



# IMPROVING ACCESS TO MEDICAL CARE & HEALTH FOR CHILDREN & ADULTS

A Russell Sage Foundation Policy Brief

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## Introduction

The War on Poverty redefined the medical safety net for poor children and families. In the early 1960s, most health care was privately financed; few among the poor had hospital insurance or insurance for physician visits, and infant mortality and life expectancy rates differed considerably by income and race/ethnicity.

The era's reforms included the creation of Medicaid and community health centers (CHC), which grew and matured into crucial parts of the health care sector today. These profound changes improved access to as well as utilization of health care among the neediest. Today, Medicaid covers approximately 41 percent of all births, and CHCs provided care to 19.5 million people in 2010. The Affordable Care Act (ACA) expansions to childless adults and increased generosity of coverage in states that have chosen to expand Medicaid should further increase access and reduce health disparities.

The War on Poverty programs, however, contributed to the increasing cost of health care: Medicaid is currently the third-largest domestic federal program in the budget (Social Security and Medicare at the two largest). In most states, Medicaid is the second-largest program.

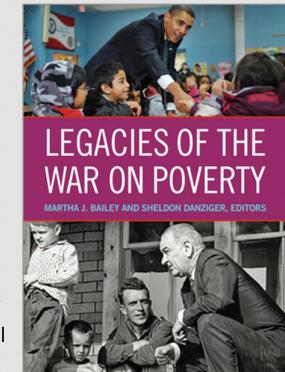
In her chapter in *Legacies of the War on Poverty*, Barbara Wolfe assesses the impact of Medicaid and other health programs introduced during the War on Poverty.

## LEGACIES OF THE WAR ON POVERTY

A new book from the Russell Sage Foundation  
Edited by Martha Bailey & Sheldon Danziger

Many believe that the War on Poverty, launched by President Johnson in 1964, ended in failure. Historical and contemporary accounts often portray the War on Poverty as a costly experiment that left doubts about the ability of public policies to address complex social problems. Featuring a multidisciplinary team of renowned scholars, *Legacies of the War on Poverty* challenges and contests this conventional wisdom as too simplistic. The volume examines the empirical evidence accumulated over the past 50 years and offers a balanced and broad assessment of the long-term impacts of the War on Poverty.

(Available September 2013; visit [russellsage.org/publications](http://russellsage.org/publications) for more information)

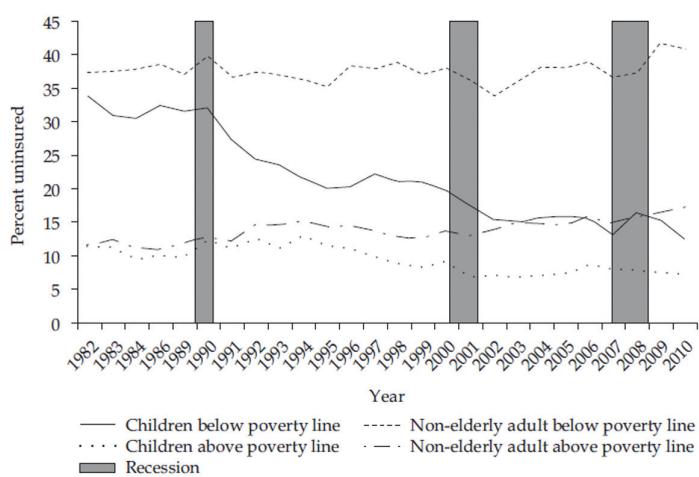


## Health Insurance

Perhaps the most direct indicator of the success of these programs is the proportion of the poor or low-income population who currently have health insurance coverage. Figure 9.3 (see below) provides an overall picture on the proportion without coverage from 1982 onward. (Official records of the uninsured were not kept earlier.)

- Many remain uninsured even today, and the proportion uninsured increases during recession periods. In 1982, 34 percent of those in families below the poverty line were uninsured; the rate fell only slightly to 29 percent by 2010.
- Medicaid covered an increasing proportion of the population over this period. In 1987, 8.4 percent were covered by Medicaid, which increased steadily through the mid-1990s, when it reached 12.2 percent. The proportion has steadily increased, reaching 15.9 percent in 2010, approximately 50.5 million persons.
- The probability of being uninsured remains largely tied to income. Many low-income, prime-age adults are not employed, are not offered employer-based options, or believe they cannot afford it.

FIGURE 9.3 / Rate of Uninsured



Source: Authors' calculations based on Minnesota Population Center and State Health Access Data Assistance Center (2012).

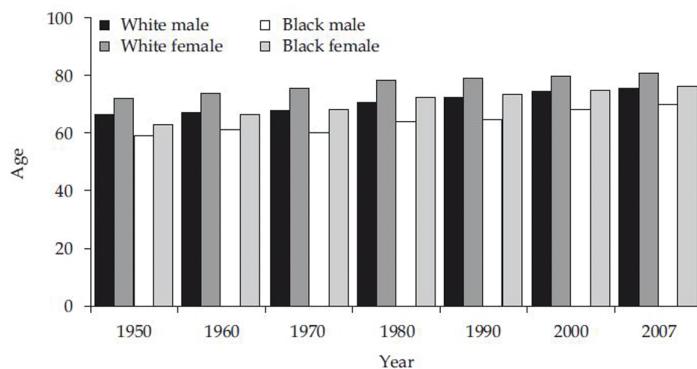
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## Use of Care

Increased coverage is one objective measure of the success of the War on Poverty medical programs, but it is also important to ask, did they increase and equalize use of care?

- Improvement in use of medical care by those in low-income families has been dramatic. In 1963, only 60 percent of low-income family members had visited a doctor in the previous year. The implementation of the War on Poverty programs greatly improved access to care for those in low-income families. As early as 1973, the rate of having had a doctor visit in the previous year was nearly identical for low- and middle-income families.
- The War on Poverty programs may have reduced gaps in equalizing health outcomes. As Figure 9.6 shows, life expectancy has increased for both sexes and both races.
- CHCs have been credited with reducing infant mortality and low birth rates, increasing recommended screenings and reducing ambulatory care sensitive hospitalizations, all at costs below those of other providers of care. Under ACA, CHCs are expected to double their patient load and serve as a primary source of care of many of the low-income newly insured.
- The ACA expansions to childless adults, increased generosity of coverage in states that have chosen to expand Medicaid to 133% of the FPL, and increased capacity of CHCs should continue the trend of increasing access and decreasing gaps in health.

FIGURE 9.6 / Life Expectancy at Birth



Source: National Center for Health Statistics (2011, table 22).

The information in this policy brief comes from the chapter "Health Programs for Non-Elderly Adults and Children" in *Legacies of the War on Poverty*. Russell Sage Foundation, September 2013

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## Conclusion and Recommendations

Prior to the War on Poverty, most health care was privately financed, and few among the poor had hospital insurance. The Johnson administration's establishment of Medicaid—the core program to increase access to health care—was largely a success in terms of increasing coverage among low-income children and non-elderly adults.

- Under Medicaid, more low-income children received coverage; indeed, to this date, the rate of coverage of children is higher than for all other groups of non-elderly. The combination of federal funding of the majority of the cost and the defining of a benefit package appears to have led to a great deal of success in coverage of the target group of low-income children.
- The second major part of the medical component of the War on Poverty was the establishment of community health centers. These are located in low-income and rural underserved areas with a goal of improving access to care. Evidence suggests that low-income persons in communities with a CHC indeed have access, at least to primary care, and that care that is available is both high quality and efficiently delivered.
- Major components of the Affordable Care Act build on successful components of the Medicaid and CHC programs. ACA is intended to reduce the number of uninsured individuals and reduce disparities in access to medical care. Improving health is a larger challenge requiring increased income, changes in health behaviors and health literacy. Nonetheless, the 50 year experience with the War on Poverty health programs suggests that the ACA expansions will reduce gaps in health for those among the poor and near-poor who were previously uninsured.