

Access to Primary Health Care Services

Definition: Primary health care services are accessible if people can receive essential services when and where they are needed. Insurance enables access. A personal health care provider is the gateway to obtaining services.

Summary

Having a personal doctor or health care provider establishes the link to primary health care that every individual needs. A personal health care provider is responsible for assessing, diagnosing, and monitoring a person's health. About 86% of Washington State children (ages 0–17) had a health care provider in 2003, the most recent year of available data. Four of every five adults ages 18 and older had a health care provider in 2006. The likelihood of having a provider increased among adults with age, and it was greatest for whites.

Having health insurance strengthens access to primary health care. In 2006, about 96% of Washington children had insurance, which included Medicaid. For the population ages 65 and older, insurance covered more than 99% of Washingtonians, due mainly to Medicare. The most critical insurance gap was for adults ages 18–64, among whom only 87% ($\pm 1\%$) reported having insurance when interviewed in 2006. Altogether, nearly 600,000 Washington residents were uninsured at that time.

Interventions to strengthen access to primary health care include all programs that stress the necessity for having a personal health care provider and securing insurance. These include community-based outreach among the uninsured and targeted programs to increase provider willingness to serve low-income clients.

Introduction

Adequate access to health care services occurs when all community residents can access what they need. Access is possible only when health care providers, facilities, and other elements of the health care system are in place. Even when

essential health care services are available, they might not be accessible. First, individuals need a consistent and continuing relationship to the primary care system by way of a health care provider (HCP). The HCP is a personal doctor or nurse who is a source of regular medical care.¹ Second, insurance enables access by providing a medical care plan.

Having insurance and having an HCP support each other to enable access to primary health care. For example, 2004–2006 data from the [Behavioral Risk Factor Surveillance System](#) (BRFSS) show that 82% ($\pm 1\%$) of Washington residents with health insurance reported having an HCP compared with only 41% ($\pm 2\%$) for uninsured adults.

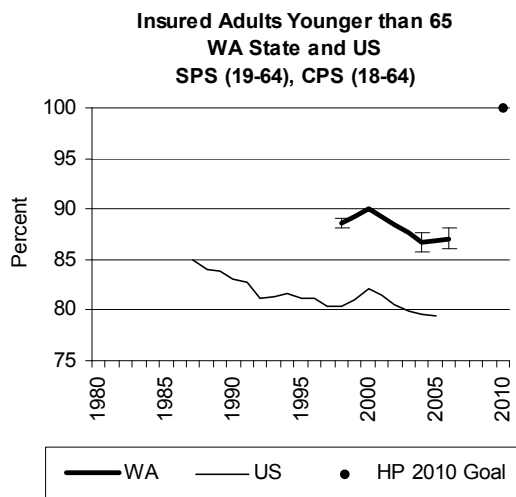
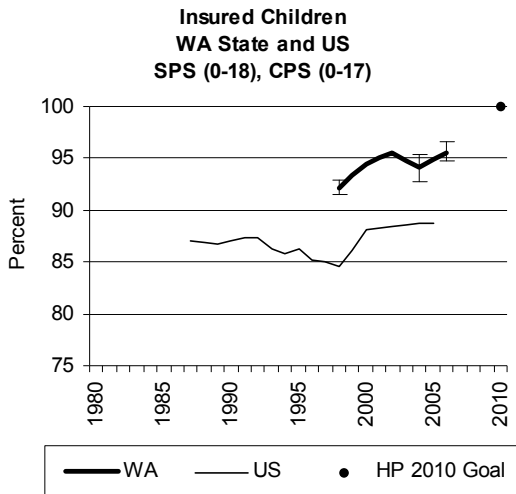
The following sections first provide data on personal HCPs, followed by data on health insurance coverage. The data sources for HCPs are from the 2003 National Survey of Children's Health (NSCH) for children younger than 18 and from the BRFSS for adults ages 18 and older. Data for health insurance coverage come from the Washington State Population Survey (SPS) administered by the Washington State Office of Financial Management, and for national estimates, from the Current Population Survey (CPS) of the U.S. Census Bureau.

Time Trends

Personal HCPs. The 2003 NSCH indicated that about 86% of Washington children had an HCP, which is slightly greater than the national average. In 2006, the BRFSS found that 78% ($\pm 1\%$) of adult Washington residents ages 18 and older had a personal HCP. The percentage of adults with an HCP has been fairly stable since 2000. Trend data are not available for children.

Health insurance. The 2006 SPS showed that nearly 600,000 Washington residents were uninsured. On the positive side, 91% ($\pm 1\%$) of residents reported having health insurance coverage at the time of the 2006 SPS survey.²

SPS data show that the percentage of children with insurance rose from about 92% in 1998 to 96% ($\pm <1\%$) in 2006. The percentage of adults younger than 65 with health insurance rose during the 1990s to about 90% and then declined to 87% ($\pm <1\%$) in 2006. Both trends reflect national trends, and they show a combination of effects, including changes in public insurance programs such as Medicaid and reductions in private, employer-based insurance.

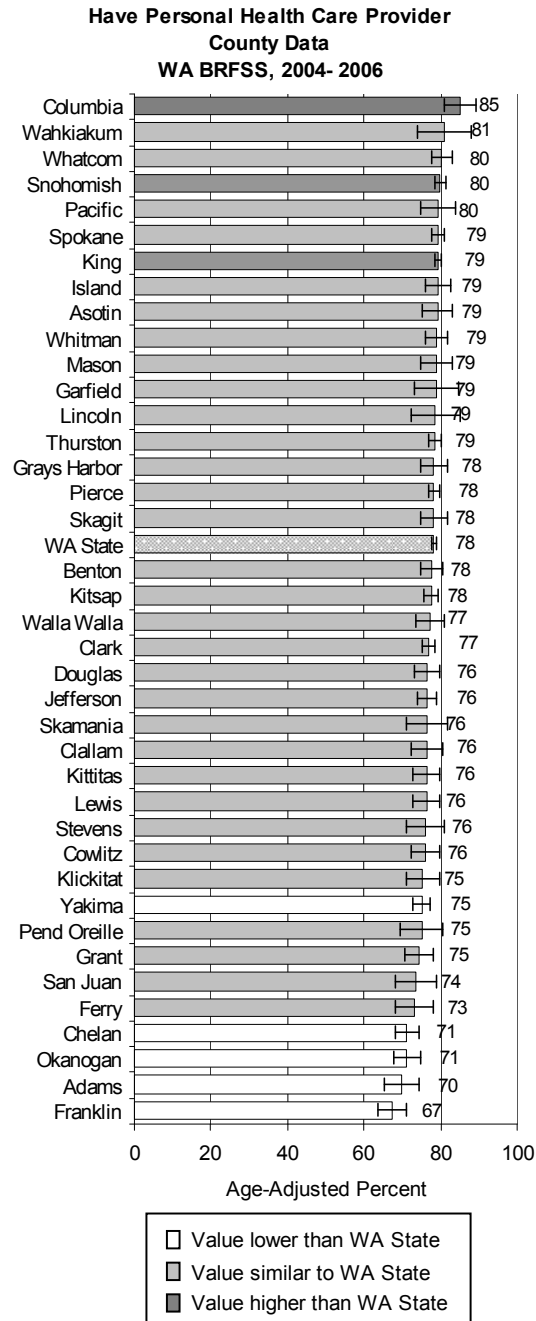


Year 2010 Goals

Personal HCPs. The national *Healthy People 2010* target is that at least 85% of people have a primary care provider. Considering that the percentage of adults with an HCP remained steady at about 78% during 2000–2006, it does not appear that Washington will meet this target.

Health insurance. Another goal is that 100% of people younger than 65 have health care coverage. Judging from the time trends, it appears unlikely that Washington will achieve this level by 2010, except possibly full insurance coverage for children.

Geographic Variation



Personal HCPs. According to BRFSS data for 2004–2006, the share of Washington adults with a personal HCP is significantly higher than the state

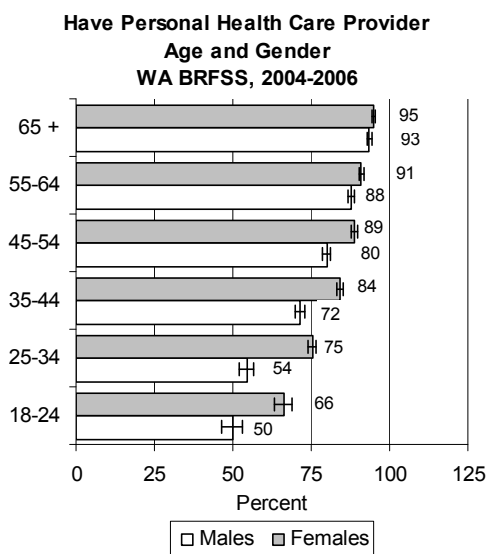
average for King, Snohomish, and Columbia counties and significantly lower for Yakima, Chelan, Okanogan, Adams, and Franklin counties.

The Washington State Office of Financial Management classifies all low-HCP counties as rural while high HCP counties are urban except Columbia County. The two lowest HCP counties are also the counties with the highest concentration of people of Hispanic origin.

Health insurance. Washington SPS data do not support health insurance estimates by county.

Age and Gender

Personal HCPs. Based on BRFSS results for 2004–2006, adult women are more likely to have a personal HCP than adult men.



The NSCH shows that about 86% of children ages 0–17 had a personal HCP in 2003. The proportion drops sharply for young adults but then gains with age, according to BRFSS data for 2004–2006. Approximately 50% of men and 66% of women ages 18–24 had a personal HCP compared with more than 90% for both men and women ages 65 and older. Having a personal HCP was strongly associated with age.

Age differences in having a personal HCP are primarily due to the high rates of insurance coverage for children and adults ages 65 and older compared with lower rates for adults ages 18–64.

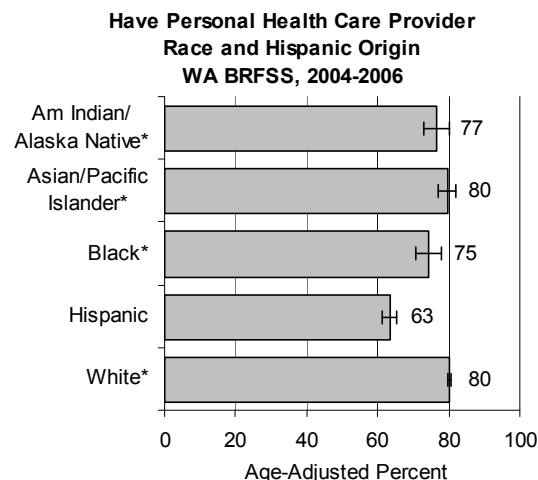
Health insurance. SPS data for 2006 show higher coverage rates for children ages 0–17

(96% \pm 1%) and adults ages 65 and older (100% \pm 1%) than adults ages 18–64 (87% \pm 1%).

Age differences in health insurance coverage are primarily due to the high rates of public insurance coverage for children and the elderly. Young adults are the least likely to have health insurance. National analyses sponsored by the Henry J. Kaiser Foundation explain that as young adults transition into the workforce, they are often not eligible for employer-based coverage.³ As they get older, they are more likely to have health care coverage, and once they reach age 65, they qualify for Medicare. At the youngest ages, an increasing number of children are insured because of the expansion of publicly subsidized programs such as the State Children’s Health Insurance Program.

Race and Hispanic Origin

Personal HCPs. NSCH data for 2003 indicate that the percentage of children having a personal HCP was largest for Asian and Pacific Islanders and whites (about 94% and 88% respectively) and smallest for children of Hispanic origin (about 71%).



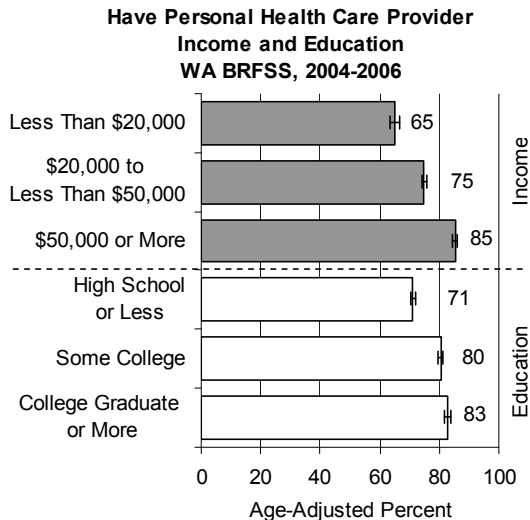
*Non-Hispanic

Among adults 18 and older, BRFSS data for 2004–2006 reported that the proportion having an HCP was greatest for whites (80% \pm 1%) and lowest for people of Hispanic origin (63% \pm 2%). In between, the proportions were 80% (\pm 4%) for Asian and Pacific Islanders, 77% (\pm 4%) for American Indians and Alaska Natives, and 75% (\pm 4%) for blacks. Several national studies also found that racial and ethnic minority groups are less likely to have a usual source of care.⁴

Insurance coverage. The SPS does not give statistically acceptable insurance coverage rates by race and ethnicity due to sampling methods.⁵

Income and Education

Personal HCPs. Based on BRFSS data, the proportion of adults in Washington with a personal HCP in 2004–2006 increased significantly with education, from 71% ($\pm 1\%$) for those with high school or less to 83% ($\pm 1\%$) for college graduates.



There is also a significant association between having a personal HCP and income. BRFSS data for 2003–2005 reported that 65% ($\pm 2\%$) of people with annual household incomes of less than \$20,000 had an HCP compared to 85% ($\pm 1\%$) of those with incomes greater than \$50,000.

Health insurance. According to SPS data for 2006, adults with higher incomes were also more likely to have health insurance. Twenty-three percent ($\pm 2\%$) of adults with low household incomes (below 100% of the Federal Poverty Level—FPL) lacked health insurance, compared to 4% ($\pm 1\%$) of individuals with higher incomes (more than 300% of the FPL). The proportion of children with health insurance also increased with income, according to NSCH data for 2003. But this association occurs only for children with household incomes of more than 200% of poverty because below that level, public programs for children provide nearly complete coverage.

Health Effects

While health care is not the only determinant of health status,⁶ those with a usual source of health care and insurance are more likely to receive a variety of preventive health care

services. The benefits include more effective diagnosis, care management, continuity of care, and often, less costly medical care.^{7, 8} The uninsured and those with no HCP are also more likely to use emergency departments, be hospitalized for potentially avoidable health conditions, be diagnosed with late-stage cancer, and in the case of pregnant women, to delay receiving prenatal care.⁹

Barriers and Motivations

Barriers to receiving primary health care can include limited financial coverage or other economic issues, fragmentation in providing and paying for health care services, lack of appropriate and willing providers, language, health practices and beliefs, location and transportation, and attitudes toward health care providers and governmental authority.¹⁰ Positive motivations can include knowledge, previous successful experience, trusted relationships with health care providers or other health advisers, and the desire to care for one's family.

Geographic access and transportation. An estimated 13% of the state's population lives in areas not served by any form of public transportation.¹¹ Weather-related closures and long distances to health care services can isolate rural populations.

Limited English proficiency. Limited English proficient residents of Washington¹² often face language barriers that influence access to care or the quality of the care received. Federal law prohibits health care providers who receive federal funds from discriminating against patients based on language or nationality, but private medical providers must bear the costs of interpreters.

The 2005 American Community Survey estimated that about 4% of households in Washington State were linguistically isolated.¹³ Isolation means that no one ages 14 or older in the household speaks English "very well." For Spanish-speaking households, the share was approximately 28%.

Other Measures of Impact and Burden

Lack of insurance has economic as well as health impacts. The state Office of the Insurance Commissioner reported in 2004 that health care providers and the insurance-buying public collectively paid more than \$318 million for uncompensated care largely resulting from lack of insurance coverage.¹⁴

Risk and Protective Factors

Medical expenditure increases and cost containment responses. Health care cost inflation in the United States consistently outpaces growth in the Gross Domestic Product. Employers who provide health insurance must decide how to deal with rising costs. Choices include absorbing cost increases, reducing or eliminating coverage for employees, or passing more costs to them via premiums and co-payments. The proportion of adults younger than 65 in Washington who receive employer-based health insurance declined from about 71% in 1993 to about 67% in 2006.¹⁵ From 1998 to 2003, the proportion of employees eligible for insurance and the “take-up rate” (percent of those eligible who enroll) both declined.¹⁶

Migrant and seasonal farm workers. In 2000, about 289,000 migrant and seasonal farm workers and dependents lived in Washington.¹⁷ These workers and their families often lack a personal HCP or insurance for reasons including low family income, language barriers, frequent moves, immigrant documentation issues, and limited transportation. Most rely on Community and Migrant Health Centers for care.¹⁸

Near-poor with health conditions. Despite their greater need for health care, people whose health is fair or poor are more likely to be uninsured than those who report being in good or excellent health.¹⁹ Many people with permanent disabilities can obtain insurance coverage through Medicare or Medicaid. But some people in poor health do not have a qualifying disability or have financial assets that disqualify them from Medicaid. They can seek individual coverage from the Washington State Health Insurance Pool, although high deductibles and expensive monthly premiums deter low-income individuals.²⁰

Intervention Strategies

Targeted programs to increase provider willingness to serve low-income clients. A good example of such programs is the Access to Baby and Child Dentistry (ABCD) initiative, which provides enhanced reimbursement to dentists who treat children on Medicaid. The program provides training for dentists on how to work with low-income patients and educates low-income patients about preventing dental disease and the need to keep appointments. Program evaluations show immediate improvement in dental access.²¹

Community-based outreach. More than 45,000 low-income Washington children and 350,000 adults were uninsured in 2006 but potentially eligible for state-subsidized insurance coverage through the Basic Health Plan.¹⁵ Evaluations show that face-to-face, individualized outreach and enrollment assistance can increase enrollment in public coverage.²² Several communities in Washington State operate programs to assist people in signing up for programs for which they qualify. For example, the Children’s Alliance in partnership with the Washington Health Foundation works with school districts to identify and enroll eligible children in Medicaid and the State’s Children’s Health Insurance Program.²³ The foundation also gives similar services to adults under the Community Health Access Program.²⁴

Expanding public programs. In Washington, the expansion of state-subsidized coverage for children from 2000 to 2006 reduced the number of uninsured. The 2006–2007 Washington Legislature passed a promising bill with provisions to increase access and coverage based on the recommendations of the governor’s Blue Ribbon Commission on Health Care Costs and Access.¹⁵ Future federal funding restrictions and eligibility rules, however, are a risk.

State efforts to reduce health care costs or make health care more cost-effective. Current Washington efforts to reduce costs include the Health Technology Assessment Program, which sets guidelines on whether new technologies will be covered by health care programs, and the Prescription Drug Program, which provides prescription drug coverage to all residents who do not have full coverage. Both programs operate under the Health Care Authority. Even though these programs are new and their effectiveness should be evaluated, they promise the development of shared, evidence-based approaches for state agencies to purchase health care.

See Related Chapters: [Health Care Services Infrastructure](#) and [Medical Homes for Children and Adults](#)

Data Sources

Current Population Survey (CPS), 1987–2005. U.S. Census Bureau.

National Survey of Children’s Health (NSCH), 2003. U.S. Centers for Disease Control and Prevention.

Washington State Behavioral Risk Factor Surveillance System (BRFSS): 2000–2005.

Washington State Population Survey (SPS), 1998, 2000, 2002, 2004, and 2006. Office of Financial Management.

For More Information

Office of Community and Rural Health, Health Systems Development Section, (360) 236-2800
<http://www.doh.wa.gov/hsqa/ocrh>

Technical Notes

Personal health care provider: The BRFSS survey has included a question on “personal health care provider” since 2001. Three years of data (2004, 2005, and 2006) were combined for current demographic estimates. The data source for personal health care provider for children (ages 0-17) is the one-time 2003 National Survey of Children’s Health, which asked about the child’s “personal doctor or nurse” in Washington State.

Health insurance coverage: A technical review of data sources for Washington concluded that the State Population Survey (SPS) offers the most complete and precise estimates of coverage for the state as a whole and for substate areas. The SPS includes children (unlike the BRFSS). National insurance coverage estimates are from the Current Population Survey (CPS) of the U.S. Census Bureau. The CPS and SPS insurance coverage estimates are not directly comparable because the SPS asks about current insurance status whereas CPS asks if a person was uninsured in the prior year. Nonetheless, the CPS is the best available data for national comparisons.

Endnotes

¹Zeni, M. B., Sappenfield, W., Thompson, D., & Chen, H. (2007). Factors Associated With Not Having a Personal Health Care Provider for Children in Florida. *Pediatrics*, 119(1), S61-S67.

²Gardner, E. (2006, November). *The Uninsured Population in Washington State*. 2006 Washington State Population Survey, Research Brief No.39 (Revised). (2006, December). *Characteristics of the Uninsured: 2006*. Washington State Population Survey, Research Brief No. 41. Olympia, WA: Washington State Office of Financial Management.

³Kaiser Commission Medicaid and the Uninsured. (2004, July). *Employer-Sponsored Health Insurance Coverage: Sponsorship, Eligibility, and Participation*. Retrieved October 19, 2007 from <http://www.kff.org/uninsured/upload/Employer-Sponsored-Health-Insurance-Coverage-Sponsorship-Eligibility-and-Participation-Patterns-in-2001-Full-Report.pdf>.

⁴Washington State Board of Health. (2001, May). *Final Report: State Board of Health Priority: Health Disparities*. Olympia, WA: Washington State Board of Health.

⁵Gardner, E. (2007, January). *Health Insurance by Race/Ethnicity: 2006*. Washington State Population Survey, Research Brief No. 42. Olympia, WA: Washington State Office of Financial Management.

⁶Pincus, T., Esther, R., DeWalt, D. A., & Callahan, L. F. (1998). Social conditions and self-management are more powerful determinants of health than access to care. *Annals of Internal Medicine*, 129, 406-411. *Healthy People 2010* (next footnote) says that 70% of premature death is due to individual behavior and environmental factors.

⁷U.S. Department of Health and Human Services. (2000, November). *Healthy People 2010: Understanding and Improving Health* (2nd ed.). Washington, DC: U.S. Government Printing Office. Discussion of Objectives 1-4 and 1-6.

⁸Institute of Medicine and Board on Health Care Services. (2002). *Care Without Coverage: Too Little, Too Late*. Washington, DC: National Academy Press.

⁹Institute of Medicine and Committee on the Consequences of Uninsurance. (2001). *Coverage matters: insurance and health care*. Washington, DC: National Academy Press.

¹⁰Robert Wood Johnson Foundation. (n.d.). *Opening doors: A program to reduce sociocultural barriers to health care. Grant results*. Retrieved January 5, 2007 from <http://www.rwjf.org/portfolios/resources/grantsreport.jsp?filename=opendoorse.htm&iid=144&gsa=1>.

¹¹Washington State Transit Association and Community Transportation Association of the Northwest. (2004, October). *The Washington State Transportation Plan: The role of public transportation*. Retrieved December 5, 2006 from <http://www.wsdot.wa.gov/NR/rdonlyres/54348A78-1EED-495D-AD03-E4578376B2D0/0/PublicTransportation.pdf>.

¹²LEP is defined here as speaking English less than “very well.”

¹³U.S. Census Bureau. 2005 American Community Survey, Table C16001. Retrieved May 14, 2007 from http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuid=datasets_2&_lang=en.

¹⁴Results of this study were reported in eight regional reports on “What the uninsured are costing you,” published in August 2004. Retrieved December 5, 2006 from <http://www.insurance.wa.gov/special/coverwashington/WhoPaysFortheUninsured.asp>.

¹⁵Wilson, V. (2006, October 27). *Presentation to Blue Ribbon Commission on Health Care Costs and Access. Washington State Planning Grant, Access to Health Insurance Project*. Retrieved December 27, 2006 from <http://www.leg.wa.gov/documents/joint/HCCA/Uninsured%2010-27%20Wilson%20OFM.pdf>.

¹⁶Washington State Office of Financial Management. (2005, October). *Employer health insurance data book. Forecasting Division*. Olympia, WA: Washington State Office of Financial Management.

¹⁷Larson, A. C. (2000, September). *Migrant and seasonal farm worker enumeration profiles study: Washington*. Bethesda, MD: U.S. Department of Health and Human Services, Bureau of Primary Health Care. This was a one-time special enumeration.

¹⁸Kaiser Commission on Medicaid and the Uninsured. (2006, April). *Key Facts: Medicaid and Ship Eligibility for Immigrants*. Retrieved October 19, 2007 from <http://www.kff.org/medicaid/upload/7492.pdf>.

¹⁹Gardner, E. (2005, September). *Health Insurance by Race/Ethnicity: 2004*. Washington State Population Survey, Research Brief No. 37. Olympia, WA: Washington State Office of Financial Management.

²⁰Monthly premiums vary by age, but for a 50-year-old they range in 2007 from \$975 per month (\$500 deductible, and 20% coinsurance with choice of any health care providers) down to \$240 per month (for a \$5000 deductible plan with 40% coinsurance unless you use a preferred provider).

²¹ Kobayashi, M., Chi, D., Coldwell, S. E., Domoto, P., & Milgrom, P. (2005). The Effectiveness and Estimated Costs of the Access to Baby and Child Dentistry Program in Washington State. *Journal of American Dental Association*, 136, 1257-1263; Milgrom, P., Hujoel, P., Grembowski, D., & Fong, R. (1999, November-December). A community strategy for Medicaid child dental services. *Public Health Reports*, 114(6), 528-532; and Lam, M., Riedy, C. A., & Milgrom, P. (1999). Improving access for Medicaid-insured children: focus on front-office personnel. *Journal of the American Dental Association*, 130(3), 365-373.

²²Kaiser Commission on Medicaid and the Uninsured (2006, April). *Outreach strategies for Medicaid and SCHIP: An overview of effective strategies and activities*. Retrieved January 5, 2007 from <http://www.kff.org/medicaid/upload/7495.pdf>; and Ringold, D. J., Olson, T. M. P., & Leete, L. (2003, July). *Managing Medicaid Take-Up. CHIP and Medicaid Outreach: Strategies, Efforts and Evaluation*. State University of New York (Albany). The Nelson A. Rockefeller Institute of Government. Federalism Research Group. Retrieved January 5, 2007 from <http://www.rockinst.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=6946>.

²³ Children's Alliance. Retrieved May 23, 2007 from <http://www.childrensalliance.org/whatwedo/outreach.cfm#outreach>.

²⁴ Washington Health Foundation. Retrieved October 19, 2007 from <http://www.whf.org/Programs/chap.aspx>.