Primary Care Issues in Inner-City America and Internationally

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KEYWORDS

• Inner city • Population • Disparities • Primary care • Cancer

KEY POINTS

- Inner-city patient populations are at high risk for poor outcomes, including increased risk of mortality.
- Barriers to delivering high-quality primary care to inner-city patients include lack of access, poor distribution of primary care providers, competing demands, and financial restraints.
- Health care issues prevalent in this population include obesity, diabetes, cancer screening, asthma, infectious diseases, and obstetric and prenatal care.
- Population health management and quality improvement activities must target disparities in care.
- Partnering with patients and focusing on social determinants of health and medical care are key areas in which to focus to improve overall health outcomes in this population.

The gap between rich and poor continues to widen. According to the Bureau of Labor Statistics, the minimum amount of income the top 10% of full-time wage and salary workers earned was nearly four times as much as what the lowest 10% earned in 1979; this ratio increased to five times by 2014.[1]

Inner-city populations are affected by this gap. The Urban Health Penalty is the observation that "inner city residents suffer the same chronic conditions as people everywhere, but that their situations are made worse by poverty, poor housing conditions, unemployment and other socioeconomic problems."[2] Delivering high-quality primary care to inner-city patients is important and challenging.

PRIMARY CARE IN INNER CITIES

The definition of "primary care" varies, but its principles remain consistent. The World Health Organization (WHO) defines primary care as first-contact, accessible,

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continued, comprehensive, and coordinated care.[3] Other descriptions build on this description adding emphasis on partnership,[4] disease prevention, advocacy,[5] and involvement of family and community, along with the patient.[6]

Inner-cities are usually older densely occupied, deteriorating, and populated by poor, often minority, groups. The Initiative for a Competitive Inner City defines inner-city as a geographic area that has a poverty rate of 20% or higher or a poverty rate of 1.5 times higher than the metropolitan statistical area and an unemployment rate of 1.5 the metropolitan statistical area and/or a median household income of 50% or less than the metropolitan statistical area.[7]

In the United States, about 25% of inner-city inhabitants are middle class, whereas roughly 60% are working class or working poor.[8] Poverty rates for African American and Hispanic populations living in inner-cities can be four to five times that of suburban rates. Disparities exist within cities. One study found 17.5% of inner-city residents were poor compared with 9.1% in other urban areas.[9]

Challenges to delivering primary care to the inner-city include the following:

1. Racism: 16% of whites, 35% of blacks, and 30% of Latinos believe racism in health care is a major problem.[10]
2. Low literacy: 12% to 28% of those ages 16 to 24 are out of school and chronically out of work.[8] Low health literacy contributes to misunderstanding of physician instructions, adherence, and becoming lost to follow-up.[11–13]
3. Competing demands: Personal challenges and economic factors, such as taking time off work, finding child care, and transportation, make accessing care challenging, even when available.[14]
4. Lack of physician resources: Inner-city physicians note financial barriers affect ability to provide medications, equipment, training, and patient education.[15]
5. Poor access:
   a. One in four inner-city residents did not have health insurance as of 2012.[16]
   b. Uninsured adults and those with Medicaid are less likely to get care as soon as wanted compared with adults with private insurance.[17]
   c. Pediatric patients with only Medicaid or Children's Health Insurance Program are less likely to get care as soon as wanted compared with children with any private insurance.[17]
   d. Provider-shortages compound the problem of access.[14] There are only 84 PCPs per 100,000 patients in urban areas.[18] Therefore, there exists a poor distribution of PCPs, which disproportionately affects inner-city areas.[19] In fact, inner-city communities require nearly 13,500 more physicians.[18]
   e. Distance to and long waits contribute to patients' avoidance of care.[14]

The most common health needs facing the inner-cities are explored next. A PCP should be aware of these health issues.

OBESITY

Obesity, defined as body mass index of greater than or equal to 30.0 in adults and as gender-specific weight-for-length greater than or equal to 95th percentile in children, is linked to increased risk for diabetes,[20] cardiovascular disease,[21] cancer,[22] and mortality.[23] Among adults, obesity prevalence increased from 13% to 32% between the 1960s and 2004.

There is an association between urban sprawl and obesity.[24] The inner-city prevalence of overweight and obesity is 21.7% and 22.5%, respectively.[25] Inner-city minority and low-socioeconomic-status groups are disproportionately affected at all ages.