely to have less access to quality health care. The aim of this study is to evaluate the access barriers of health services in North and Central Mississippi by measuring the quality of health care available, identifying the health programs or policies enforced, and determining if those programs or policies are effective.

First, this study documents disparities in access to quality health care services in middle- and low-income populations in Mississippi, using a framework incorporating quality, availability, financial accessibility, geographic and demographic factors. Multiple national surveys rank Mississippi below most states on several health system performance measures. The three most significant barriers are defined as lack of insurance, poor access, and unaffordable costs. A high percentage of uninsured individuals most likely experience difficulty in obtaining both insurance and quality care. Access concerns are another most common barriers among publicly insured families, and families with private insurance mention cost of services as a factor. Families make a clear distinction between insurance and access, and having one or both elements does not assure quality health care.

Key ingredients of success include concerted efforts to reach the poor, engaging communities, and disadvantaged people, encouraging local adaptation, and careful monitoring effects on the poor. The challenge remains to find ways to ensure that underserved and uninsured populations have a say in how strategies are developed, implemented and accounted for in ways that demonstrate improvements in access by those individuals.

Recommendations of this study are to raise revenue and protect the underserved and uninsured population simultaneously and to improve both the health care system and the chances of that population contributing to the economic development. Policy makers could introduce modest fees, maintain greater subsidies for poorer communities and for lower levels of health care, and carefully evaluate how fees affect the decisions of individuals about whether and where to seek medical care. The Mississippi Health Advocacy Program combines research, analysis and grassroots organizing to improve health policies, practices and funding in Mississippi and will be the primary sources of proposing change in for the barriers listed in this study.
Introduction

It has become evident that there exists a critical need for change in this country’s healthcare system in order to meet the special and particular needs and medical costs of the uninsured and underserved populations of the United States. Americans living in poverty are less likely to have access to affordable healthcare than their middle- and upper-class counterparts. The aim of this study is to identify and evaluate the existing barriers to accessibility to healthcare services by comparing the county-wide healthcare services between North and Central Mississippi for the quality of healthcare available, then identify enforceable healthcare programs and policies, and determining potential impacts if those programs or policies are indeed effective for the State of Mississippi.

This study attempts to document various access disparities to quality health care for middle- and low-income populations in Mississippi, using a framework incorporating quality, availability, financial accessibility, as well geographic and demographic factors. Multiple national surveys have ranked Mississippi well below most states on several health system performance measures. We find that the three most significant barriers are lack of health insurance, poor or limited access to insurance and health services, and unaffordability of costs related. Further, it stands to reason and is evident by the research, that individuals lacking health insurance in the United States in general and Mississippi (or any other economically depressed state or region) in particular, are more likely to experience difficulty in obtaining quality healthcare, regardless of urgency, necessity, or seriousness of condition. A 2009 study by the American Journal of Public Health, in fact, estimated that nearly 45,000 annual American deaths were associated with lack of health insurance, while uninsured, working-aged Americans have a 40% higher risk of premature death than their privately insured counterparts, compared to 25% in 1993 (Wilper et al., 2009). Unfortunately, many of these deaths were brought on by conditions that are otherwise very much treatable with adequate health coverage, including hypertension, heart disease, diabetes, and even cancer. Healthcare concerns affiliated with accessibility to care are the most common of barriers among publicly insured families, while families with private insurance generally point to cost of overall services as a prevailing barrier. It should be noted that when examining the healthcare needs of families in general, a clear distinction is made between the respective need of insurance and the need of access, as having one or both elements does not necessarily assure quality healthcare.

Mississippi is certainly not the only state who sees a significant number of its people live in want of adequate healthcare, nor are we the only state that has witnessed the wide and growing disparity between our own “haves” and “have-nots,” i.e., those who have access to quality and affordable healthcare and those who, by virtue of any number of varying factors, do not, but we are indeed among those states in most critical condition. In a report by the Commonwealth Fund from 2014, Mississippi ranked 51 out of 51 for overall state health system ranking, dead last in a system that measured 42 different metrics. Mississippi placed, 47th for Prevention and Treatment, 48th for Access, 49th for Equity, and 51st both for Available Hospital Use & Costs and Healthy Lives. If Mississippi could, hypothetically, improve its performance and accessibility of healthcare system to those of the best performing state in the country, a number of great things could happen, including seeing over 308,000 more adults insured; 268,500 fewer citizens of the state going without healthcare due to cost; 2,046 fewer hospitalizations; and a savings of $67
million a year. But for such a feat to occur, in order to elevate Mississippi to a place alongside states such as Minnesota and Vermont who, by this same study, tied for first according to these same metrics, that the healthcare system and that system’s ability to access services has to work in tandem in order for the beneficiary, the citizen, to receive the potential maximum outcome (Radley et al., 2014).

Hypothesis

We propose a research hypothesis: poverty level is correlated with barriers of health care in Mississippi. We believe there are ways to eliminate this discrepancy. Further, there are effective programs and policies in Mississippi that can ameliorate the health disparity that plagues our communities. But how do citizens access them? Which leads us to the research question: Are there more effective programs and policies to remedy the health care disparity among the uninsured and underserved population? The results of this study indicates yes.

Methods

To test the proposed hypothesis, we selected two counties in Mississippi: Desoto County in the northwest region of the state and Hinds County in central Mississippi (Table 1). Data collected on the two counties was reported by the 2010-2014 United States Census Bureau website, http://www.census.gov/quickfacts/table/PST045214/28033,00. A 2015 data report on the health statistics on both counties and the state came from a Robert Wood Johnson Foundation program that reports county by county health rankings and roadmaps at http://www.countyhealthrankings.org/app/mississippi/2015/compare/snapshot?counties=033%2B049. The 2014 data report on Mississippi’s state health system ranking was retrieved on The Commonwealth Fund’s website at http://datacenter.commonwealthfund.org/scorecard/state/26/mississippi.

Table 1. Background of the two counties

<table>
<thead>
<tr>
<th>Total Population</th>
<th>Desoto County in North MS</th>
<th>Hinds County in Central MS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rank</td>
<td>1</td>
<td>34</td>
</tr>
<tr>
<td>Median household income</td>
<td>$58,505</td>
<td>$37,626</td>
</tr>
<tr>
<td># of non-profit clinics</td>
<td>2</td>
<td>15*</td>
</tr>
</tbody>
</table>

*includes free clinics

(Source: http://www.countyhealthrankings.org/app/mississippi/2015)

An original survey was also conducted as part of this research on the populations that frequented two clinics out of Hinds County and Desoto County for a two-month period. The 385 respondents were 18 years or older and self-pay, uninsured patients. The participants verbally agreed to answer an anonymous 20 question interview, which took less than five minutes to complete. The dichotomous outcome measure, access barriers of health care, was assessed by asking participants why they were not insured and what is the primary barrier between them and quality health care. The three barriers identified in the survey were lack of insurance coverage, limited accessibility, and unaffordable costs.
Table 2. Demographics of Desoto County and Hinds County in Mississippi

![Bar chart showing demographics](chart.png)

**Results**

First, significant differences between the two counties are found. Over 20% of residents in Hinds County do not have health insurance, while only 16% of residents in Desoto County are reported as not insured (Table 3). Thus, the two counties show significant differences in medical service accessibility for doctor’s visit between 14% in Desoto County and 20% in Hinds County.

The resulting health disparities between the two Counties are summarized in Table 5. All of the selected seven indicators show that people in Hinds County have been suffering from poor public health services, including diabetes, HIV prevalence, infant mortality, to name a few.
Table 3. Uninsured population in Mississippi

![Bar chart showing uninsured population in Desoto County, Hinds County, and Mississippi.]

(Source: http://www.countyhealthrankings.org/app/mississippi/2015)

Table 4. Breakdown of healthcare spending of the two counties

<table>
<thead>
<tr>
<th></th>
<th>Avg. health care cost</th>
<th>Population not accessible to doctor due to cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desoto Co.</td>
<td>$10,435</td>
<td>14%</td>
</tr>
<tr>
<td>Hinds Co.</td>
<td>$9,654</td>
<td>20%</td>
</tr>
</tbody>
</table>

- The health care cost of the Desoto Co is almost equal to the state average
  (source: http://www.countyhealthrankings.org/app/mississippi/2015)

Table 5. Health disparities between the two counties

<table>
<thead>
<tr>
<th></th>
<th>Desoto Co.</th>
<th>Hinds Co.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td>HIV prevalence</td>
<td>171</td>
<td>1,091</td>
</tr>
<tr>
<td>Premature age-adjusted mortality</td>
<td>386.0</td>
<td>464.4</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>7.2</td>
<td>11.8</td>
</tr>
<tr>
<td>Child mortality</td>
<td>51.0</td>
<td>93.2</td>
</tr>
<tr>
<td>Food insecurity</td>
<td>15%</td>
<td>25%</td>
</tr>
<tr>
<td>Limited access to healthy foods</td>
<td>8%</td>
<td>11%</td>
</tr>
</tbody>
</table>

(Source: http://www.countyhealthrankings.org/app/mississippi/2015)

Discussion

Mississippi ranks 48th in the nation in the incidence of diabetes and 50th in infant mortality and premature death (http://www.americashealthrankings.org/MS). Racial disparities largely account for the state’s low rankings: African Americans with diabetes in Mississippi have a mortality rate 264 percent higher than whites (MS center for Justice). And, while the state has the highest rate of leg amputations, the amputation rate for African Americans is more than four times that of whites: 4.41 per 1,000 Medicare enrollees versus 0.92 for non-blacks. As for medical insurance coverage, one in four nonelderly African Americans is uninsured, compared to...
one in ten whites. Marino Bruce, professor of criminal justice and sociology at Jackson State University, observes that “the ACA has been framed in a way that has been racialized. For instance, when it comes to Medicaid expansion, the discourse in the media is ‘we are against it, and we don’t want handouts (Barnes, 2015).’ ‘Handouts’ is racialized language that goes back to the Reagan era. People equate Medicaid to welfare.” (Marchevsky and Theoharis, 2000). Both the coded language of many ACA opponents and the reality of health care inequities suggest a very basic question: does the ACA, as currently structured, lessen or exacerbate racial inequities in health care enrollment and access to care? While it is too early for a definitive answer, examining trends in both enrollment and access to care for whites and African Americans can offer some preliminary conclusions.

Table 6. Medical Coverage, by Race

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Answered Yes (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black/African American</td>
<td>62.1%</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>61.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Answered Yes (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black/African American</td>
<td>25.0%</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>9.1%</td>
</tr>
</tbody>
</table>

The Department of Health & Human Services reported that 59.5 percent of enrollees in the Mississippi ACA marketplace were African American and 33.3 percent were white, as of mid-April 2014 (DHH, 2014). A primary reason for the low rates of insurance was that many people who wanted insurance either were not able to qualify for it or could not afford it. In Mississippi, “the parent/caretaker in a family of three would be ineligible for Medicaid if he or she earned more than $384 a month (Wiltz, 2015).” According to a report by Kaiser Family Foundation, two-thirds of Mississippi adults who fall into the Medicaid “coverage gap” (with earnings too high to qualify for Medicaid but too low to qualify for marketplace subsidies) are part of working families (Garfield, et al., 2014). Rims Barber, Director of the Mississippi Human Services Coalition, agrees: “People who fall below the poverty line are too poor to qualify for the ACA. Parents that are under 24% of the poverty line are also too poor to qualify for insurance yet at the same time are too wealthy to qualify for Medicaid.” Using a specific municipality as a concrete example, Angel Greer, Executive Director of Coastal Family Health Center, pointed to East Biloxi, where “22,000 individuals are uninsured and only 200 out of that number were eligible, signed up, and chose a health plan. Two thirds were not eligible because they didn’t make enough money for the marketplace.” (Gold & Rau, 2012)

All organizations and programs are said to make positive impacts on the underserved populations of Central and North Mississippi. The only negative reports were given from clinics that offer the sliding fee program/policy. Many patients do not abide by the requirements, refusing to provide documentation to qualify to utilize the program. On the other hand, some patients do not pay the required copayment for the discounted services, and nonprofit clinics cannot turn them away, thus losing profit for the organization.
Further from the survey, we found that the mean age of participants was 49 (with a standard deviation of 12.2y); 42% had attended college; 38.2% were married; 55.4% were employed; 62% had an annual income less than 25,000; 53% at least had one chronic illness; 59% did not have insurance coverage, 37% and 25% use the emergency room (ER) as their primary source of care. The outcome variables with potential predictors showed that income and lack of coverage were the primary barriers of quality health care, while the largest obstacle in eliminating the lack of coverage is the failure to expand Medicaid.

Also we found that race also plays a role in the lack of coverage for Mississippians, as declining to expand Medicaid denies coverage and health care for African Americans. Finally, there exists a racial gap regarding overall knowledge of health plans between Caucasians and African Americans, according to a study conducted by Kaiser Family Foundation (Kaiser Family Foundation, March/April 2006 Kaiser Health Poll Report Survey, April 2006). Raising public and provider awareness is essential in addressing racial health care disparities. Many African Americans are unaware of services, health plans and providers available to low-income families, and therefore cannot take advantage of what is available.

Therefore, our recommendations include:

- Medicaid expansion for Mississippians – expand insurance coverage in the state through federal funding by expanding Medicaid. Minorities in Mississippi are less likely to have private insurance through employment because they are expected to be self-employed or unemployed.
- Community-outreach programs that assist Mississippians on health promotion, prevention, healthcare options, including HealthCare.gov: aim for enrollment for low-income residents that are already enrolled in income-based programs.
- Universal coverage for all Americans: The need for equitable access to quality health care has never been greater for Mississippians, as well as for citizens all over the country. In the 20th century, universal health care has been available to few high-income countries, but in the past two decades, lower- and middle-income countries have successfully reformed health care to make it universal as well. India and China are pursuing universal health care, and over 80 countries have asked the World Health Organization for implementation assistance (Distler and Scalera, 2014). Healthy people can only help stimulate economic growth.
- Improve language accessibility by considering multilingual materials and web access for the four percent of Mississippians that are Hispanic and Asian.
- Require hospitals to address the unmet needs of the community they serve: African Americans and Latinos are twice as likely as Whites to rely upon a hospital outpatient department as their regular source of care, rather than a doctor’s office where opportunities for continuity of care and patient-centered care are greater (Kaiser, 2008).
References


America’s Health Rankings, United Health Foundation, retrieved from http://www.americashealthrankings.org/MS


analysis/blogs/stateline/2015/1/26/many-africanamericans-fall-into-a-health-coverage-gap.