Access to Essential Health Services

Definition: "Essential health services" are primary health care, short term general hospital care, prenatal and postpartum care for uncomplicated births, pharmacy services, and emergency medical services. Access to such services is affected by such factors as time, transportation, geography, distance, socioeconomics , language, and culture.

Summary

In 1994, 84.3% (±1.3) of adults in Washington had at least one regular source of primary health care, according to the Washington State Behavioral Risk Factor Survey. There are problems with access for the working poor and uninsured, particularly those who are isolated by geographic, linguistic, and cultural factors.

For the state as a whole, 98% of the population live within 30 minutes of general acute hospitals; however, there are 35 census divisions in twenty rural counties whose population is beyond 30 minutes.[1]

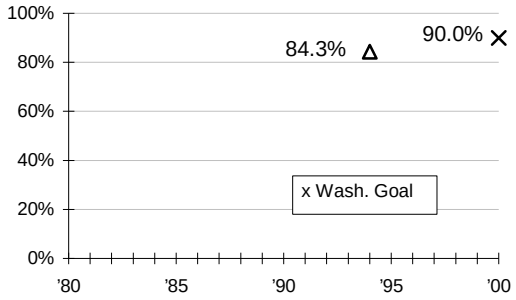
Eight rural hospitals do not provide obstetric services. Six of these are in eastern Washington, yet there is only one childbirth center east of the Cascades to lessen the travel distance for birthing.

Especially vulnerable are seven rural towns that contain hospitals with the only pharmacist in town doubling as the hospital pharmacist and local retailer.[2]

In 1994, 83.3% of the population lived in an area served by public transit; however, fifteen rural counties had none.[3]

64,625 persons age 18 and over (about 1.5% of the total adult population) responded to the 1990 Census that they do not speak English very well or at all.

Percent of Adults With a Usual Source of Primary Health Care
with Year 2000 Goal



Time Trends

The number and utilization of publicly subsidized health centers providing primary health care to the low income population has increased steadily over the past two decades. Currently, many local public health jurisdictions are trying to focus more on core public health functions and population-based preventive services. In some areas this means that there is less emphasis on providing primary care services.

Due to mergers and conversions, the number of general acute hospital beds has decreased by 1,036 in the past ten years. Mount Linton Hospital in rural Pend Oreille County closed completely; the financial stability of some other rural hospitals is tenuous.[4]

The number of chain store and mail order pharmacies are increasing and neighborhood pharmacies are decreasing. The impact on access to and quality of pharmacy services is undetermined.

Obstetric care for low income women became more accessible as Medicaid's First Steps Program broadened eligibility and increased payment to practitioners and hospitals.

Year 2000 Goal

The only Year 2000 access goal for essential health services addresses primary health care. The national goal is that at least 95 percent of the population will have a specific source of ongoing primary care for coordination of their preventive and episodic health care. In 1991 the national baseline for adults was 80%.

Washington's goal is for at least 90% of adults to have at least one usual source of primary care. The goal focuses on adults because they are the population surveyed in the Behavioral Risk Factor System Survey (BRFS), the state's main source of data on this subject. In 1994, 84.3% of the adult population had at least one regular source of primary care.

Race and Ethnicity

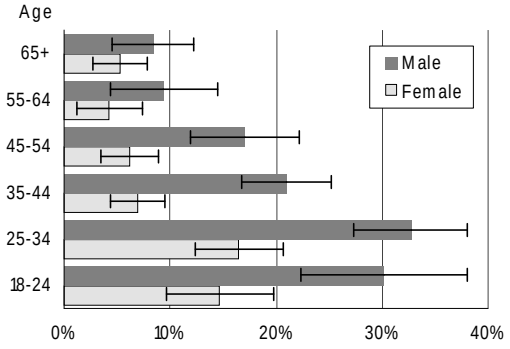
For the BRFS survey, the difference between responses of the white and non-white population was not statistically significant.

Groups of Particular Interest

Age and Gender: According to Washington's 1994 Behavioral Risk Factor Survey (BRFS), 15% of the adult population did not have a regular source of primary care. Younger adults, especially the 25-34 age group, were most likely to not have a source of care.

For the adult population under age 55, the proportion of males without a usual source of care was significantly higher than that for females. For the total population, the survey showed that 21.4% of all males and 9.4% of all females reported no usual source of primary health care.

Adults With No Usual Source of Primary Health Care
by Age and Gender, Wash., 1994



The Poor: The BRFS survey asked why the respondent had no usual source of primary health care. Of those who answered the question, 55% said they did not need a doctor, and 16% said they could not afford one. The numbers indicating no need suggest that primary care is perceived as a source of treatment more than prevention. Another BRFS survey question showed that 11% of the adult population had needed but not seen a doctor during the previous twelve months because of cost.

Hospitalization for conditions that are potentially avoidable with adequate and timely care (ambulatory care sensitive conditions) can be an indicator of accessibility. One study compared hospital admission rates of these diseases in low and high income neighborhoods and determined that adults living in low income neighborhoods are about three times more likely to be hospitalized for ambulatory care sensitive conditions, particularly asthma and bacterial pneumonia.[5]

People with Disabilities: Children with special care needs and disabled people of any age have special problems accessing primary care. Most physicians in rural areas are generalists and may not be trained in delivering services to the special needs population. Also, insurance that contracts to cover a specific population for a fixed premium may not be capable of absorbing significant financial risk that chronic disabilities bring. The average cost per Medicaid recipient for a disabled child age one through five is 11.7 times greater than that for a non-disabled child.[6]

American Indian /Alaska Native Population: This is the smallest subpopulation group in the state. The 1990 Census showed 77,627 American Indians and 3,856 Alaska Natives residing in Washington state, a total of 81,483. Between the two, American Indians are the poorer, with 53% of their population living below 200% of the federal poverty level.

Members of federally recognized tribes get services through complex health care arrangements including Indian Health Services (IHS), tribally-operated clinics and programs, contract health services for hospitalization and specialty care, urban Indian health care programs, and private providers. Access to primary care is affected by several unique issues: eligibility criteria, IHS funding that is below the level of need, and the lack of IHS or tribally-operated hospitals and specialty care services in the state.

Migrant-Seasonal Farmworkers: According to federal estimates, the migrant farmworker population in Washington state peaks at 175,600; the seasonal farmworker population at 266,800.[7] Both estimates include dependents. A work group of the Washington Health Services Commission used the estimate of 201,000 seasonal workers and adult dependents in need of health coverage.[8] The group assumed that expansion of Medicaid would cover the children.

Migrant and seasonal farmworkers are generally low wage employees and many do not work a full year. Eighty percent are Hispanic. The transient lifestyle of migrant farmworkers and their families makes it impossible for them to maintain continuity in health care.

Access Barriers

Geographic: People living in rural areas often face a shortage of providers, mountain roads, and longer distances, combining to cause more travel to receive health care. In urban areas, traffic congestion and complex public transit routings can be barriers to seeking care. Populations concentrated on islands in Puget Sound present problems in geographic access seldom experienced by other states.

Linguistic and Cultural: 64,625 persons age 18 and over responded to the 1990 Census that they do not speak English very well or at all. Spanish was the language most often spoken in the home. Counties where migrant farmworkers have "settled out" are the ones most in need of Spanish-speaking health professionals. In Yakima County, 35% of the Hispanic population do not speak English well or at all. Urban neighborhoods are experiencing an influx of refugees and immigrants. In King County, 20% of the Asian/Pacific Islander population do not speak English well or at all.

Ideally, services must be available in the person's language or interpretation services need to be made available for medical consultation and appointment times.

Groups with strong cultural cohesion choose services consonant with their belief system, if they have a choice. Some of the small health programs for American Indians/Alaskan Natives do not provide prenatal care on site but make referrals to the larger community. Some women choose to forego prenatal care rather than go outside the tribal clinic.

Transportation: In 1994, 83.3% of the state population lived in areas served by public transit. The eleven urban counties have 90% coverage.[9] In the 28 rural counties of the state, 53% of the population was served by public transit. Even so, its existence in rural counties does not imply scheduling that accommodates use for medical appointments. Fifteen rural counties had no public transit.

Despite creativity, expense and use of human service agencies' volunteers, categorical transportation programs for selected clients still is a primary concern in geographic areas.

Intervention Points, Strategies, and Effectiveness

Much effort is going into making essential health services geographically accessible to all people in Washington state. The Legislature has supported activities to strengthen the health care delivery system and provide incentives for health personnel to practice where they are most needed. Diminishing resources require effective program implementation and continued examination of alternatives to create access to health services in the most remote parts of the state.

System Design/Capacity: System design should include services which are culturally and linguistically appropriate; operate when people are not working; are accessible to the disabled; accept appointments without an unreasonably long waiting period; and are sensitive to individual needs related to gender, sexual orientation, confidentiality, religious beliefs, cultural practices, and differing abilities to understand and cope with the health care system.

The State Health Care Authority recommended a structure for reimbursement of specific enabling services such as those above be developed and maintained.[10] The former Washington Health Care Commission recommended the state use a coordinated effort which would empower communities to respond to specific access barriers as they arise.[11] The National Rural Health Association advocates that Medicare ensure managed care organizations provide enrollees reasonable geographic access to services by including primary care services within the lesser of 30 minutes or 30 miles from their place of residence if enrollees live in a rural area, unless exceptions are approved by the Secretary of the Department of Health and Human Services. The State Insurance Commissioner's evaluation of managed care insurance plans could include access criteria.

Development of networks such as physician/hospital organizations (PHOs) and physician/hospital/community organizations (PHCOs) unites local resources in strategic ways to stabilize supply and preserve access. In the future, provider service organizations (PSOs), if approved by Congress, could be a boost to stability by allowing PHO type networks to function as insurers rather than trying to achieve stability by imposing provider-contracting criteria on plans.

The legislature funded an American Indian Health Care Delivery Plan to be developed by the State Department of Health in collaboration with the Tribes and Indian Health Service. Strategies to improve the health care delivery system for American Indians and Alaska Natives will be identified in the plan and integrated with other planning efforts such as the Health Personnel Resource Plan and the Public Health Improvement Plan.

Data on ambulatory health care, perhaps through the Health Plan Employer Data and Information Set (HEDIS) or a similar instrument, would provide critical information for evaluation of access issues. The HEDIS report card for managed care plans is a national standardized data set measuring access and quality. Initially HEDIS is collecting information on the insured and employed populations, with the next HEDIS to target the Medicaid population.

Primary Health Care: The Availability of Health Care section of this document describes programs to recruit practitioners to serve in shortage areas.

To encourage rural health clinics to participate in managed care contracts, the State Medical Assistance Administration has provided them an enhanced rate for taking this risk in 1996.

The community and migrant health centers have developed a statewide health maintenance organization, Community Health Plan of Washington, to directly participate in managed care.

Short-Term General Hospitals: Various proposals are being made at the national level to assure continuance of rural hospital services in some form. The Essential Access Community Hospital/Rural Primary Care Hospital Program allows limited inpatient services for up to 72 or 96 hours, respectively. These alternatives build networks of hospital services, linking local services with other referral services, assuring appropriate access for ambulatory, emergency, and inpatient care. The alternative models are reimbursed on a reasonable cost basis rather than the usual fixed rate.[12]

Washington state has available an alternative model, the Rural Health Care Facility, which envisions a network of services providing limited inpatient, low risk obstetrics, 24-hour emergency, laboratory and radiology services. Medicare conditions of participation do not recognize Washington's alternative as eligible for inpatient reimbursement, so no Rural Health Care Facilities have yet been established.

Prenatal and Postpartum Care for Uncomplicated Births: The First Steps Program has demonstrated models that help improve geographic access through its Alternative Maternity Care Clinics staffed by nurse practitioners-certified nurse midwives and by providing transportation services.

Transportation: In 1989 the State Department of Social and Health Services' Medical Assistance Administration began a non-ambulance transportation program for Medicaid patients traveling to approved health services. This plan has been expanded to include eligible clients of the Offices of Mental Health Services, Aging and Adult Services, Disability Insurance, and Adoption Support. Limited transportation is also funded to Area Agencies on Aging.

The 1992 Legislature established a Rural Mobility Grant Program, administered by the Washington Department of Transportation. It is intended to increase and improve access to basic services for people in rural communities. Where rural communities with a demonstrated need have inadequate or no services, it provides a chance to implement public transportation. In 1995, twenty three projects were chosen, mostly public transportation-related, serving seniors, people with special needs, and those who are most isolated from basic services.

For More Information

Office of Community and Rural Health, State Department of Health, (360) 705-6764.

Endnotes:

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[1] *Rural Access to Medical Care in Washington State,* State Health Coordinating Council, October 1986.

[2] *Unpublished,* Board of Pharmacy, State Department of Health, December 1995.

[3] *Public Transportation Systems in Washington State,* State Department of Transportation, 1994 Summary.

[4] *Medical Service Area Profiles of Southwest Washington Counties,* Choice Regional Health Network, June 1996.

[5] *Access to Health Care: Key Indicators for Policy,,* prepared by Center for Health Economics Research for the Robert Wood Johnson Foundation, November 1993, page 67.

[6] Presentation by John B. Coombs, M.D., *Serving Children with Special Health Care Needs in Rural Areas: Issues and Approach,* May 5, 1995.

[7] *An Atlas of State Profiles,* Department of Health and Human Services, Public Health Service, 1990.

[8] *Seasonal Employee Health Insurance: Analysis and Recommendations*: *Report to Governor Mike Lowry,* Seasonal Workers' Health Benefits Work Group of the Washington Health Services Commission, December 17, 1993.

[9] *Public Transportation Systems in Washington State,* State Department of Transportation, 1994 Summary.

[10] *Primary Care Access Study,* Washington State Health Care Authority submitted by SLR Health Care Consultants and Architects Inc., November 4, 1994, Recommendation #2.

[11] *Final Report to Governor Booth Gardner and the Washington State Legislature,* Washington Health Care Commission, November 30, 1992, Recommendation #3.3.

[12] *The Next Generation of Limited-Service Rural Hospitals,* Daniel M. Campion, Alpha Center, October 1995.