



The great divide: More thoughts on an old problem

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Beginning with the Boxing Day Asian tsunami of 2004, the planet has endured the worst year of natural disasters and consequent suffering that I can remember. It may seem that the biggest take-away message from 2005 was our nation's ill-preparedness to respond to disaster, but another important story—laid bare by Hurricane Katrina and its aftermath—is the growing problem of poverty in this country and the inequality it breeds.

Exposing the great divide

The poorest people of New Orleans, living in low-lying areas without means to escape the flooding, were disproportionately affected by Katrina. Wealthier residents fled the area well before the storm hit, but the poorest were left behind to provide us with many heart-breaking images of their misery and suffering.

"The people of New Orleans weren't just abandoned during the hurricane," observed Barack Obama recently. The US senator for Illinois went on to point out, "They were abandoned long ago—to murder and mayhem in the streets, to substandard schools, to dilapidated housing, to inadequate health care, to a pervasive sense of hopelessness."¹ Indeed, Louisiana has the largest percentage of children living in poverty in the nation and—along with Mississippi—the highest infant mortality rate.

Thanks to Katrina, Louisiana's longstanding pre-existing health care disparities were magnified. Well away from the horrors encountered by clinicians at the Superdome and the New Orleans Convention Center, volunteers rushed to set up community health clinics, only to encounter widespread chronic diseases afflicting residents who had never had a primary care provider. Among the many PAs who helped with Katrina's relief efforts was Mindi Valuckas, a Maryland resident who was working in orthopedics before she was deployed to New Orleans with the Maryland Defense Force. Within 24 hours of arriving in Louisiana, her team had established six community health clinics where, instead of managing cases of trauma, as she had expected to do, she

encountered scores of patients with undiagnosed hypertension, diabetes, and other chronic diseases. These patients had never had any medical care. "People would come in for tetanus shots, and we'd find blood pressures like 220/140," she said during a telephone interview. Typically, she and her medical colleagues would hear that these patients had never seen a doctor before.

A recent survey of hurricane survivors in shelters in Houston showed that four in every 10 evacuees from Louisiana had a chronic disease or were physically disabled.² Sixty percent had annual incomes of less than \$20,000.² Half had no health insurance.² Diabetes serves as a good example of the disease rates and inequality in care affecting poorer communities. Almost 16% of Louisiana residents who live in households with an annual income of less than \$15,000 have diabetes, and the prevalence goes down as yearly income increases, with the lowest prevalence of diabetes in Louisiana residents with annual incomes of more than \$50,000.³

Homeless, and more

Many of the poorest residents of New Orleans lost their homes to Katrina, but many never had a "medical home" to lose. Having a medical home—which is a regular source of care—is a better predictor of receiving care than is having health insurance.⁴ Patients who have a medical home and access to a particular provider receive better care and have better health outcomes.⁵

One in eight Americans is without a medical home, in part because of a shortage of practicing primary care clinicians.⁶ Many primary care safety net facilities are struggling to meet the needs of increasing numbers of uninsured people in the face of a dwindling workforce. Since 1997, US medical school graduate matches in family medicine have declined almost 50%.⁷ While the proportion of PAs practicing in primary care settings has held steady at 41%,⁸ the increasing trend toward specialization, along with the projected 25% decrease in new PA graduates by 2020,⁹ may reduce our profession's attempts to improve health care for the poor.

Lack of access is only one reason why many living in poverty do not seek medical care. Ms. Valuckas said, "I

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saw patients with uncontrolled chronic diseases who had never seen clinicians because they were afraid of what they would find out.” A cultural aversion to sharing intimate information with outsiders, along with distrust of government and medical establishments, has kept generations from seeking care. PAs’ life-long learning agenda must include continuing cross-cultural training if we are to reach more segments of our increasingly diverse society. Additionally, each of us, as much as we can, should support the 2005-2006 philanthropic efforts of the AAPA, the PA Foundation, the Student Academy, and the PA Education Association, who have chosen reducing health disparities as their annual project.

The storm that exposed to all of us the poverty existing in New Orleans and other Gulf Coast regions could end up being Congress’s justification for cutting into the safety net programs that benefit these same populations. With the costs of Katrina in the federal budget estimated to be as high as \$200 billion, lawmakers are searching intently for ways to trim the deficit. In November, the House of Representatives and the Senate both passed budget reduction bills that, in varying degrees, cut into antipoverty programs like Medicaid and food stamps. Under the House bill, health care programs would be cut by \$976 million.¹⁰ The bill also contains a 2-year extension of tax cuts on capital gains

and dividends that would mostly benefit the nation’s most affluent households.

In 2006, we are unlikely to see as many natural disasters as we did this past year. That presents us with an opportunity to concentrate on our manmade disasters, such as poverty and inadequate access to health care. If we as a society are unwilling to distribute our wealth in a more equitable way, then PAs as a profession should work doubly hard to devise ways to ensure that more of our impoverished fellow citizens get a better share of good health care. □

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