

MY HEALTH, MY RESPONSIBILITY, OUR COMMUNITY

State of Community Health Report

on

Poverty, Income, and Health

This is the fifth in a series of monthly reports from the

Chattanooga-Hamilton County Regional Health Council

Viston Taylor, Chairman

William Hicks, Vice Chairman

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The Regional Health Council is a community-based organization designated by the Tennessee Department of Health to be responsible for community health assessment, regional health planning, and providing input on funding decisions for health and health-related initiatives. Council members are appointed by the County Executive and the Hamilton County Commission.

The Council identified and prioritized the key health issues facing the community and is developing targeted strategies to address each issue. The five key preventable health issues are: obesity, poor diet and lack of exercise; tobacco use; risky sexual behavior; alcohol and drug use; and lack of involvement in health screenings and other preventive measures.

Data in the report comes from the Hamilton County Behavioral Risk Factor Surveillance Survey (BRFSS), and other sources. The data were compiled and analyzed by the Community Research Council, Inc.

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Poverty in Hamilton County (1990 Census)

	Below Poverty
Total Residents	13%
Race	
White	9%
Black	31%
Other	10%
Gender	
Male	11%
Female	15%
Age	
<18	19%
18-34	13%
35-54	8%
55-64	10%
65+	16%
Type Household	
Married couple Family	5%
Male HOH, No Spouse	11%
Female HOH, No Spouse	33%
Live Alone	23%

- Poverty is three times more prevalent among blacks than among other races.
- Almost one-fifth of children under age 18 are living below the poverty level.
- In families with children, poverty levels are significantly higher among households headed by a single females, especially in black families.

The Working Poor

Often, when families go from welfare to work, they have no health insurance. While 90% of employees earning \$15 or more per hour are offered health insurance, only 42% of those making \$7 or less per hour are offered coverage. (*Kaiser Commission on Medicaid and the Uninsured, 1997*)

Only one-fourth of parents moving from welfare to work have employer-sponsored health insurance. Almost half of women and nearly a third of children are uninsured one year after leaving welfare. (*Families USA, 2000*)

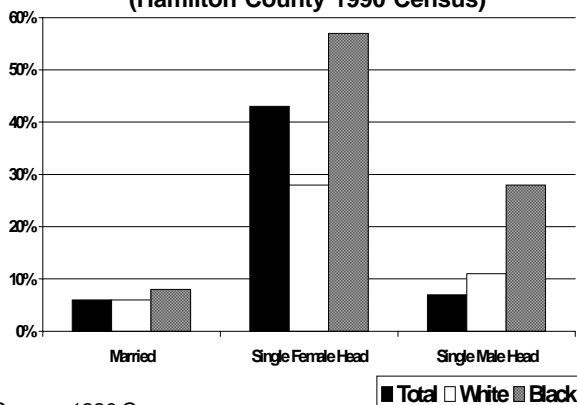
Many times, when coverage is offered, it is too expensive for low-income workers. Further, an employee who cannot afford employer-sponsored health insurance no longer qualifies for TennCare even at wages below poverty level. Children do qualify for TennCare coverage at family incomes of up to 200% of the poverty level. (*Chattanooga/ Hamilton County Health Department*)

Adult Health

Low-income adults are more likely to experience financial barriers and may delay seeking needed health care than those with higher incomes. This may result in a more serious illness requiring hospitalization, which could otherwise have been avoided.

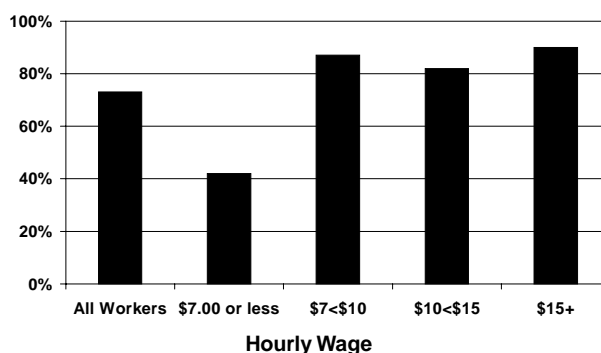
Half of all premature deaths result from behavioral risk factors, such as smoking, drinking, being overweight—all behaviors more prevalent among persons of lower socioeconomic status. Death rates from heart disease, lung cancer and diabetes are higher among people of lower socioeconomic status. Studies have found that, even after adjusting for known major behavioral risk factors, the elevated risk of heart disease among lower income groups remains, suggesting that other factors also contribute to higher mortality.

Percentage Households With Children Under Age 18 Below Poverty (Hamilton County 1990 Census)



Source: 1990 Census

Workers With Employer Coverage, by Wage, 1996



Source: Calculations based on Cooper and Schone, 1997

HEALTH INDICATORS, 1999 Hamilton County

	<u><\$15K</u>	<u>\$15K<\$25</u>	<u>AVERAGE PERSON</u>
GENERAL HEALTH			
Poor Health (self-reported)	21%	10%	6%
Avg. No. Days Past Mo. Physical Health Not Good	18.1	13.9	12.0
Avg. No. Days Past Mo. Mental Health Not Good	14.6	11.4	9.6
Avg. No. Days Poor Mental/Physical Health Restricted Activities	14.5	13.7	11.3
RISK FACTORS			
Smoke Cigarettes	38%	31%	27%
Drink Alcohol	32%	38%	43%
Have High Blood Pressure	32%	22%	20%
Have Diabetes	15%	12%	7%
Overweight	43%	39%	42%
Don't Always Wear Seat Belt	39%	36%	34%
ACCESS TO CARE			
No Health Insurance	12%	14%	8%
Could Not See Doctor Due to Cost Last Year	20%	20%	12%
SCREENINGS/IMMUNIZATIONS			
Dental Visit Past Year	38%	44%	61%
Routine Checkup Past Year	73%	66%	71%
Blood Pressure Checked Past Mos.	83%	81%	78%
Cholesterol Ever Checked	79%	66%	61%
Flu Shot Past Year	38%	24%	26%
Ever Had Stool Blood Test - Over Age 50	41%	46%	44%
Ever Had Colonoscopy or Sigmoidoscopy - Over 50	41%	46%	42%
Pap Smear Past 3 Yrs - Women	78%	77%	83%
Ever Had Mammogram - Women	70%	70%	70%

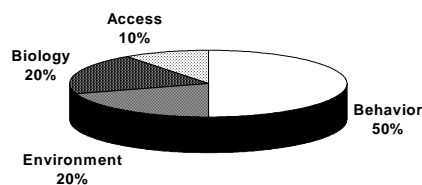
In general, people below or near the poverty level tend to report poorer health than the general population. They also tend to engage in risky behaviors more than the general population, which may partially explain the reported poor health.

Overall, people below or near the poverty level are more likely to report not getting needed medical care due to cost. However, they also report obtaining preventative care and health screenings at levels similar to the average person. Dental care, generally not covered by TennCare or Medicare, is a notable exception.

Hamilton County's Uninsured (1999 BRFSS)

- Eight percent of all adults.
- Sixty-two percent are employed, and 21% are self-employed.
- Ninety percent have total household incomes under \$30,000 annually. Almost half (47%) had incomes between \$15,000 and \$25,000 annually.
- Eighty-seven percent have at least a high school diploma, and 36% had at least some college education.
- One third of the uninsured have children under the age of 16.
- One third have never married, and another third are married.
- Sixty-two percent are male.

Determinants of Premature Death



Centers For Disease Control

This report represents a subset of data from the 1999 Behavioral Risk Factor Surveillance Survey (BRFSS) of 1,037 adults, including 120 with total household incomes under \$15,000, and 221 with total household incomes between \$15,000 and \$25,000. The questionnaire and methodology used were similar to the Centers for Disease Control's BRFSS survey, which is conducted annually nationwide. While every effort was made to design a questionnaire that would not be leading or tend to encourage particular responses, and the methodology was designed to collect data in as impersonal a manner as possible, it should be remembered that all activities and personal information were self-reported. Due to the personal nature of this study and human nature, certain health-related behaviors may have been over- or under-reported.

Income, Poverty, and Health Linked Together

People who live in or near poverty are five times more likely to suffer from poor health than their more affluent neighbors. Less educated and preoccupied with survival issues, the poor often are unaware of preventive health measures and frequently overlook illnesses until they reach crisis level.

The key to eliminating such health problems, experts agree, is to enable poor individuals and families to escape the cycle of poverty. And that cannot be done without the combined efforts of entire communities, including employers, politicians, schools, religious leaders, medical providers and numerous other groups.

The health consequences of poverty have long been known. For example:

- ❑ Poor people are subject to major health problems such as AIDS, diabetes and high blood pressure, many of which could be eliminated or reduced with preventive health practices.
- ❑ Among poor children, 8.5 percent suffer from severe functional disabilities, compared to 4.9 percent of families with higher incomes.
- ❑ Poor mothers, who had neither the knowledge nor the resources to support a healthy pregnancy, often give birth to low birthweight infants who either do not survive or suffer disabilities.
- ❑ For many poor children and elderly, the major health problem is malnutrition.

Stereotypes of the poor — that they are inherently lazy and dishonest — are not borne out by statistics. In fact, 52 percent of all poor people live in families where one or more members work. The primary earners in working poor families tend to work full-time, full-year — but for lower wages than their non-poor counterparts.

Studies indicate that it is the factors that cause people to have low incomes — rather than low incomes

themselves — that often prove to be impossible barriers to eliminating poverty. Even when presented with opportunities to improve their life chances, many poor individuals and families are unable to take full advantage of them.

Poor families' increased vulnerability arises from a complex tangle of environmental and social risk factors associated with poverty; these can include, educational failure, single-parent families, limited job skills, lack of decent-paying jobs, long-term stress and depression, risky behaviors, and isolation from mainstream society.

"In many cases, the problems are generational," according to authors of the Family Life Program.

"Family members, for years, have seen few opportunities for better jobs and are content with a set of values focusing on family and community, rather than on upward mobility . . . Poor children living in families with at least one working parent often feel hopeless as they see . . . their families continue to live in poverty."

Traditionally, programs aimed at eliminating or reducing poverty have taken piecemeal approaches. Welfare-to-work programs, for example, concern themselves with job skills and employment. Substance abuse counselors concentrate on weaning clients from drugs and alcohol dependence.

Such efforts often do little to improve the overall quality of life for participants.

In Wisconsin, which cut its welfare rolls by more than 90 percent by imposing the nation's toughest welfare-to-work program, studies show that the change has failed to translate into economic progress.

After a year in the work force, only 36 percent of the former welfare recipients had more total income than they had on welfare. And off the job, they still faced the same hardships: bare cupboards, violent neighborhoods, depression, drugs, and no health insurance.

Predictors of Populations at Risk

