**Cause of Death: Financial Inability to Access Adequate Healthcare**

*“[The Millennium Development Goals] also embody basic human rights- the rights of each person on the planet to* ***health****… The Goals are ambitious but feasible and, together with the comprehensive United Nations development agenda, set the course for the world’s efforts to alleviate extreme poverty”*

*United Nations Secretary-General BAN Ki-moon*

Living in extreme poverty should not be a death sentence. However, health inequality in America is a multifaceted problem that kills people every day. In the fight to end extreme poverty, it is necessary to address the lack of access to healthcare.[[1]](#footnote-1)

The stories of low-income residents of Baltimore, can be echoed by many throughout the country.[[2]](#footnote-2) As more businesses become more technologically advanced, those living in poverty have extra hurdles to schedule appointments being that they lack ready access to the internet to find information on healthcare providers or schedule appointments using online forms. Even the phones provided by Medicaid are no longer meeting the needs of Medicaid recipients when it comes to setting up appointments. Moreover, without automobiles, physically getting to a location for medical attention can be near impossible. For people living in extreme poverty, the difficulties of finding medical professionals who are willing to care for them, transportation to receive treatment, and the ability to schedule appointments all contribute to the struggle in accessing adequate healthcare.

Access to hospitals, clinics, doctors’ offices, skilled professionals, medical technology, essential medicine, and proper procedures to deal with illness and disease in areas plagued with extreme poverty is already a problem and continues to dwindle. Since the insurance market is privately run and they decide how much the doctors receive for services, there are less doctors choosing primary care practices because they need to make enough income to repay their school loans.[[3]](#footnote-3) Without the ability to receive necessary medical attention, the life expectancy of those living in extreme poverty is well below that of the average American.[[4]](#footnote-4) In Milwaukee, Aurora Health Care, Urban Ministry Center, and Convoy of Hope and hosted a health clinic in the parking lot of a vacant hospital and eight thousand people showed up[[5]](#footnote-5); people want to live in good health, but the availability of adequate healthcare is not accessible for everyone.

A deficiency of healthcare access can be fatal to the most vulnerable populations, especially females.[[6]](#footnote-6) This is evident through the maternal mortality rate change after the State of Texas defunded Planned Parenthood in 2011 and drastically reduced their family planning budget.[[7]](#footnote-7) A large portion of the reproductive health clinics that were forced to shut down were in low-income areas where there was no other way to access reproductive healthcare. In 2013 Texas refunded the budget because of a study by the University of Maryland reporting that the maternal mortality rate doubled as a result of the clinics closing. Unfortunately, for a large portion of the country, the access to adequate healthcare is already an issue.

“Health professional shortage areas” are those which have fewer than one physician for every 3,500 persons. The HSRA has found medically underserved areas to largely overlap with areas of poverty.[[8]](#footnote-8) Moreover, these shortage areas exemplify the racially disparate impact of healthcare access, as physicians tend to choose wealthy areas to practice and white patients to give adequate service.[[9]](#footnote-9) The lack of access to adequate care deprives impoverished Americans of the human right of health and a violation of United States civil rights laws[[10]](#footnote-10).

**Recommendations for Concluding Observations**

1. The United States Congress should ratify the International Covenant of Economic, Social and Cultural Rights so that the United States can recognize healthcare as a right of Americans.

*“Health status should be of concern to policymakers in all sectors…to develop policies and programs that tackle the fundamental causes of health inequity.”*

*HHS National Stakeholder Strategy for Achieving Health Equity Executive Summary*

1. The implementation of a single-payer healthcare[[11]](#footnote-11) would allow the government to incentivize providers to focus on efficient and preventative medicine and availability of the providers will be more ready for persons who need immediate medical attention.[[12]](#footnote-12)
2. HRSA should subsidize transportation costs and provide a means of spreading communication to those who do not have access to the internet to make sure persons in extreme poverty can make appointments and see a doctor when they need.
3. Medical professional associations should require volunteering at health clinics, especially in areas with a low-income population, as a licensing requirement.
4. The Department of Education should provide student loan subsidies for health care professionals entering practices providing healthcare to low-income individuals in order to address the shortage of physicians in low-income areas.
5. Congress should provide tax credits to clinics, hospitals, and doctor’s offices in underserved areas to address the financial burden placed on facilities helping low-income persons.
6. Congress and state governments should ensure adequate access to reproductive healthcare by increasing grants for reproductive health clinics to operate in underserved areas.

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1. The World Bank, *Health Overview* (June 19, 2017), http://www.worldbank.org/en/topic/health/overview (“access to health care is fundamental to ending poverty, building robust economies, and achieving [Universal Health Care]”). *see also* World Health Organization, *WHO| Poverty*, http://www.who.int/topics/poverty/en/ (last visited Sept. 19, 2017) (“illness can reduce household savings, lower learning ability, reduce productivity, and lead to a diminished quality of life, thereby perpetuating or even increasing poverty.”). [↑](#footnote-ref-1)
2. Brittany Britto and Nate Kresh, *Barriers block path to better health care for poor in Baltimore (*Febuary 15, 2016), *available at* http://cnsmaryland.org/baltimore-health/story/barriers-block-access-to-better-health-care-for-poor-in-baltimore.html. [↑](#footnote-ref-2)
3. Katie Lobosco, *Betsy* *DeVos’s loan overhaul would hurt doctors and lawyers*, (May 26, 2017), *available at* http://money.cnn.com/2017/05/26/pf/college/student-debt-doctors-lawyers/index.html. [↑](#footnote-ref-3)
4. Alvin Powell, *The costs of inequality: Money = quality health care = longer life* (February 22, 2016), *available at* https://news.harvard.edu/gazette/story/2016/02/money-quality-health-care-longer-life (The life expectancy of those in extreme poverty can be up to 30 years younger than that of the richest Americans). [↑](#footnote-ref-4)
5. Lillian Thomas, *Poor Health: Poverty and scarce resources in U.S. cities* (2014), *available at* http://newsinteractive.post-gazette.com/longform/stories/poorhealth/1/(last visited Sept. 19, 2017). [↑](#footnote-ref-5)
6. Amnesty International, *Deadly delivery: The maternal health care crisis in the USA*, Amnesty International Publications (2010) http://www.amnestyusa.org/sites/default/ files/pdfs/deadlydelivery.pdf. [↑](#footnote-ref-6)
7. Marian F. MacDorman et al, *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues*, Vol. 128, Issue 3 Obstetrics & Gynecology 447, 447-455 (September 2016). [↑](#footnote-ref-7)
8. *See* Human Resource and Service Administration, *Medically Underserved Areas/ Population Map* (sept. 19, 2017), https://datawarehouse.hrsa.gov/ExportedMaps/HPSAs/HGDWMapGallery\_BHPR\_HPSAs\_PC.pdf [↑](#footnote-ref-8)
9. M. van Ryn and J. Burke, *The effect of patient race and socio-economic status on physicians' perceptions of patients*, 50.6 Soc Sci Med 813, 813-28 (March 2000) (Study showed physicians tended to perceive African-Americans and members of low and middle socio-economic status groups more negatively on a number of dimensions than they did Whites and upper socio-economic status patients.) [↑](#footnote-ref-9)
10. Health and Human Services, National Stakeholder Strategy for Achieving Health Equity Executive Summary, https://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf (“requirement of non-discrimination for healthcare access …[is] also is a moral imperative and a practical necessity for achieving health equity”), *see also* 45 CFR 80. (HHS Non-Discrimination under the Civil Rights Act of 1964) [↑](#footnote-ref-10)
11. Katherine Swartz, *Health care for the poor: For whom, what care, and whose responsibility?,* Vol 26, No. 2 Focus (Fall 2009), https://www.irp.wisc.edu/publications/focus/pdfs/foc262l.pdf. [↑](#footnote-ref-11)
12. *See* Powell, *supra* note 3. [↑](#footnote-ref-12)