

**SICK IN SUBURBIA:
HOW THE SUBURBANIZATION OF POVERTY HAS CREATED
DISPARITIES IN ACCESS TO PRIMARY CARE AMONG THE
METROPOLITAN POOR**

Cameron Lee '17

Dr. Kelly Brotzman

Poverty and Human Capability Studies Capstone

Washington and Lee University

Winter 2017

Abstract

Poverty has been suburbanizing since the 1990's in the United States. This metropolitan trend has created disparities in access to primary care between the urban and suburban poor, introducing additional barriers to access for low-income individuals in the suburbs. This differential access is characterized by disparities in spatial access, health insurance coverage, and language and cultural barriers. Using social justice frameworks from Norman Daniels and Martha Nussbaum, I argue that the failure by safety net primary care organizations to respond to this demographic shift has created unjust disparities in access to primary care. Worsened access for the suburban poor relative to the urban poor signifies society's failure to place primary care resources in the most disadvantaged communities and to secure health capability for all individuals. I then propose several recommendations that would ensure greater equity in access to primary care for low-income individuals across metropolitan areas.

Introduction

“There is a new group of people who don’t know where to go for help. They are newly poor and don’t know what to do.”¹ This remark from a suburban Chicago survey respondent epitomizes the trend known as the suburbanization of poverty, which has recently but steadily occurred throughout the United States. As America entered the new millennium, the geography of poverty began to transform drastically, leading to the translocation of low-income individuals from urban centers. This phenomenon has continued to the present day, creating various disparities, including access to social services, between the urban and suburban poor. These services include primary health care, which is not only needed to achieve optimal health but also critical to socioeconomic improvement. The decrease in access to primary care among the suburban poor which has coincided with the suburbanization of poverty impairs the fulfillment of their human capabilities and demonstrates an unfair distribution of health care resources across metropolitan areas. In this paper, I argue that the widening inter-community disparity in access to primary care within metropolitan areas must be addressed to promote health care equity and foster the attainment of fundamental human capabilities for impoverished Americans.

Background

Suburbs, according to the Census Bureau, are defined as municipalities with greater than 2,500 people that lie outside of central cities but inside metropolitan statistical areas.² Even though the growth of poverty in these communities is a relatively new trend in the United States, changing metropolitan landscapes have occurred for over a century. After the end of World War II in the 1940’s, the G.I. bill allowed returning soldiers to obtain low-cost mortgages. Due to the coinciding Baby Boom, many families purchased cheap housing in newly-formed suburbs within

commuting distance to the inner city. These mostly white families, however, also flocked to the suburbs following the influx of African American industrial workers in the inner city, which is known as the “white flight.” Preexisting socioeconomic disparities between whites and blacks at the time eventually led to urban decay, instilling in Americans the perception of the “crumbling ghetto” in inner cities.³ While the Civil Rights Movement ended legal segregation, socioeconomic-based segregation has not diminished. Despite the suburbanization of poverty that has since ensued, perceptions of a rigid dichotomy between impoverished urban centers and wealthy suburbia have persisted to the modern day.⁴

While metropolitan areas in 2000 possessed the largest concentration of impoverished populations in their primary cities, suburban communities experienced greater poverty than both urban cores and rural areas by 2008. By this year, suburbs of large metropolitan areas contained over 1.5 million more individuals in poverty than their respective urban centers and housed nearly one-third of the nation’s poor population. During this eight-year period, suburban poverty grew faster than poverty in any other American community type, including a rate of five times that of primary cities.⁵ Poverty growth data on these community types are displayed in Table 1 below.

	2000	2008	Percent Change
Primary Cities	10,387,549	10,969,243	5.6%
Suburbs	9,991,292	12,491,486	25.0%
Rural Areas	6,941,946	7,783,779	12.1%
United States	33,899,812	39,108,422	15.4%

Table 1: Change in the U.S. Poor Population By Community Type from 2000 to 2008.

Population estimates represent individuals below at or below 100% of the Federal Poverty Level. Percent changes are significant at the 90% confidence level. These data originate from the 2000 Census and 2008 American Community Survey (ACS) and were obtained from Kneebone 2010.⁵

Furthermore, the impoverished population in high-poverty urban neighborhoods grew by 21 percent from 2008-2012, yet this number more than doubled in high-poverty suburban neighborhoods, where poverty increased by 105 percent.⁶ This means that poverty not only was increasing in the suburbs but also was becoming more concentrated in highly distressed neighborhoods, or tracts with poverty rates of 40 percent or higher,⁶ signifying the potential for compounding deleterious effects, such as violent crime or poor health outcomes, among the suburban poor.⁷

While individuals may believe that poverty has moved to the suburbs due to gentrification, other causes behind the changing (sub)urban landscape exist. American metropolitan areas are not uniformly transforming, either; factors driving the suburbanization of poverty vary among cities.² This is evident from the differential experiences of American cities over the past decade: some have been thriving economically and/or growing in population, while others have been struggling economically and/or shrinking in population.⁸ Nevertheless, the primary forces driving poverty's relocation to the suburbs include a renewal of urban affluence, which may displace low-income families to the suburbs due to consequently rising housing costs; the decentralization of low-income housing in inner cities; and the shift and growth of low-income jobs to the suburbs.^{2,9}

Why Does Access Matter?

Along with the recent suburban shift in poverty, disparities in access to safety net services have emerged between the urban and suburban poor. These services address individuals' material needs (e.g., food and shelter) and aspects that affect wellbeing (employment, etc.).² One key factor that secures wellbeing and preserves dignity is reaching and maintaining good health.

Furthermore, primary health care is critical for reaching good health, helping to prevent “illness and death, regardless of whether the care is characterized by the supply of primary care physicians, a relationship with a source of primary care, or the receipt of important features of primary care.”¹⁰ Therefore, primary care has positive implications for the health and wellbeing of individuals, regardless of socioeconomic status or community of residence. These effects, however, may have a greater impact on individuals experiencing poverty than wealthier populations. Moreover, research has demonstrated that having a relationship with a regular source of primary care is associated with better health, reduced overall costs of care, and reductions in SES-based health disparities.¹¹ Some of these cost savings include reduced visits by low-income individuals to the emergency room, which sometimes serves as their only form of health care, due to increased access to preventative care.⁹ Ultimately, access to primary care not only assists low-income individuals in maintaining adequate health but also ensures that the United States distributes health more equitably among its population.

A common misconception surrounding access, especially when involving access to primary care, is that it is strictly spatial. After all, the New Oxford American Dictionary provides one definition of the word as “the right or opportunity to approach or see someone.”¹² This use makes sense when describing individuals’ interactions with the health care system itself; however, access is also defined as “the right or opportunity to use or benefit from something,”¹² such as receiving the care itself. Therefore, when discussing access to primary care, one must consider not only the spatial dimension, but also individuals’ health insurance coverage, language barriers, and more.⁹ Socially disadvantaged populations that are uninsured are less likely to have a source of primary care and, therefore, experience less access to the health system at large than socially advantaged populations.¹⁰ Even though health insurance may increase the

likelihood that low-SES individuals access care, insurance plans vary in the services they cover and do not ensure equitable access for everyone covered. Individuals' physical proximity to primary care providers and clinics also impacts their ability to obtain primary care. This spatial access is often characterized by the number of primary care providers situated within a particular community and the distance patients must travel to visit a care facility. Other factors that impact the access to care for low-SES individuals are if language barriers impede their ability to communicate with physicians, navigate health care centers, or know how to access care. Nevertheless, each of these aspects of access to primary care, while unique, often compounds the ability of impoverished individuals to access this care.

Primary Care in Impoverished Communities

The most common primary care facilities available to low-income populations in both urban centers and suburbs consist of nonprofit community health centers (CHCs), religiously affiliated or secular free clinics, or local health departments.⁹ Even though a sufficient supply of privately practicing physicians may be available in either suburban or urban areas, only 45 percent of primary care providers were accepting new uninsured or Medicaid patients in 2015 because of their lower reimbursement rates.¹³ This acceptance was lower than 33 percent in states like Texas.¹⁴ These physician refusals disproportionately disadvantage the suburban poor due to the large service delivery areas in the suburbs that reduce their likelihood of finding physicians that treat Medicaid enrollees or the uninsured nearby.⁹ Additionally, health departments seldom provide a full array of direct health care services;⁹ most offer services strictly pertaining to public health such as immunizations or nutrition programs.¹⁵ Furthermore, while charitable free clinics may serve a significant number of impoverished individuals in the

inner city, private philanthropies supporting nonprofit social service providers tend to target organizations in urban areas rather than those in the suburbs.¹⁶

Unlike these sources, CHCs, the dominant source of primary care for uninsured and underserved patients in overall metropolitan areas, served 24.3 million patients in 2015 with 71 percent lying at or below the federal poverty level.¹⁷ As Federally Qualified Health Centers (FQHCs), CHCs obtain special payment rates through Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). To receive federal grants, however, these facilities must be situated in a Medically Underserved Area (MUA), administer comprehensive primary care, charge patients based on a sliding scale, and be governed by a community board.¹⁸ MUAs, which are designated by the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS), are determined based on the ratio of primary care providers per 1,000 individuals, the percentage of population over age 65, infant mortality rates, and the ratio of impoverished individuals to the area's total population.⁸ While there are not cutoffs for these criteria, each are assigned weighted values and added to create an Index of Medical Underservice (IMU). Service areas with IMUs of 62.0 or below qualify for MUA designation.¹⁹

Impact of Suburbanization on Access

Spatial Barriers to Access

While impoverished populations experience reduced access to care relative to more affluent people, the suburbanization of poverty introduces additional access issues to the suburban poor. Spatial disadvantage remains the most common access issue among poor suburbanites. Despite the high number of patients served at CHCs, HRSA updates MUAs rarely

and only upon request, ignoring population shifts, such as the relocation of poverty to the suburbs. Federal law does not require HRSA to update MUAs, yet HRSA accepts petitions for MUA designation from local governments in coordination with state primary care offices (PCOs).²⁰ However, HRSA has estimated that nearly half of the current MUAs would lose their designation if current data were used to assess MUA status. This has caused many CHC-dense localities to pressure PCOs into not requesting updates at all,²⁰ hindering potential requests made by medically underserved suburban communities. Furthermore, the Government Accountability Office (GAO) has noted that the “service areas used as the basis of [MUA] designations do not always reflect realistic market boundaries for health services,”²⁰ likely overemphasizing the availability of services in adjacent areas. Therefore, many suburban service areas, even with updates, may not qualify for MUA status based on their placement.

For instance, the Cleveland metropolitan area in 1994 contained 163 medically underserved areas with urban MUAs housing 51 percent of the metropolitan impoverished population.⁸ However, Cleveland MUAs contained only 39 percent of the population by 2009 following the suburbanization of poverty, and none have been updated or created since 1994.^{8,21} Furthermore, only communities with the largest proportion of poor individuals, rather than communities with the largest poor population, are designated as MUAs. This is evident from the map of Cleveland CHCs in Figure 1, which demonstrates the absence of CHCs in newly poor suburbs immediately south and west of urban Cleveland. Sadly, Cleveland is not alone; numerous suburban communities lack access to CHCs despite annual reporting to HRSA, including the Atlanta and Detroit metro areas, whose CHC disparities between their urban cores and suburbs are displayed in Figures 2 and 3.⁸

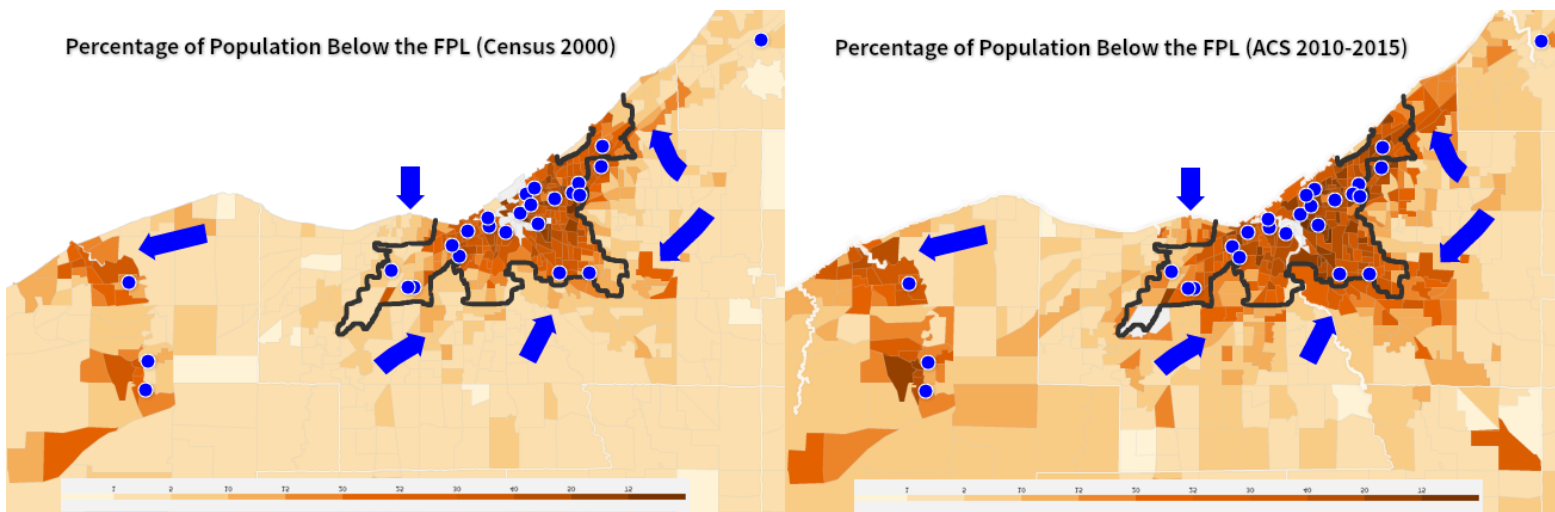


Figure 1: Community Health Centers and Poverty Levels in Cleveland Metropolitan Area, 2000 and 2010-15. Unchanging locations of Community Health Centers demonstrate the infrequent updates of Medically Underserved Areas in Metropolitan Cleveland. Suburban areas outside of downtown Cleveland (outlined in black) that became darker from 2000 (left) to 2010-2015 (right) represent the spread of poverty to suburban areas. Blue arrows designate some of these notable areas. Blue dots represent the locations of CHCs in MUAs, which were determined by 1994 poverty data. Shades of orange represent percentages of the population of each municipality below the Federal Poverty Level (FPL). 2000 poverty data comes from the Census, while 2010-2015 Poverty Data comes from the American Community Survey (ACS). CHC locations were obtained at the Health Resources and Services Administration website (hrsa.gov). Maps were generated using Social Explorer® software (socialexplorer.com).

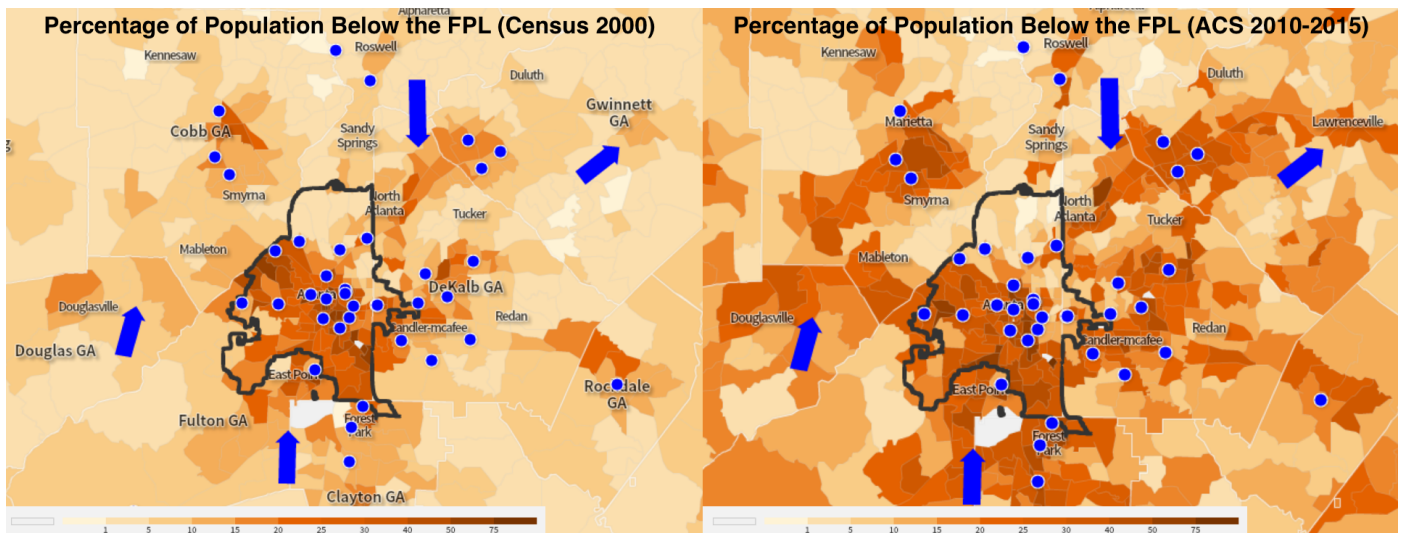


Figure 2: Community Health Centers and Poverty Levels in Atlanta Metropolitan Area, 2000 and 2010-15. Relatively unchanging locations of Community Health Centers demonstrate the infrequent updates of Medically Underserved Areas in Metropolitan Atlanta. Suburbs outside of downtown Atlanta (outlined in black) that became darker from 2000 (left) to 2010-2015 (right) represent the spread of poverty to suburban areas. Blue arrows designate some of these notable areas. Blue dots represent the locations of CHCs in MUAs, which most were determined by 1994 and some with 2010 poverty data. Shades of orange represent percentages of the population of each municipality below the Federal Poverty Level (FPL). 2000 poverty data comes from the Census, while 2010-2015 Poverty Data comes from the American Community Survey (ACS). CHC locations were obtained at the Health Resources and Services Administration website (hrsa.gov). Maps were generated using Social Explorer® software (socialexplorer.com).

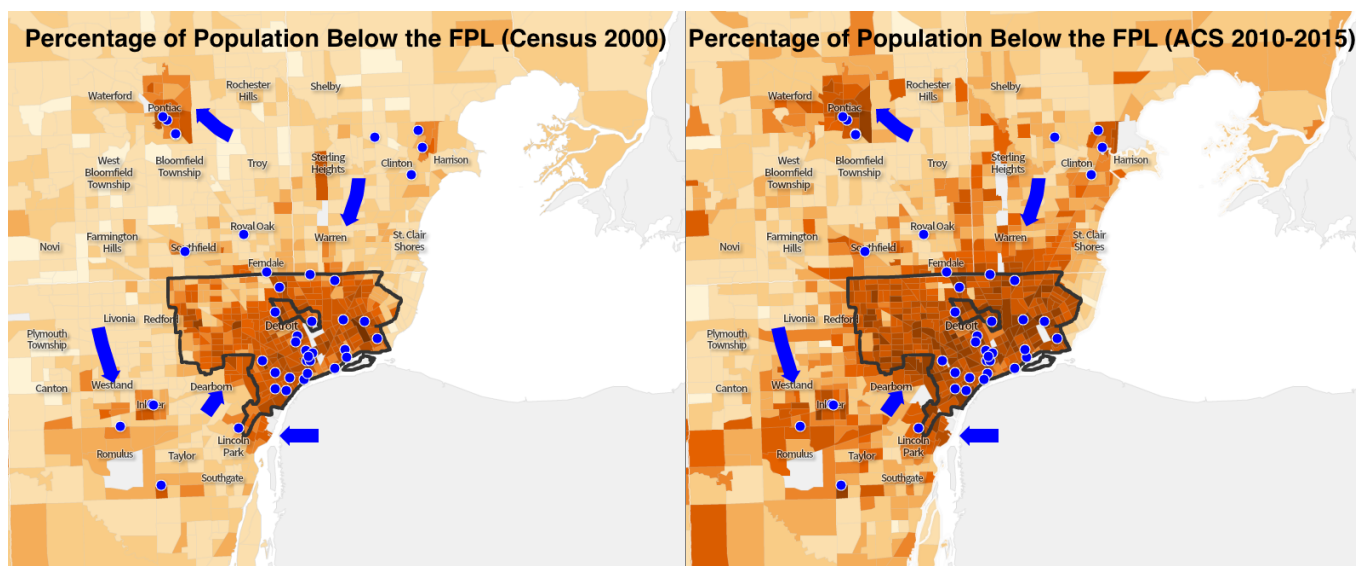


Figure 3: Community Health Centers and Poverty Levels in Detroit Metropolitan Area, 2000 and 2010-15. Relatively unchanging locations of Community Health Centers demonstrate the infrequent updates of Medically Underserved Areas in Metropolitan Detroit. Suburban areas outside of downtown Detroit (outlined in black) that become darker from 2000 (left) to 2010-2015 (right) represent the spread of poverty to suburban areas. Blue arrows designate some of these notable areas. Blue dots represent the locations of CHCs in MUAs, which most were determined by 1978 and 1994 poverty data. Shades of orange represent percentages of the population of each municipality below the Federal Poverty Level (FPL). 2000 poverty data comes from the Census, while 2010-2015 Poverty Data comes from the American Community Survey (ACS). CHC locations were obtained at the Health Resources and Services Administration website (hrsa.gov). Maps were generated using Social Explorer® software (socialexplorer.com).

Because MUAs are updated neither frequently nor consistently between metropolitan areas, spatial access to primary care has not followed the socioeconomically disadvantaged to the suburbs. Despite the inequitable distribution of primary care resources created by the MUA definition, many disadvantaged suburban communities would likely qualify for MUA designation and, therefore, CHCs. Ultimately, the suburbanization of poverty has generated disparities in spatial access between the suburban and urban poor, especially when considering the location of CHCs.

Along with the lack of primary care providers within poor communities, the physical inaccessibility of care facilities further compounds the distress of suburban poverty. Compared to urban settings, lower population density matched with the larger service area of primary care providers in the suburbs reduces the physical proximity that low-SES suburbanites have to a

source of preventative care. While this may not hinder the spatial access of a more affluent suburban family with private transportation, poor individuals are five times less likely to own private vehicles than the non-poor.²² Transportation issues are not as profound among the urban poor, either; metropolitan public transportation typically follows a hub-and-spoke model, which provides transportation within the city and between the city and suburbs but not within suburbia.⁹ Research has also shown that geographical distance to safety net services like CHCs dictates the likelihood that socioeconomically disadvantaged people will use these services; the further these services are from the suburban poor, the less likely they are to use them.²³ An Indianapolis CHC employee noted that if a “[procedure or test] can’t be done [at the closest hospital to the CHC], you can tell the patient’s stress level rises,”⁹ which can create long-term health consequences in itself. Although the lack of spatial access to primary health professionals is common among the majority of low-income individuals, the growth of suburban poverty has worsened this spatial disadvantage.

Coverage Barriers to Access

Regardless of the number of primary care providers present within a community, health insurance coverage plays a critical role in one’s receipt of health care services. This is especially true among Medicaid enrollees and even more so among the uninsured. Although health insurance coverage does not ensure equitable access to primary care among low-income populations, studies have found that socioeconomically disadvantaged groups that are uninsured are less likely to have a source of primary care and also lack access to the health system overall.¹¹ Along with the aforementioned spatial issues, a lack of coverage, both public and private, may further disadvantage those living in suburban poverty relative to the urban poor.

Nevertheless, while there is not a large coverage disparity between urban and suburban low-income populations, the suburban poor received less Medicaid, private, and public coverage than the urban poor from 2009 to 2011 (Table 2).²⁴

	U.S. Total	Low-Income Total	Suburban Low-Income	Urban Low-Income
Uninsured	15.3%	27.8%	29.1%	26.8%
Medicare Recipient	14.8%	11.6%	11.8%	10.1%
Medicaid or means-tested Recipient	16.9%	48.4%	45.8%	49.9%
Any Coverage	84.7%	72.2%	70.9%	73.2%
Private Only	55.1%	17.3%	17.9%	18.2%
Public Only	18.5%	49.0%	46.5%	50.2%
Public and Private	11.1%	5.9%	6.4%	4.8%

Table 2: Health Insurance Coverage for the Urban and Suburban Poor in the United States, 2009-2011. Health insurance coverage data from the American Community Survey (ACS). Private coverage includes insurance received through an employer or a union or insurance purchased directly from an insurance company. Public coverage includes Medicare, Medicaid, CHIP, VA Medical Benefits, or any other low-income or disability benefits received from the government. This data has been adjusted from Rog et al 2014.²⁴

This includes 4 percent less of both Medicaid and total public insurance coverage and over 2 percent more uninsured patients for low-income suburban populations. Furthermore, this differential coverage or lack thereof based on (sub)urban status has persisted, but slightly declined, even in the years following Medicaid expansion under the Affordable Care Act (ACA) (Table 3).²⁵

Year	% Urban Poor Uninsured	% Suburban Poor Uninsured
2015	17.0%	18.1%
2014	20.5%	22.0%
2013	24.8%	26.8%
2012	25.4%	27.5%
2011	26.6%	28.6%
2010	27.1%	29.6%

Table 3: Percent Uninsured for the Urban and Suburban Poor in the United States, 2010-15. Data manipulated and obtained from the American Community Survey (ACS), 2010-2015. Individuals are those that lie below 100% of the Federal Poverty Level (FPL). Uninsured signifies not receiving any insurance coverage, public or private.²⁵

While the percentages of uninsured impoverished individuals living in both urban and suburban areas have decreased in this six-year span, poor urbanites receive more coverage, and likely better access to primary care, than their suburban counterparts. Suburbanization, therefore, has made low-income individuals more susceptible to the community-based disparities in public and private insurance coverage upon their relocation to the suburbs.

The reasons behind these disparities in health insurance coverage are not evident, yet they likely involve issues surrounding the Medicaid enrollment process and/or difficulties in navigating the ACA health exchange. To enroll in Medicaid, individuals may submit applications online, over the phone, in the mail, or in person at county-level or district-level Social Services offices.²⁶ However, Social Services offices are more accessible by urban low-income individuals as they are more often located in the primary cities within metropolitan counties.²⁷⁻²⁹ Because urban and suburban low-income individuals have similar levels of Internet usage,³⁰ differential Internet access likely does not drive disparities in health insurance coverage. Nevertheless, the urban and suburban poor experience differential access to “health care navigators” that assist low-income individuals with paperwork and documentation when applying for Medicaid or other health insurance coverage.³¹ Funded through federal grants, navigators mostly work within CHCs.^{31,32} Because CHCs are disproportionately located in urban communities, the suburban poor have less access to in-person assistance with the potentially confusing health insurance application process. Ultimately, health insurance coverage disparities between the suburban and urban poor can likely be attributed to their differential spatial access to Social Services offices and health care navigators, which are indispensable resources during the insurance enrollment process.

Language and Cultural Barriers to Access

Additional factors that hinder access to primary care in suburban areas include language and/or cultural obstacles. Language barriers can impede appointment scheduling, limit a patient's choices in care providers, inhibit doctor-patient interactions, and decrease adherence to treatment.³³ These obstacles disproportionately affect immigrants that have recently arrived to the United States and individuals that are not proficient in the English language. Likely following job growth in the suburbs, the immigrant population increased over twice as fast in suburban areas than in primary cities between 2000 and 2009.³⁴ Furthermore, 59 percent of immigrants in large metropolitan areas lived in the suburbs by 2011.³⁴ Included in this figure are metropolises like Atlanta, which housed 95 percent of its immigrants in the suburbs.³⁵ In 2009, the newly arrived, those living in the United States for less than 10 years, were more likely to be poor in the suburbs (22 percent) than those who had lived in the country for at least 10 years (13 percent).³⁴ Because exactly half of the foreign-born population in the United States has limited English proficiency (speak less than "very well"),³⁶ many newly arrived immigrants likely experience language barriers and possess concepts of medicine and health inconsistent with American biomedicine. Suburban primary care facilities less frequently offer language interpreter services than those in urban areas, hindering some individuals' ability to communicate effectively with providers and further compounding their spatial disadvantage.⁹ Additionally, suburban facilities less often deliver care that is sensitive and responsive to the medical preferences and beliefs of immigrants and/or other minority groups.^{1,9} Therefore, the increased movement of poor immigrants to the suburbs places them at a greater disadvantage in terms of access to primary care relative to their urban counterparts.

Other Barriers to Access

Individuals unfamiliar with the health care services available within suburban areas, especially those that have recently fallen below the poverty line, also receive less access to primary care facilities. Since the Great Recession of 2007-2009, 73 percent of suburban social service providers have encountered clients without a previous history of using safety net resources, including CHCs.¹ This influx of newly impoverished people to the suburbs also encompasses individuals that lack knowledge of the available primary care resources. Furthermore, some within this group view reduced-cost health services, like CHCs, as “only for the poorest uninsured and Medicaid patients.”⁹ Therefore, the potential stigmatization associated with utilizing safety net services may also prevent the new suburban poor from accessing them. Nevertheless, CHCs, too, experience difficulty in publicizing their services to the unaware poor. A suburban Cleveland CHC director has claimed that the “word of mouth is [the] number one [recruiting tool],” yet individuals lacking transportation may be unaware of assistance that some clinics may provide.⁹ Unfortunately, prolonged lack of access to holistic preventative care can exacerbate the struggles of these low-income populations and mire them in long-term poverty.

Health, Justice, and Capability

The suburbanization of poverty has introduced or worsened obstacles to primary care for low-income suburban individuals. The simultaneous presence of these obstacles seriously compromises their access to primary care. Because the lack of access increases the incidence of preventable illness among impoverished populations relative to more affluent groups,³⁷ additional barriers to access for the suburban poor likely worsen their overall health. John Rawls’ second principle of justice suggests that social and economic inequalities must be arranged to be

of the greatest benefit to society's most disadvantaged.³⁸ Rawls further states that departure from equality of primary goods within a society is justified provided that the condition of those newly worst off improve relative to their experience within the previously equal distribution. While Rawls' difference principle fails to consider health care (or access to primary care) a primary good, Norman Daniels claims that health care is a special social good due to its positive implications for the opportunities of low-income individuals. Therefore, Daniels allows Rawls' concept of primary goods to encompass access to safety net primary care services like CHCs.³⁹

Within Daniels' framework, achieving social justice would entail an improvement in primary care access for those newly worst off. I have shown how the suburban poor are now at a greater disadvantage than the urban poor. Since access for the suburban poor has worsened relative to the access of their urban counterparts, Daniels would deem this inequality unjust. Moreover, failure of CHCs to respond to suburbanization has unfairly prevented additional services from entering the lowest resource suburban communities. Governments must eliminate disparities in access to primary care between the urban and suburban poor by ensuring fair distribution of health care resources between their communities.

Rawls' second principle of justice also declares that social and economic inequalities must satisfy conditions of fair equality of opportunity.³⁸ This equality requires that all individuals with the same talents and desire to use them have the same opportunities to hold social positions regardless of their socioeconomic status. In a Daniels framework, primary care is a critical means for achieving fair equality of opportunity; accessing care minimizes the chance that illness or disease cuts into one's fair share of opportunity.³⁹ I have shown how access to primary care is unequal between the suburban and urban poor. Daniels would also deem this inequality unjust since social inequalities exist alongside inequalities in primary care access and, therefore,

inequalities of opportunity. Therefore, governments are morally obliged to provide all metropolitan individuals with the same opportunity to access primary care. Some contend that equal distribution of primary care resources across metropolitan areas would not ensure good health outcomes and fair equality of opportunity for everyone. Moreover, they suggest that the advantages of suburban communities (e.g., lower population densities) would foster a healthier environment by reducing the prevalence of illness, which would provide suburbanites with greater opportunity. However, such health capability-enhancing conditions do not by themselves cancel out other capability-compromising conditions, such as obstacles to primary care access.

The capabilities approach to human development sees the lack of access to primary care as a serious deprivation of significant human capabilities. Amartya Sen's theoretical framework centers around the idea that "the freedom to achieve well-being is of primary moral importance," and that this freedom "is to be understood in terms of people's capabilities, that is, their real opportunities to do and be what they have reason to value."⁴⁰ When capabilities are realized through human choice and agency as functionings, people actually live the life they value.⁴¹ Whereas Sen's approach is concerned with enhancing individual freedom, Martha Nussbaum's modified capability approach is founded on respecting human dignity. Nussbaum has deemed ten "central human capabilities" universally necessary for human dignity, which include bodily health, i.e., being able to have good health.⁴⁰ Nussbaum asserts that wellbeing must be evaluated by assessing whether individuals possess all of the requisite means to secure these central capabilities.⁴⁰ Access to health care resources is of instrumental significance for securing health capability; individuals are not free to be healthy if they lack access to these resources. Moreover, the deprivation of capability hampers humans' ability to choose the life they value. For low-income individuals that value good health, lacking access to primary care impedes their health

capabilities. In this sense, poor health due to compromised health capability is unjust and reflects society's failure to respect human dignity. Therefore, governments and other societal institutions are obliged to secure access to primary care as a critical means to health capability.

The capabilities approach suggests that disparities in primary care access, and therefore health capability, must be mitigated as a matter of basic social justice. I have shown that the suburban poor are worse off with respect to accessing primary care following the suburbanization of poverty. Lack of access for low-income suburbanites signifies that they lack both choice and agency in being healthy. Conversely, better access to primary care for low-income urban populations indicates that their health capability has been better secured. Nussbaum would deem the disparities in access to primary care between the urban and suburban poor unjust because health capability has not been secured for all individuals. To ensure fair allocation of resources among medically underserved communities, the government and health care system possess the moral obligation to ameliorate these unjust disparities in access and secure health capability for all low-income individuals. Ultimately, the suburbanization of poverty has created inequitable access to primary care resources between the suburban and urban poor, further hindering the dignity of the suburban poor.

Future Directions

The increasing divide in access to primary care between the metropolitan poor following the suburbanization of poverty must be addressed to remedy injustice. Policy change must ensure equitable access for the increasingly disadvantaged suburban poor. Safety net primary care organizations, like CHCs, have failed to respond to the unjust disparities in access between urban

and suburban communities. Therefore, official agencies must respond and take positive steps to reverse this trend and prevent similar trends from occurring in the future.

MUAs: Mandating Updates and Altering Service Area Definitions

CHCs are the most effective vehicles for enhancing the health and health capabilities of low-income Americans.¹⁷ Extending their availability to the suburban poor is the first step toward eliminating disparities in access to primary care. Currently, CHCs only enter communities designated as medically underserved, which tend to be located in urban areas.^{8,21} However, most MUAs are based on pre-2000 demographics that were accurate prior to suburbanization; more impoverished and medically underserved individuals live in the suburbs today.⁸ Current policies regarding the MUA designation process must be adjusted to incentivize the establishment and growth of CHCs in suburban communities. HRSA should be mandated to update MUAs annually to better incorporate metropolitan demographic shifts into MUA designations. Some contend that the rapid occurrence of suburbanization may have prevented HRSA from conducting timely updates. However, the incidence of MUAs that have never been updated seems to imply that frequent updates have not been a priority for HRSA.

CHCs must be located in communities with the highest need, and these are not static but subject to rapid change. Although some communities may lose their MUA designation with annual updates, primary care resources would be concentrated in communities with the greatest disadvantage like they ought to be. Because these updates would secure health capability for more individuals, they would curtail HRSA's unjust selectivity when it comes to choosing which populations are provided with this capability. Localities currently report population data to HRSA annually, so frequent MUA updates are feasible. Financial constraints may prevent

primary care resources from shifting from urban communities to the suburbs with more frequent MUA updates, yet the diversion of some CHC resources to the suburbs would completely justify additional HRSA expenditure. Moreover, annual MUA updates would enable the suburban poor to have the same chance of benefitting from increased access to primary care by way of CHCs.

Additionally, HRSA must better analyze the service areas that are used as the foundation for MUA designations to better target areas with the greatest medical needs. The GAO suggests that these service areas are often chosen arbitrarily and do not always reflect realistic primary care delivery areas.^{20,42} Currently, most urban service areas chosen by HRSA are smaller in size than suburban areas and centered on densely populated neighborhoods with high poverty rates.^{21,42} While impoverished suburbanites outnumber their urban counterparts, they do not reside as closely together as the urban poor and are likely lumped into larger service areas that contain more affluent individuals.⁴² Moreover, the current HRSA consideration of health care professional shortage, a component of MUA status, is a ratio of 1 provider to 3000 residents.⁴³ Incorporating more affluent neighborhoods in a service area with poor suburbanites would increase this ratio and imply that the area is not short of primary care providers. Because urban service areas are more likely to encompass concentrated poverty, primary cities more readily qualify for CHCs. Furthermore, service areas considered for MUA status range from the size of a census tract to several counties;⁴⁴ impoverished suburbanites in large service areas are at an inherent disadvantage since these areas may indicate sufficient primary care resources despite a shortage of providers in their immediate vicinity. Therefore, ignoring physician proximity to low-income individuals within service areas disregards spatial access issues, which especially hinder the suburban poor's ability to receive care.

Designating MUAs based on medical underservice in areas of fixed population size would better combat these inter-community issues associated with spatial disadvantage. Areas with lower population density should also be limited by geographical size to take into account spatial barriers that prevent low-income individuals from accessing care. Limiting the size of these areas would also provide a better view of local poverty rates. Furthermore, HRSA should base MUAs only on the primary care resources that are truly available to low-income individuals, i.e., primary care providers that accept Medicaid enrollees and the uninsured. Updating the current metrics for MUA designation would mitigate the current disadvantage experienced by suburban communities and better secure health capability for all low-income individuals. Ultimately, a more fair analysis of medically underserved areas must be conducted to provide more equitable access to primary care between the poor in urban and suburban communities.

Improving Transportation to Primary Care Services

Although updating policies related to MUA designation may eventually reduce inequity in access to primary care, some low-income individuals will continue to live in non-MUA designated communities in the interim. The capability approach suggests that their unsecured health capability must not be ignored. To combat spatial disadvantage, governments must increase transportation services to CHCs with large service delivery areas. In metropolitan areas with adequate public transportation systems for the suburban poor (i.e., non-hub-and-spoke systems), transportation vouchers given to patients would alleviate the spatial issues associated with large service delivery areas. Providing CHCs with vehicles would also allow them to pick up patients.

Forty states have implemented brokerage systems, where either private companies or state agencies connect Medicaid patients in areas without public transport to transportation providers for CHC appointments. Because broker routes are predetermined and often fixed, they are efficient and cost-effective.⁴⁵ Expanding brokerage conditions to suburban communities with inadequate public transportation would mitigate their lack of spatial access to primary care. Furthermore, if budget constraints prevented CHCs from opening in areas newly designated as medically underserved, transportation services would likely be more cost effective. While changes that focus on CHCs and MUAs would likely bring about the most immediate and profound impact in the reduction of access-based disparities, policymakers must not neglect individuals that experience multiple compounding barriers to accessing primary care.

Increasing Suburban Health Insurance Coverage

Eliminating disparities in health insurance coverage will also narrow the primary care access gap between urban and suburban communities. While the factors driving these coverage disparities are not apparent, they likely involve the increased presence of state Social Services offices and CHC-based health care navigators in urban areas. Although Social Services offices are not as prevalent within suburban communities, financial constraints likely prevent additional openings in the suburbs. Nevertheless, increasing the availability of health care navigators in suburban CHCs would likely have a more direct effect on Medicaid enrollment rates of the suburban poor. Diverting some CHC resources to the suburbs following more frequent MUA updates would also assist HRSA in placing additional navigators in these communities.

Another reason for suboptimal Medicaid enrollment figures among the suburban poor may stem from the lack of awareness of Medicaid eligibility or the ways to enroll. Suburban

CHCs have reported an increased demand for care from those who have recently lost their jobs and health insurance.⁹ Because many of these individuals are newly poor, they are likely unfamiliar with the enrollment process for Medicaid or other health insurance coverage. A maternal child health education text messaging service called Text4baby has been developed to inform pregnant women and new mothers on how to apply for Medicaid/CHIP coverage.⁴⁶ The majority of those that subscribe to this free service also have limited knowledge of Medicaid/CHIP before subscribing. Because 91 percent of suburbanites and 86 percent of low-income individuals own cell phones,⁴⁶ text messaging services like this, if also applied to non-mothers, could eliminate enrollment disparities among the metropolitan poor. These services could also be used to inform individuals of safety net primary care services, like CHCs, available in suburban communities.

Additionally, urging states to participate in Medicaid expansion through the ACA would expedite the already decreasing disparities in numbers of Medicaid enrollees and uninsured individuals between urban and suburban communities. Upon expansion, those between 100% and 138% of the Federal Poverty Level that meet the criteria for Medicaid eligibility would have the opportunity to obtain Medicaid coverage. Promising results include Kentucky's adult uninsured rate, which dropped from 38 percent in 2013 to 13 percent in 2015 after full ACA implementation in 2014.⁴⁷ Therefore, providing greater opportunities for the suburban poor to enroll in Medicaid or other subsidized health insurance programs will eliminate unfair enrollment disparities between low-income suburbanites and urbanites.

Mitigating Language Barriers and Cultural Incompetence

Removing language and cultural obstacles for suburban CHC patients is also essential for improving low-income suburban access to primary care. Currently, suburban CHCs offer fewer language interpreter services and less culturally sensitive care than urban CHCs.⁹ These barriers significantly hinder access for recently arrived immigrants, who are more likely to be poor in the suburbs than other immigrant populations.³⁴ Therefore, language and cultural barriers unjustly prevent these individuals from fulfilling their health capability. To eliminate language barriers, HRSA must provide additional medical interpreters or train current multilingual staff to facilitate physician-patient communication. HRSA funds or federal grants through the ACA should be used to boost the number of certified medical interpreters in suburban CHCs. States may currently receive federal matching funds to provide interpreter and written translation services for clinics serving Medicaid patients; therefore, these additions would likely be feasible.⁴⁸ Training CHC staff to be competent of different cultural health practices and beliefs will also ensure more culturally relevant and appropriate care for all individuals. Enhancing cultural competence in CHCs will better secure health capability for the suburban poor.

Conclusion

The suburbanization of poverty has created unjust disparities in access to primary care between the urban and suburban poor. Federal, state, and local governments must work together to reverse these disparities by placing primary care facilities in the most under-resourced communities. When reforming the status quo, governments must keep all dimensions of access in mind to secure health capability for everyone. In the future, CHCs and HRSA must proactively combat disparities in primary care access created by demographic shifts. Ensuring

equity in access for the metropolitan poor will improve the lives of the most disadvantaged and place the American health care system on the path to justice.

References

- (1) Allard, S. W.; Roth, B. Strained Suburbs: The Social Service Challenges of Rising Suburban Poverty | Brookings Institution. *Brookings*, 2010.
- (2) Murphy, A. K.; Allard, S. W. *Focus* **2015**, 32 (1).
- (3) Boundless. *Boundless* **2016**.
- (4) Badger, E. *The New York Times*. October 11, 2016.
- (5) Kneebone, E.; Garr, E. The Suburbanization of Poverty: Trends in Metropolitan America, 2000 to 2008 | Brookings Institution. *Brookings*, 2010.
- (6) Kneebone, E. The Growth and Spread of Concentrated Poverty, 2000 to 2008-2012 | Brookings Institution. *Brookings*, 2014.
- (7) Hartley, D. Public Housing, Concentrated Poverty, and Crime [https://www.clevelandfed.org:443/newsroom and events/publications/economic commentary/2014 economic commentaries/ec 201419 public housing concentrated poverty and crime](https://www.clevelandfed.org:443/newsroom%20and%20events/publications/economic%20commentary/2014%20economic%20commentaries/ec%201419%20public%20housing%20concentrated%20poverty%20and%20crime) (accessed Mar 1, 2017).
- (8) Kneebone, E.; Berube, A. *Confronting Suburban Poverty in America*; Brookings Institution Press, 2013.
- (9) Felland, L. E.; Lauer, J. R.; Cunningham, P. J. *Res. Brief* **2009**, No. 13, 1–12.
- (10) Starfield, B.; Shi, L.; Macinko, J. *Milbank Q.* **2005**, 83 (3), 457–502.
- (11) Starfield, B.; Shi, L. *Pediatrics* **2004**, 113 (Supplement 4), 1493–1498.
- (12) *New Oxford American Dictionary*; Stevenson, A., Lindberg, C., Eds.; Oxford University Press, 2010.
- (13) Boccuti, C.; Casillas, G.; Hamel, L.; Fields, C. *Primary Care Physicians Accepting Medicare: A Snapshot*; 2015.
- (14) Doctors Threaten to Pull Out of Texas Medicaid <http://www.nbcdfw.com/news/health/Doctors-Threaten-to-Pull-Out-of-Texas-Medicaid-98202569.html> (accessed Mar 31, 2017).
- (15) National Association of County and City Health Officials. *Programs: Community Health*; National Association of County and City Health Officials, 2016.
- (16) Reckhow, S. E.; Weir, M. *Building a Resilient Social Safety Net*; SSRN Scholarly Paper ID 1642285; Social Science Research Network: Rochester, NY, 2010.
- (17) Health Resources and Services Administration: Health Center Program. *Uniform Data System Report*; 2015 Health Center Data Snapshot.
- (18) The Henry J. Kaiser Family Foundation. Community Health Centers Fact Sheet, 2009.
- (19) Health Resources and Services Administration. Medically Underserved Area/Population (MUA/P) Application Process <https://bhwh.hrsa.gov/shortage-designation/muap-process>.
- (20) Salinsky, E. *Health Care Shortage Designations: HPSA, MUA, and TBD*; Background Paper 75; National Health Policy Forum, 2010.
- (21) Health Resources and Services Administration Data Warehouse. *MUA Find*; 2017.
- (22) Berube, A.; Deakin, E.; Raphael, S. *Socioeconomic Differences in Household Automobile Ownership Rates: Implications for Evacuation Policy*; The Brookings Institution, 2006.
- (23) Allard, S. W.; Tolman, R. M.; Rosen, D. *J. Policy Anal. Manage.* **2003**, 22 (4), 599–613.
- (24) Rog, D. J.; Hexter, K. W.; Henderson, K. A.; Hubble, D.; Haight, J. R.; Reed, M. C.; Boxler, A. *Poverty and Service Delivery in Suburban America Framing Paper*; Westat, 2014.

- (25) United States Census Bureau. *2010-2015 American Community Survey*; U.S. Census Bureau's American Community Survey Office, 2015.
- (26) How to Qualify For Medicaid and CHIP Health Care Coverage <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> (accessed Apr 8, 2017).
- (27) Michigan Department of Health and Human Services. Map of County Listings http://www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.html (accessed Apr 9, 2017).
- (28) North Carolina Department of Health and Human Services. Local County Department of Social Services (DSS) Offices <https://www.ncdhhs.gov/divisions/dss/local-county-social-services-offices> (accessed Apr 9, 2017).
- (29) Alabama Medicaid. Applicant Contacts https://medicaid.alabama.gov/content/10.0_Contact/10.2_Applicant_Contacts.aspx (accessed Apr 9, 2017).
- (30) Perrin, A.; Duggan, M. *Americans' Internet Access: 2000-2015*; Pew Research Center, 2015.
- (31) Natale-Pereira, A.; Enard, K. R.; Nevarez, L.; Jones, L. A. *Cancer* **2011**, *117* (15 0), 3543–3552.
- (32) U.S. Centers for Medicare & Medicaid Services. Find Local Help <https://localhelp.healthcare.gov/#intro> (accessed Apr 9, 2017).
- (33) Dunne, N. Navigators Help Patients Overcome Healthcare Inequities <http://news.feinberg.northwestern.edu/2015/02/simon-health-navigators/>.
- (34) Suro, R.; Wilson, J. H.; Singer, A. *Immigration and Poverty in America's Suburbs*; Metropolitan Opportunity Series; 2011.
- (35) Singer, A. *Immigrants in 2010 Metropolitan America: A Decade of Change* | *Brookings Institution*; State of Metropolitan America; The Brookings Institute, 2011.
- (36) Zong, J.; Batalova, J. The Limited English Proficient Population in the United States <http://www.migrationpolicy.org/article/limited-english-proficient-population-united-states> (accessed Apr 10, 2017).
- (37) WHO | Part Two. The urgent need for action http://www.who.int/chp/chronic_disease_report/part2_ch2/en/ (accessed Mar 15, 2017).
- (38) Rawls, J. *A Theory of Justice*; Harvard University Press, 2009.
- (39) Daniels, N. *Just Health Care*; Cambridge University Press, 1985.
- (40) Robeyns, I. In *The Stanford Encyclopedia of Philosophy*; Zalta, E. N., Ed.; Metaphysics Research Lab, Stanford University, 2016.
- (41) Sen, A. Equality of What?, 1979.
- (42) Jagger, S. F.; Pasquier, F.; Baumgartner, L.; Clouse, T.; Smith, E.; Stenersen, S.; Stoll, E.; Rachiele, J. *Health Care Shortage Areas: Designations Not a Useful Tool for Directing Resources to the Underserved*; United States General Accounting Office, 1995.
- (43) Health Professional Shortage Designations | Florida Department of Health <http://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/health-professional-shortage-designations/index.html> (accessed Mar 21, 2017).
- (44) Health Resources and Services Administration. Medically Underserved Areas and Populations (MUA/Ps) <https://bhw.hrsa.gov/shortage-designation/muap> (accessed Mar 21, 2017).
- (45) Myers, A. *Non-Emergency Medical Transportation: A Vital Lifeline for a Healthy Community*; National Conference of State Legislatures, 2015.

- (46) Gates, A.; Stephens, J.; Artiga, S. *Profiles of Medicaid Outreach and Enrollment Strategies: Using Text Messaging to Reach and Enroll Uninsured Individuals into Medicaid and CHIP*; The Kaiser Commission on Medicaid and the Uninsured; The Henry J. Kaiser Family Foundation, 2014.
- (47) Hayes, S. L.; McCarthy, D.; Radley, D.; Collins, S. R. Health Care Coverage and Access Rates in Kentucky Reflect the ACA's Successes
<http://www.commonwealthfund.org/publications/blog/2017/mar/health-care-coverage-access-kentucky-aca-success> (accessed Apr 10, 2017).
- (48) Mann, C. Increased Federal Matching Funds for Translation and Interpretation Services Under Medicaid and CHIP, 2010.