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# Not So Affordable Healthcare

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*Not So Affordable Healthcare*

An Honors Thesis submitted in partial fulfillment of the requirements for Honors in  
*Jiann- Ping Hsu College of Public Health*

By  
*Ashlee Charles*

Under the mentorship of *Dr. Ashley Walker*

ABSTRACT

Rising healthcare cost in the United States has created a need to understand how a lack of healthcare coverage is decreasing women's quality of life and leading to negative health outcomes. Though the goal of the 2010 Affordable Care Act is to give more Americans access to affordable health insurance and to reduce the growth in health care spending, it still remains unaffordable for many Americans. The purpose of this study was to identify what ecological factors impede and/or promote the quality of life for medically uninsured women. Through a focus group, participants shared information on how living without health insurance has affected their quality of life. The participants of the study were medically uninsured women who have an income at or below 200% of the federal poverty guideline. The results of this study uncovered the women's challenges and how lack of healthcare coverage has affected their quality of life. Results supported the identification of the main ecological factors which include: (1) importance of a free clinic, (2) scarcity of options (3) the cost of care, and (4) cost of medications. Though the study does not represent every medically uninsured woman in the United States, many of the themes identified are likely to be same for them as they were for the women in South East Georgia

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## CHAPTER I

### INTRODUCTION

Forty million individuals in the United States live without health insurance each year. Most of the uninsured people in the United States are in low-income working families (Kaiser Family Foundation, 2014). In 2014, 8 out of 10 of the individuals who are uninsured were working families, and over 5 in 10 have family income below 200% of the federal poverty line (FPL) (Kaiser Family Foundation, 2014). Many uninsured Americans are below age 65 and receive their health insurance as a job benefit but not everyone has access to or can afford this type of coverage (Majerol, Newkirk, & Garfield, 2015).

Though Medicaid and the States Children's Health Insurance Program (S-CHIP) help fill in the gaps to help give coverage for millions, Medicaid eligibility for adult's remains limited in some places and few people can afford to purchase coverage on their own (Majerol, Newkirk, & Garfield, 2015). SCHIP has enrolled nearly 5 million children, but unfortunately 60 percent of uninsured children are eligible for either Medicaid or S-S-CHIP, but they are not enrolled (Barr, 2011). The gaps in the health insurance system affect many people, but those with the lowest income face the greatest risk of being uninsured. Barriers the uninsured face may inhibit them to receive preventive care and more likely be hospitalized for conditions that could have been prevented (Majerol, Newkirk, & Garfield, 2015). Low-income families that are uninsured struggle to meet the financial basic needs and medical bills can quickly lead to medical debt (Majerol, Newkirk, & Garfield, 2015).

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Health insurance coverage plays a critical role in making health care accessible and affordable to women (Kaiser Family Foundation, 2014). Low-income women, women of color, and immigrant women are at greater risk for being uninsured (Kaiser Family Foundation, 2014). The women who have inadequate access to care get a lower standard of care and have poorer health outcomes (Kaiser Family Foundation, 2014). In comparison to women who have insurance, uninsured women have low usage of critical preventive services such as mammograms and Pap tests. Uninsured women are also two to three times more likely to ignore medical services due to cost (Kaiser Family Foundation, 2014).

In a recent report, Georgia received a “D” on health factors and ranks 37<sup>th</sup> in the nation based on health factors analyzed (Center for American Progress Action Fund, 2013). More than 20 percent of women in Georgia are uninsured under the affordable care act (Center for American Progress Action Fund, 2013). The Medicaid program provides a broad package of benefits, including preventive, acute and long term care. Many of these services are critical to meeting a woman’s health care needs but not readily accessible without health insurance (Kenney et al., 2012).

### **Statement of the Purpose**

The purpose of this study is to identify what are the current sociological, economic, environmental, political, and cultural factors which impede and promote the quality of life of medically uninsured women in South East Georgia.

### **Research Questions**

The following questions and sub-questions guided the research:

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1. What are the ecological factors which impede the quality of life of medical uninsured women in South East Georgia?
  - a. What improvements are needed to improve existing community health and support services?
2. What are the ecological factors which promote the quality of life of medical uninsured women in South East Georgia?
  - a. What are the existing community assets that promote the quality of life among medical uninsured women in South East Georgia?

### **Theoretical Foundations**

The theoretical foundation that guided the study is the Socio-Ecological Model (SEM).

The Socio-Ecological Model (SEM) suggests individuals interact with their environment across time by actively shaping and being shaped by their environments (Ward & Doering, 2014). The SEM helps address complex public health problems that require comprehensive prevention approaches, especially when addressing health disparities (Ward & Doering, 2014). A SEM can be conceptualized as consisting of six levels of influence (Sharma, 2017). The first level is the intrapersonal level, where individual-level factors are targeted (Sharma, 2017). The second level is the interpersonal level, where the interactions between individuals are targeted (Sharma, 2017). The third level is the social level, where social interactions are targeted (Sharma, 2017). The fourth level is the community level where cultural and organizational factors are targeted (Sharma, 2017). The final level is policy level, where policy level and environmental change factors are targeted (Sharma, 2017). Understanding that health behaviors are

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influenced by multiple levels of influence better equips community health workers serve their target audiences.

### **Limitations**

This study will have the following limitations:

1. Small sample size
2. Convenience sample
3. Self-reported data
4. Lack of generalizability of results

### **Delimitations**

The study had the following delimitations:

1. Sample included medically uninsured women to improve authenticity of results.
2. Researcher incorporated a consistent protocol when conducting the focus group with participants.
3. Triangulation was used to improve reliability and validity of results

### **Assumptions**

The following assumptions were made in order to conduct this study:

1. The participants all speak English
2. All of the participants responded truthfully to the questions asked.
3. All of the participants read and understood the consent form.

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### **Definitions of the Terms**

Preventive Care: Under the Affordable Care Act, an individual or their family may be eligible for some preventive service which can help them avoid illness and improve their health (i.e. cancer screenings, blood pressure and cholesterol tests) (U.S. Department of Human & Health Services, 2013).

Medically Uninsured: a person or group of individual who have no health insurance (Kaiser Family Foundation, 2016).

Peach Care: a state run program that allows uninsured children to have access to affordable health insurance (Health Care Financing, 2014).

Low-income: people who have an income at or below 200% of the federal poverty guideline.

CHAPTER II

LITERATURE REVIEW

Over time, women's lives have changed. In the 1900s, a women's life span was about 50 years (Life Expectancy, 2016). Now, average life expectancy for American women is 82 years of age and it is continuing to rise (Life Expectancy, 2016). Not only are they living longer, but women now have the possibility of enjoying a better quality of life. To be able to accomplish a better quality of life, it is essential women are able to manage their own care and make health care decisions. If women have adequate access to health insurance, then their health can be monitored and they can improve their quality of life. When a woman does not have adequate access to health insurance, then their health may decline and their quality of life can be affected (Kaiser Family Foundation, 2016).

**Health Care Today**

The reason why so many Americans cannot afford health care is fundamentally a problem of cost (Jost & Poolack, 2016). The Centers for Medicine and Medicaid Services estimated that in 2014, on average, \$9,695 was spent for every man, women, and child in the United States on health care (Keehan et al., 2015). This means that the average household of 2.54 persons spent on average, over \$24, 625 (Statista, 2015). The median household income in the United States in 2014 was \$53,657, so the average household with a median income spends almost 46 percent of its income on healthcare, when costs and income evenly distributed across the population (DeNavas-Walt & Proctor, 2014). The 2014 Federal Reserve data indicated that 47 percent of Americans have difficulty paying anything more than \$400 for an unexpected expense (Federal Reserve, 2015).

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Most low- and moderate-income Americans lack basic savings to cover the deductibles on their health insurance policies, much less the out-of-pocket limits (Claxton, Rae, & Panchal, 2015).

Affordable Care Act or ACA is the landmark health reform legislation signed into law in March 2010. The ACA intended to extend coverage to millions of uninsured Americans, to implement measures that will lower health care costs and improve system efficiency, and to eliminate industry practices that include rescission and denial of coverage due to pre-existing conditions (Rosenbaum, 2011). Although the ACA remains intensely controversial six years after enactment, its achievements are irrefutable (Jost & Poolock, 2016). The number of uninsured dropped by 16 million between 2013 and 2015 (Martinez, Cohen, & Zammitti, 2016). The percentage of adults 18 to 64 who are uninsured dropped from 18 percent in 2013 to 11.9 percent in 2015 (Marken, 2016). An estimated 20 million people now have health insurance coverage because of ACA (Jost & Poolock, 2016). Even with the ACA's achievements, health insurance and health care still remain unaffordable for many Americans.

### **Low- Income Families**

Barriers to health care can be many for low-income families, even those with insurance coverage (Berenson, Doty, Abramas, & Shih, 2012; Devoe et al., 2007). Health insurance coverage has expanded for those with low-income and family physicians can provide essential services to these vulnerable populations (Devoe et al., 2007) Despite efforts, many Americans still do not have access to medical care (Devoe et al., 2007).

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Devoe et al. (2007) reported three major barriers among low income families: lack of insurance coverage, poor access to services, and unaffordable cost. Vulnerable populations are more likely to have poor health and experience worse health care outcomes due to being uninsured (Berenson, Doty, Abrams, & Shih, 2007; Wilper, Woolhandler, Lasser, McCormick, & Himmelstein, 2008).

### **No PeachCare, No Options**

One of the coverage provisions of the 2010 Affordable Care Act (ACA) is the expansion of Medicaid eligibility to nearly all low-income individuals with incomes at or below 138 % poverty (\$27, 310 for a family of three) (Garfield, Damico, Stephens & Rouhani, 2014). While the expansion was intended to be national, the June 2012 Supreme Court ruling essentially made it optional for states to choose whether or not to expand Medicaid (Garfield, Damico, Stephens & Rouhani, 2014). There are currently 19 states that are not adopting the expansion of Medicaid, including Georgia (Obamacare Facts, 2014). For the states choosing to expand Medicaid, they can provide Medicaid coverage for low-income adults without children and be guaranteed coverage through Medicaid. Further, because, the ACA envisioned low-income people receiving coverage through Medicaid, it does not provide financial assistance to people below poverty for other coverage options (Garfield & Damico, 2016). As a result, in states that do not expand Medicaid, many adults fall into a “coverage gap” of having incomes above Medicaid eligibility limits but below the lower limit (Garfield & Damico, 2016).

In 1997, the United States Department of Health and Human Services (HHS) began the States Children’s Health Insurance Program (SCHIP) to cover children from families whose incomes are low but too high for Medicaid (Georgia Department of

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Community Health, 2017). PeachCare for Kids was founded in 1999 as Georgia's SCHIP (Georgia Department of Community Health, 2017). PeachCare is a state run program that allows uninsured children in Georgia to have access to affordable health insurance (Georgia Department of Community Health, 2014).

When a child turns 19, they are no longer eligible for PeachCare. Once a child in Georgia turns 19 and is no longer eligible, it is a challenge to get access to healthcare if they are also unemployed. PeachCare is a critical program that helps many low-income families in Georgia get access to affordable health insurance and medical care. According to the Georgia Department of Public Health in 2015, one in two of all children in Georgia have Medicaid or PeachCare (Georgians for Healthy Future, 2017). Without PeachCare, low-income families have few options for their children to receive healthcare.

### **Cost of Care**

Most of the nonelderly in the United States obtain health insurance through an employer, but not all workers are offered employer-sponsored coverage nor can afford their share of the premiums (Kaiser Family Foundation, 2016). Medicaid covers many low-income individual, however eligibility is limited in some states and few people can afford to purchase coverage without financial assistance (Kaiser Family Foundation, 2016). Millions of uninsured adults fall in a "coverage gap" because they earn too much to qualify for Medicaid but not enough to qualify for marketplace premium tax credits (Damico & Garfield, 2016). Cost is still a major barrier for those who are uninsured. According to the Kaiser Family Foundation Health Tracking Poll in 2015, 46% of uninsured adults said that the primary reason they were uninsured was because it was too expensive, making it the most common reason cited for being uninsured (DiJulio, Firth,

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& Brodi, 2016). Not all individuals who work have access to coverage through their job. In 2016, 73% of nonelderly uninsured workers worked at a job said their job did not offer health benefits (Kaiser Family Foundation, 2016).

### **Free Clinics are a Safety Net**

Decreasing the number of uninsured is a key goal of the, which extends Medicaid coverage to many low income individuals in states that have expanded (Kaiser Family Foundation, 2016). The ACA's major coverage provisions went into effect in January 2014 and at end of 2015 the number of uninsured nonelderly Americans stood at 28.5 million, a decrease of nearly 13 million since 2013 (Kaiser Family Foundation, 2016). Even under the ACA, many uninsured people cite the high cost of insurance as the main reason they lack coverage (Kaiser Family Foundation, 2016). Many people do not have access to coverage through a job, and some people, particular poor adults in states that did not expand Medicaid, remain ineligible for financial assistance for coverage (Kaiser Family Foundation, 2016)

In one study, the reason why uninsured free clinic patients chose not to apply for health insurance was observed. (Kamimura et al., 2015). When the study was completed, three main findings were discovered. The study found difficulty to obtain information on their eligibility for coverage, how to apply, and cost were the three major factors influencing intentions to apply for health insurance (Kamimura et al., 2015).

Though ACA aimed to decrease cost, uninsured visits to the hospital remain high (Kamimura et al., 2015). The uninsured visits to the hospital remain high especially in the states that opted out of Medicaid expansion (Kamimura et al., 2015). The ACA does not

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provide universal coverage, so free clinics serve as a safety net for the insured and will likely continue to serve the underserved populations (Kamimura et al., 2015). Free clinics rely on volunteers and other health professionals to provide medical, dental, pharmacy, vision and/or behavioral health services to poor and underserved people (Health Resources and Services Administration, 2016). With at least 16 percent of the population uninsured, free clinics may become more prominent because of their ability to serve the uninsured population. Patient satisfaction is high specific to care received at free clinics (Health Resources and Services Administration, 2016). Approximately 97% total of patients were satisfied with the care they received, and most reported greater satisfaction at the free clinic compared to their prior care (Gertz, Frank, & Blixen, 2010). The patients also reported that if the free clinic did not exist, the majority of patients (70%) would seek care at another free clinic, or the emergency department (Gertz, Frank, & Blixen 2010).

### **Present Challenges Surrounding Health Care for Women**

Health insurance coverage is an important factor in making healthcare accessible and affordable to women (Kaiser Family Foundation, 2016.). Lack of medical insurance can affect a woman's quality of life and lead to negative health outcomes. With the rise in healthcare cost in the United States, there is a need to understand how lack of healthcare coverage is affecting women. The high costs and poor outcomes that characterize the performance of the United States' health system are the result of many factors (Rice, Unruh, Rosenau, Saltman, & Vann Ginneken & 2014). These factors include poverty, lack of universal health coverage, and poor health behaviors (Rice, Unruh, Rosenau, Saltman, & Vann Ginneken & 2014).

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Among the 98 million women in between the ages of 19 to 64 residing in the United States, most had some form of coverage in 2015 (Kaiser Family Foundation, 2016). However, gaps in private sectors and publicly-funded programs left one in ten women uninsured (Kaiser Family Foundation, 2016.) Uninsured women may have improper access to care, receive a lower standard of care when they are in the health system, and have poorer health outcomes. (Kaiser Family Foundation, 2016; Rice, Unruh, Rosenau, Saltman & Vann Ginneken & 2014). In a survey conducted in the fall 2014, uninsured women were less likely to have a regular source of care compared to women with any form of insurance (Kaiser Family Foundation, 2016.)

### **Insurance Status, Chronic Disease and Negative Health Outcome**

Women without medical insurance or with limited insurance are less likely than individuals with insurance coverage to receive preventive services and seek medical care (Ahluwalia, Bolen, & Garvin, 2007; Halpern, Bian, Ward, Schrag, & Chen, 2007;; Ku, Bysse, Steinmetz & Bruen, 2016). For example, breast cancer is the most common non-skin cancer and the second leading cause of cancer-related mortality among women (Halpern, Bian, Ward, Schrag, & Chen, 2007). Early detection is critical and, if done in a timely manner, can help improve health outcomes (Halpern, Bian, Ward, Schrag, & Chen, 2007). Studies have shown that being uninsured may be a barrier to early breast cancer detection and receipt of high-quality care (Ahluwalia, Bolen, & Garvin, 2007; Halpern, Bian, Ward, Schrag, & Chen, 2007; Ku, Bysse, Steinmetz & Bruen, 2016).

Halpern et al. (2007) reports compared with privately insured women, the women who were uninsured or had Medicaid had a greater likelihood of diagnosis at stage II or stages III/IV versus stage I. The main finding in this was most diagnosis in later stages

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are seen in lower income uninsured or Medicaid women. (Halpern, Bian, Ward, Schrag, & Chen, 2007).

Access to affordable healthcare and participation in preventive screenings are important to the well-being of women (Ahluwalia, Bolen, & Garvin, 2007; Halpern, Bian, Ward, Schrag, & Chen, 2007; Ku, Bysshe, Steinmetz & Bruen, 2016). Lack of health insurance coverage, access to healthcare and preventive services are thought to result in increased morbidity and mortality for women (Ahluwalia, Bolen, & Garvin, 2007). Nearly 1 in 5 working age women in the United States are uninsured (Ahluwalia, Bolen, & Garvin, 2007). Having health insurance is a major indicator of access to healthcare and preventive services (Ku, Bysshe, Steinmetz & Bruen, 2016). Studies have shown an association between lack of health insurance coverage, unmet medical need, poor health status and access to healthcare services (Ahluwalia, Bolen, & Garvin, 2007; Halpern, Bian, Ward, Schrag, & Chen, 2007; Ku, Bysshe, Steinmetz & Bruen, 2016).

In one study, women who did not have health insurance coverage were more likely to report not having had a routine checkup within the past two years, they were less likely than those with insurance to have a regular doctor, and they reported cost as a barrier to obtaining care (Ahluwalia, Bolen, & Garvin, 2007). Millions of working-age adults with chronic conditions do not have insurance and have poorer access to medical care than their insured counterparts (Wilper et al., 2008). Studies show that without health insurance, vulnerable populations in the United States lack proper access to care can lead to negative health outcomes (Berenson, Doty, Abrams, & Shih, 2007; Wilper et al., 2008).

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### **Summary**

When a woman does not have adequate access to health insurance, then their health may decline and their quality of life can be affected. The reason why so many Americans cannot afford health care is fundamentally a problem of cost. Even with the ACA's achievements, health insurance and health care still remain unaffordable for many Americans. Medicaid covers many low-income individual, however eligibility is limited in some states and few people can afford to purchase coverage without financial assistance. Though CHIP and PeachCare can provides some financial relief, without low-income families have few options for their children to receive healthcare. Many people do not have access to coverage through a job, and some people, particular poor adults in states that did not expand Medicaid, remain ineligible for financial assistance for coverage. Since the ACA does not provide universal coverage, free clinics will continue to serve as a safety net for the insured and uninsured populations. If the free clinic did not exist, many would have to rely on hopefully being able to afford care in the emergency department or not receive care at all. Access to affordable healthcare and participation in preventive screenings are important to the well-being of women. Unmet medical needs and lack of health insurance could result in increased morbidity and mortality for women.

CHAPTER III

METHODS

The qualitative study used a focus group as the primary data collection method. The focus group was held at a local clinic dedicated to serving those who are medically uninsured and have an income at or below 200% of the federal poverty guideline. The researcher aimed to create an accepting environment that put participants at ease allowing them to thoughtfully address questions in their own words, created a safe place where the group will felt comfortable to form their own thoughts and shared their opinions about the factors the participants perceived are impeding or promoting their quality of life. Because participants were allowed to voice their opinions, the primary researcher discovered the barriers impacting the participant's quality of life and the information helped the local clinic discover which services are working, and what improvements can be made to meet the needs of their patients.

**Participants**

Participants included seven women who are currently receiving health care services from the Hearts and Hands Clinic. The Hearts & Hands Clinic offers the following series to those who are eligible: primary medical care for adults with chronic illnesses, vision/optometric services, dental extractions and minor filing for those who are in pain, and women's wealth/ mammograms. The participants of the Hearts and Hands Clinic are medically uninsured and have an income at or below 200% of the federal poverty guideline. One focus group with 7 participants took place at the Hearts and

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Hands Clinic. Ethical approval was obtained from the participating academic institution and all participants gave written informed consent prior to the focus group.

The participants were recruited through flyers and sign-up sheets placed in the Hearts and Hands Clinic waiting room two weeks prior the focus group. The researcher contacted each person individually using the information provided on the sign-up sheets to explain to the women about the study. The researcher scheduled those who agreed to participate. The incentive for participation was a \$5 gas gift card.

### **Ethics and Confidentiality**

Before the study began, IRB approval was obtained from the participating academic institution. The purpose of obtaining IRB approval is to protect the rights and welfare of human subjects involved in research activities being conducted under study. All participants gave written informed consent prior to the focus group. The participants were informed the study involved no more than minimal risk. Minimal risk included fatigue and physical and emotional discomfort during the focus group. Participation in the focus group was completely voluntary. If the participant began to experience fatigue or other discomforts, they were instructed they could take a break, stop answering questions, or stop participation without penalty.

Participants were reminded confidentiality is paramount in this study and were asked to answer honestly. The researcher ensured the participants had no moral or legal obligations to report any answers or information provided to anyone. The participants were instructed not to provide identifiable information and if this information was provided it would not be used on any recorded information so the data could not be

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linked. The participant's information was assigned a code number. When the study was completed and the data has been analyzed, the recordings will be destroyed. The participant's name will not be used in any report. Audio recordings and notes of the participant's answers taken on poster board paper were only available to the researchers. The recordings and notes taken will be stored in a locked filing cabinet in the faculty advisor's office for a period of seven years. After seven years, all the information will be deleted permanently. The participants were assigned a code name during transcription to ensure their statements remain confidential.

### **Data Collection**

A focus group guide was developed for the focus group. The researcher developed a focus group guide based on literature review in the areas of focus group research (Fowler, Reid, & Minnis, 2014). The questions in the guide were created specifically for the aim of the research. The researcher used an audio recorder to record the scheduled focus group. The focus group session began with the researcher reading the informed consent with the participant to ensure they were aware of the risk and the information would be kept confidential. The session took place for 30 minutes. After the session, the participants received their incentive of a \$5 gas card. The session was audio recorded.

### **Data Analysis**

The audio recordings were transcribed verbatim by the primary researcher. Member checking was utilized to verify the accuracy of the transcriptions. Member checking allows participants to correct errors, challenge what they perceive as wrong

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interpretations and an opportunity to summarize preliminary findings (Deborah Cohen's Publication, 2008).

Content analysis was used to identify emergent themes. The primary researcher reviewed the transcriptions line by line and identified reoccurring terms, phrases, and patterns. A codebook was then created and shared with the faculty advisor to verify its accuracy. The faculty member worked with the primary researcher to revise the existing codes and make additions to the codebook as needed. Once the codebook was finalized, the researcher reviewed the transcriptions and began coding the data. From the coding, categories and themes were identified. Illustrative quotes were used to support the categories and themes which emerged from the analysis.

The audio recordings and any notes taken during the focus groups were only available to the researchers. The audio recordings and transcriptions were stored in a locked filing cabinet in the faculty advisor office for seven years. After seven years, all the information will be deleted permanently. The primary researcher assigned code names during transcription to ensure individual participants' statements remain anonymous. No data files show any participants name or other personal identifying information.

### **Summary**

At the end of the focus group, the researchers summarized the themes from the discussion. General themes emerged after analyzing context and participants word choices throughout the transcripts. Themes that were recurring were noted and separated according to which level of the Ecological Model it fit under. Qualitative data analysis

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revealed five overarching themes. After major themes were identified, supporting quotes that captured the themes were identified. The quotes reflect the voice of the participants and sensitive information about how living without health insurance has affected their quality of life.

CHAPTER 4

RESULTS

The researcher identified six themes through content analysis. Guided by the ecological model, the six themes were categorized based on three of the five levels. The prominent levels found in the analysis are: intrapersonal, community, and public policy.

|                            | <b>Categories associated with Levels of the Ecological Model</b> |   |
|----------------------------|--|---|
| <b>Intrapersonal Level</b> | <b>Community Level</b>   | <b>Public Policy</b>  |
| Taking Medications         | Positive and Negative Aspects of the Hearts and Hands Clinic     | Primary Services Impeding Uninsured Women's Quality of Life |
| Going to the Physician     | Lack of Affordable Health Insurance Options                      | Fears and Anxieties about Healthcare Today                  |
| Health is Everything to Me |  |   |

**Intrapersonal**

Intrapersonal level factors are considered those related to individual responsibility. Some of these factors are age, education, or income. The participants noted that their health is impacted by individual choices.

**Easiest Way to Care for Health**

The participants mentioned individual level factors-those they have more control over as the easiest and most affordable way to maintain overall health and well-being. For example, participants noted taking medication as the easiest. Though taking their medications is easy, the increase of medication cost creates a challenge in being able to

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afford medications. Without health insurance to help cover the medication cost, the participants are not able to take care of their health resulting in a decrease in their quality of life. The participants also found going to see the physician at the hearts and Hands Clinic was an easy way to take care of their health. If they have a question or a concern about their health, the participants found going to get it checked a simple way to take care of their health.

### **Health is Everything to Me**

Health can be defined in several ways. Each individual has their own definition about what health means to them. Taking medication and actively monitoring their chronic illness was seen as an important part of their health. The participant pointed out taking care of their health is a challenge due to lack of easy access to healthcare, which they felt depletes their health.

Participant 1 stated:

I know with myself I have a hard time. I have multiple health issues and it is very hard to get the care I need. If anyone is like me and has a hard time getting their medicines for all their health issues, then it depletes your quality of life. I guess what I am trying to say is, if you do not have good healthcare or health then you do not have a good quality of life

### **Community Level**

Community level looks at the setting, like schools, workplaces, and neighborhoods where social interactions occur. The participants discussed the Hearts and Hands Clinics plays an important role in their life.

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### **The Hearts and Hands Clinic is Essential to My Life**

The participants who receive care at the Hearts and Hands Clinic pointed out their opinions based on their experiences. A negative aspect of the clinic was the expenses. Though the fees for care are small, having to choose between grocery and medicine makes a big difference. The participants noted an eye center and a nutritionist were seen as a need at the clinic. Besides the few negatives, the all the participants felt as if the Hearts and Hands Clinic has more positive aspects. The clinic is seen as a wonderful place to the individuals within the South East Georgia region who cannot afford healthcare.

Participants 2 stated:

The Hearts and Hands Clinic is wonderful, because they go above and beyond to put the needs of all the patients first over their own needs. I am very thankful the Hearts and Hands Clinic devotes their time to people like me, who have no other place to go.

### **Scarcity of Options**

Children in Georgia can get PeachCare, but once an individual turns 19 it is a challenge to get access to healthcare if they are also unemployed. The participants rely on PeachCare to help cover the medication cost for their children. PeachCare is a state run program that allows uninsured children in Georgia to have access to affordable health insurance (Georgia Department of Community, 2014). When child turns 19, they are no longer eligible for PeachCare. The participants feel after PeachCare, there are not any real options for adults to get care. For example, between 2007 and 2016, the cost for

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EpiPen, an epinephrine auto-injector used to treat allergy reactions, has seen its price increase from \$57 to \$500 (Woodyard, Layton & Press, 2016). Participant 1 stated The EpiPen is a life or death medicine for me. Taking my medication comes easily for me, but when they are expensive then it makes things harder. If an employer does not offer health insurance, then affording medications can be difficult. A few of the participants mentioned their employers do not offer health insurance. The Hearts and Hands Clinic offers affordable medications for their patients. If it was not for the Hearts and Hands Clinic, the participants stated they would not be able to get access to their medications. The participants rely on PeachCare to help cover the medication cost for their children. When child turns 19, they are no longer eligible for PeachCare. The participants feel that after PeachCare, there are not any real options out there for adults to get care.

### **Public Policy Level**

The public policy level looks at the broad societal factors like economic, educational and social policies. Economic factors were the most pressing for the participants. Public policy factors are also the one's participants feel are 'out of their hands.'

### **Lack of Affordable Anything**

Participant 1 summed up one of the major issue they are facing by stating, "I have to say the expense of it all and the lack of affordable anything. There are not any options at all whatsoever for uninsured, poor, broke, food stand people."

Participant 6 stated:

No insurance, for sure. Many people cannot afford it, because if you do not fit in the income bracket then you do not get coverage. I wish there was something for

## NOT SO AFFORDABLE HEALTHCARE

those who are in-between. But without it, there is not anything you can do about it besides trying to survive.

For the services that are available, the participants felt as though people take advantage the services. People who make \$50,000 come to the free clinic and use our resources and then those who make less get deprived of the resources they truly cannot afford. Participants discussed they have gone to apply for Medicaid have been turned down numerous times, because they did not meet the requirements. When the employer does not offer health insurance, do not meet the requirements to get Medicaid, and live in an area that offers free care the participants felt as though they have fallen through the cracks and just are stuck. No job, no coverage, and then no care. With no means to cover healthcare cost or medications, quality of life and health decreases. Participants 5 felt as though the only other option for the uninsured was “to just do what you can to survive.”

### **The Distress of Healthcare Today**

Living without health insurance is a challenge that can cause fears and anxieties about getting care and being able to afford the care they need. For Participant 1 who has Medicaid, they felt as though if it went away then they would be scared to death and would not be able to afford their life threatening medication. With Medicaid, participant 1 stated:

Without the means to afford my medications, I would die. The medicines are a simple thing, but the government makes it expensive and unattainable for people to afford. Some in the community just have to go without, and their chronic illnesses get worse and their

## NOT SO AFFORDABLE HEALTHCARE

quality of life decreases. It is a snowball effect. If you do not have healthcare you are going to end up in a rut. It is a shame.

The participants are afraid when they go to the emergency room to get care, they will not get treated because they cannot afford it.

Participant 2 stated:

When I need to go to the emergency room I am afraid I will not get the treatment need, because I do not have Medicare or the money. I have tried to get it plenty of times, but I have been denied each time. I want to go to the doctor, but I just do not have a good way to. When I get sick, I feel as if I am not getting the proper care I need, simply because I can only afford so much. My diabetes is causing me to have a lot of health problems. But I do not have any health insurance so I cannot afford to get the proper exams I need. I am just kind of stuck.

Others felt as if they are scared what would happen to them if the Hearts and Hands Clinic were to end due to lack of funding. For the participants who cannot get approved for Obamacare, Medicaid, they felt as if they are just stuck. With the means to afford care, the participants fear they will not get the proper care they need and will become sicker.

### **Summary**

Among the themes analyze, the cost of care was discussed the more out of any other topic. Living without health insurance is a challenge that can cause fears and anxieties about getting care and being able to afford the care they need. Without health insurance to help cover the medication cost, the participants are not able to take care of

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their health resulting in a decrease in their quality of life. The participant's health means everything to them, but without the means to afford quality care, sometimes they just have to do without and hope they do not get sicker.

CHAPTER V

DISCUSSION

The results of this study uncovered the challenges of medically uninsured women and how lack of healthcare coverage has affected their quality of life. Results support the identification of the main ecological factors which impede and/or promote the quality of life for medically uninsured women including: (1) importance of the free clinic, (2) scarcity of options (3) the cost of care, and (4) cost of medications.

The results of this study indicated there are many factors impeding medically uninsured women's quality of life and few factors promoting their quality of life. It was assumed transportation to a medically facility would be the barrier impeding medically uninsured women's quality of life. The results indicated the cost of care was the leading barrier impeding medically uninsured women's quality of life. None of the participants stated transportation was associated with being a factor impeding their quality of life. The most prominent factor promoting the participants quality of life was having the Hearts and Hands Clinic offer affordable medications and care for their health.

The participants live in a state where Medicaid was not expanded, which they discussed is the reason why it is difficult to meet the requirements to receive Medicaid benefits. To the participants health means everything to them, so the difficulty to afford care prevents them from being able to manage their health. The Hearts and Hands Clinic serves as a safety net for the participants, because they discussed their affordable service helps them manage their health. The results of this study supported the findings from Gertz et al. (2010), which found if the free clinic did not exist the majority of patients

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(70%) would have to seek care at another free clinic, or the emergency department.

Unlike the patients in the Gertz et al. (2010) report, the participants in this study do not have the option to seek care at another free clinic. The participants discussed they would use the emergency room, but feared they would not receive the care they need due to the cost.

State health insurance plans are lifelines among families. Participants in this study noted the benefits and challenges of the state option which are similar to the barriers noted by Devoe et al (2007). Devoe et al. (2007) reported three major barriers when accessing health care for their children among low income families: lack of insurance coverage, poor access to services and unaffordable cost. The participants in this study all have families, lack insurance coverage, and struggle to afford the high cost of medical care. Like the women in the Kamimura et al. (2015) study, the participants noted cost is key factors influencing their intentions to apply for health insurance. The participants use PeachCare to help their children receive affordable medical care. Without PeachCare, the participants feel as if their children would have no other option to receive affordable medical care.

The poor are generally less healthy and thus would be expected, with equal access, to use medications more frequently (Morgan & Kennedy, 2010). Unfortunately, prescription drug spending continues to rise faster than overall health spending (Stack, 2016). Participants pointed out due to the rising cost of medications they may have to do without. Participants can connect to the cost-related access problems noted in the Devoe, et al. (2007) study which are skip a medical test, treatment, follow-up visits, did not go to a doctor or clinic when sick or did not see a doctor when it was needed. The participants

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discussed they fear the future of healthcare is going to leave them with no other option, but to do the best they can and hope they do not get sicker. With no means to cover healthcare cost or medications, they feel their quality of life and health decreases. The participants felt as though their only other option was “to just do what you can to survive.”

### **Summary**

This study provided a rich account of what the ecological factors impede the quality of life for medically uninsured women. Though the study does not represent every medically uninsured woman in the United States, many of the themes identified are likely to be same for them as they were for the women in South East Georgia. The themes identified cover the problems impeding the quality of life for medically uninsured women, the barriers to affording medications, the positive and negative aspects of the Hearts and Hands Clinic, the primary roles impeding their quality of life and the fears and anxieties of healthcare today.

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Appendix A

**JIANN-PING HSU COLLEGE OF PUBLIC HEALTH**

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**INFORMED CONSENT**

My name is Ashlee Charles and I am a Senior Public Health student majoring in Health Education and Promotion Georgia Southern University. I am conducting a research study entitled, “Not so Affordable Healthcare: Ecological Factors Impeding Uninsured Women's Quality of Life.”

The purpose of the research is to identify the current sociological, economic, environmental, political, and cultural factors which impede and promote the quality of life for uninsured women in South East Georgia.. If you agree to participate in this study, you will be asked to participate in a focus group. Each focus group will be audio-recorded. The audio-recording will be used to help gain a deeper understanding of your responses. The audio-recordings of the interviews will only be available to the researchers. No data files or notes taken will show your name or

The focus group will occur at the Hearts and Hands Clinic and will last approximately one hour. A researcher developed focus group guide will be used to guide an open discussion related to health care decisions. The focus group guide was developed using the research literature, input from the Hearts and Hands director, and other faculty experts in public health.

Participation in this study involves no more than minimal risk. Minimal risks include fatigue and physical and emotional discomfort during the interviews and release of confidentiality. You may take breaks throughout focus group session(s) or discontinue participation at any time.

Through participating in the focus group and voicing opinions, researchers will be able to discover what barriers impact medically uninsured women’s quality of life. This information will also help the Hearts and Hands Clinic discover which services are working, what is not working and what improvements can be made to meet the participant’s needs and the needs of other patients.

## NOT SO AFFORDABLE HEALTHCARE

You may feel slight emotional discomfort in discussing your opinions with the researcher. If you feel any discomfort, please remember that your participation in this study is voluntary and you may skip a question or withdraw completely from the study at any time without penalty. If, as a result of your participation in this study you need or want to visit with someone about the sensitive issues which might arise, you may contact a low-cost community based counseling service-Pineland at 912-764-6906.

Please keep in mind that confidentiality is paramount in this study so please feel free to answer honestly. The researchers have no moral or legal obligations to report any answers or information provided to anyone. The participants name will never be used on any recorded information so the data cannot be linked. The participant's information will be assigned a code number. The list connecting your name to this code will be kept in a locked filing cabinet. When the study is completed and the data have been analyzed, this list will be destroyed. The participants name will not be used in any report. The focus group will be audio recorded. The audio recordings of the focus group will only be available to the researchers. The recordings, hard copies of the interview transcriptions, jump drives containing transcribed text, survey responses, and photographs will be stored in a locked web browser and a locked filing cabinet in Dr. Walker's office for a period of seven years. After seven years, all the information will be deleted permanently. Dr. Walker will assign code names during transcription to ensure individual participants' statements remain anonymous. No data files will show your name or other personal identifying information.

You have the right to ask questions and have those questions answered. If you have questions about this study, please contact the researcher named above or the researcher's faculty advisor, whose contact information is located at the end of the informed consent. For questions concerning your rights as a research participant, contact Georgia Southern University Office of Research Services and Sponsored Programs at 912-478-5465.

Incentive for participation: A \$5 gas card.

Participation in the research is voluntary and you may end your participation at any time by telling the person in charge.

There is no penalty for deciding not to participate in the study. If participants don't want to participate further, participants may withdraw without penalty. Participants who complete the focus group will receive a \$5 gas card.

You must be 18 years of age or older to consent to participate in this research study.

NOT SO AFFORDABLE HEALTHCARE

You will be given a copy of this consent form to keep for your records. This project has been reviewed and approved by the GSU Institutional Review Board under tracking number **H16432**.

Title of Project:

Not so Affordable Healthcare: Ecological Factors Impeding Uninsured Women's Quality of Life.

**Principal Investigator:**

Ashlee Charles, Georgia Southern University, PO Box 08555, Statesboro, GA, 30460  
ac07909@georgiasouthern.edu, 706-844-2414

**Other Investigator(s):**

Dr. Ashley Walker, Georgia Southern University, PO Box 8015, Statesboro, GA, 30460, [awalker@georgiasouthern.edu](mailto:awalker@georgiasouthern.edu), 912-478-2477

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

I, the undersigned, verify that the above informed consent procedure has been followed.

\_\_\_\_\_  
Investigator Signature

\_\_\_\_\_  
Date

Appendix B

**The Hearts and Hands Clinic, INC:  
A Volunteers In Medicine Alliance**  
[www.theheartsandhandsclinic.org](http://www.theheartsandhandsclinic.org)



**P.O Box 224  
Statesboro, GA 30459  
(912) 681-9519 – Phone**

**127 North College Street  
Statesboro, GA 30458  
(912) 681-9520 Fax**

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**Letter of Cooperation for Data Collection**

**April 25, 2016**

Human Subjects - Institutional Review Board  
Georgia Southern University  
P.O. Box 8005  
Statesboro, GA 30460

Hearts and Hands Clinic,

Ashlee Charles has requested permission to collect research data from clients at Hearts and Hands Clinic through a project entitled not so Affordable Healthcare: Ecological Factors Impeding Uninsured Women's Quality of Life. I have been informed of the purposes of the study and the nature of the research procedures. I have also been given an opportunity to ask questions of the researcher.

As a representative of Hearts and Hands Clinic, I grant permission to have Ashlee Charles conduct a focus group and is also permitted to collect research data during the clinics operation hours.

If you have any questions, please contact me at 912-681-9519

Sincerely,

***Lena Hudson***  
**Interim Executive Director**

*Provide the name and official  
title of the person who has  
authoritv to arant permission*

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Appendix C

*Hearts and Hands Clinic*

*Focus Group*

*October 12<sup>th</sup> or 14<sup>th</sup> at 10 am*

*Volunteer Sign-Up Sheet*

| Name | Number | What day would you like to attend? |
|------|--------|------------------------------------|
|      |        |                                    |
|      |        |                                    |
|      |        |                                    |
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|      |        |                                    |