Status Report

Access to Critical Health Services, Phase II (2001-2003)

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EXECUTIVE SUMMARY

The Washington State Board of Health (the Board) identified "access to critical health services" as a priority for Washington State in 2000 and agreed to define access for use within the Public Health Improvement Partnership's (PHIP) *Public Health Standards for Washington State* and for broader state health policy purposes. That work was completed in 2001, and the *Menu of Recommended Critical Health Services for Washington State Residents* was published. After determining that collecting one-time, statewide data on access to the *Menu's* services might not be cost-effective, the Board decided to promote use of the *Menu* by public purchasers and by local health jurisdictions in the context of the PHIP's standards. This is a progress report on the Board's 2002 work plan to accomplish those goals. The key findings of this report are summarized below:

- In the medical literature, there is growing evidence that access to a wide range of public health, clinical preventive, primary, secondary, tertiary and chronic care services improves health outcomes; lack of access is associated with poor outcomes.
- Access to health services is a high priority for most Washington residents, but, following the events of September 11, it is not as high a priority as emergency preparedness and the economy.
- Access to health care remains inadequate for many Washington residents due to gaps in insurance coverage, a rise in the number of uninsured, and erosion of the health-care provider safety net.
- Double-digit increases in health-care costs continue to overwhelm private employers, insurers, and public budget writers. They have responded to these challenges by cutting provider reimbursements, reducing coverage comprehensiveness, and shifting toward consumer-driven health care. These trends in health-care financing will likely lead to further access problems for Washington's residents.
- Since 1995, and extending through 2005, the Board has reaffirmed the importance of promoting access to a core set of critical health services that are necessary to protect the public health.
- The Board and PHIP developed the *Menu* during the Phase I (2000-2001) efforts to improve access to critical health services. In the medical literature, the evidence base for the *Menu* continues to grow. The methods for setting health service "priorities" are also improving and, in some instances, clearly indicate that the relative cost-effectiveness of certain interventions do not equal that of others.
- The Board's Phase II work plan for improving access to critical health services called for promoting the *Menu* and the intellectual approach upon which it was based within local health jurisdictions and to state purchasing and regulatory agencies.
- Although many of the tasks in the Phase II work plan have been completed, service program examples have been implemented, and policy initiatives in state

government that are consistent with the *Menu* have been developed, the *Menu* itself has not been widely adopted by state purchasing and regulatory agencies.

This report discusses the continued efforts of the Board to ensure that all Washington residents have access to critical health services. This report also provides a detailed analysis of the context within which these efforts take place and guides recommendations for further efforts to improve access on several levels.

RECOMMENDATIONS

The Conclusions section of the main report discusses the rationale behind the following recommendations.

1. Public Health Improvement Partnership

1.1 Consider creating a new Committee on Access to Critical Health Services within the PHIP to review the feasibility of the current PHIP access standards, identify ways to enhance the sharing of "best practices" by local health jurisdictions (LHJs), coordinate access data collection across public and private organizations, and determine the need for additional work to update the research and articulation of the *Menu*.

1.2 Consider including tribal governments, the Washington Health Foundation (WHF), the Washington State Medical Association, the Washington State Hospital Association, and the Washington Association of Community and Migrant Health Centers in the newly created PHIP Committee on Access to Critical Health Services.

1.3 Continue disseminating information about state, federal, and private funding for access promotion projects to LHJs.

1.4 Encourage LHJs to collaborate with the WHF as one of the primary local partners for WHF's planned forums on health and health-care priorities in each county of the state.

1.5 Encourage tribal health clinics or any other willing community provider groups that now exist in rural or medically underserved areas to expand their eligibility to include care of Medicare, Medicaid, Basic Health Plan, privately insured, or uninsured patients.

2. Local Health Jurisdictions

2.1 Build local coalitions around access issues with local health leaders and area businesses.

2.2 Use data on access to inform any local community mobilization efforts to promote access.

2.3 Provide support to community groups that are interested in applying for federal, state or private funds to expand access to critical health services.

2.4 Consider accepting the offer of the WHF to serve as the primary local partner for public forums on access in each county of the state.

3. Public Medical Care Purchasing Agencies

3.1 Expand the use of the *Menu* and other evidence about efficacy, safety, and quality to guide "value-based" purchasing of health-care services for the residents of Washington.

3.2 Be sure to give equal weight to evidence about the efficacy and public health value of mental, behavioral, and dental health services, when designing benefits packages for enrollees.

4. State Department of Health

4.1 Continue using the Office of Community and Rural Health and the Health Provider Shortage Area Survey data to generate funding through Health Resources and Services Administration (HRSA) grants and achieve Rural Health Clinic status for area clinics.

4.2 Provide information to the WHF so that they can include it in a statewide assessment of access to critical health services (PHIP Standard 1.6.1: Access to Critical Health Services).

5. Private Foundations

5.1 The Washington Health Foundation should consider assisting the Washington State Department of Health (WSDOH) in implementing the PHIP standards (that now call for a WSDOH role in access to critical health services) by modifying County Health Profiles to include available information from the WSDOH, community clinics, LHJs, willing health carriers, and other sources on receipt of critical health services (PHIP Standard 1.1:The Availability of Critical Health Services).

6. Local Health Provider Organizations

6.1 Consider sharing information with local health jurisdictions, the WHF, and others that document the need for federal state or private resources to provide expanded access to critical health services.

6.2 Collaborate with other local health provider groups, local boards of health, and local hospital jurisdictions to assure access to critical health services.

7. Legislators

7.1 Consider a periodic reappraisal of all current health insurance mandates using updated evidence on efficacy, quality, safety, value, and other criteria. Such a process might be similar to the one already authorized for studying new mandated benefits proposals (Chapter 48.47 RCW).

8. Washington Residents

8.1 Consider two important questions: "Can we afford the health-care choices that we want?" and "Are there any health-care services, other than immunizations, that government should take steps to guarantee for all residents?"

1. INTRODUCTION

The Washington State Board of Health (the Board) has a long-term interest in promoting access to health care for the residents of Washington State. Beginning in 1995, the Board began collaborating with the Public Health Improvement Partnership (PHIP)[1] to improve access on the state and local level. By 2001, the Board and the PHIP adopted community-level standards for access to health care and began promoting a *Menu of Recommended Critical Health Services for Washington State Residents (*the *Menu*).[2] This is a status report on the Phase II (2001-2003) efforts of the Board to promote access to health-care services.[3] This report also provides a detailed analysis of the context within which these efforts take place and guides recommendations for further efforts to improve access on several levels. The following paragraph describes the content of each section of this report.

Section two introduces and defines the concept of health-care access, including its impact on health outcomes. Section three frames the public opinion about access to health care and places it in the context of other national priorities. Section four summarizes the most up-to-date information on access to health care in Washington State. Section five reviews the state and national trends in health-care expenditures and insurance coverage, and section six discusses the potential impact of these trends on access to health care in Washington State. Section seven revisits the *Menu* and the growing body of medical literature that supports its use in setting health-care priorities for access promotion. Section eight provides community- and state-level examples of access promotion that use the *Menu* and other priority setting strategies. Section nine, Conclusions, analyzes our findings from a variety of perspectives, including public, private, state, and individual. It is this synthesis that guides our recommendations for further efforts to improve access to health care.

2. HEALTH-CARE ACCESS DEFINED

With the following factors in mind, we define "access to critical health services" as the ability to obtain safe, evidence-based health-care services that have a predictable benefit to the health status of the community-at-large.[2]

In the United States, we have experienced annual reductions in infant mortality, increases in life expectancy, and decreases in the rates of death from heart disease, atherosclerosis, and cancer.[4, 5] There is growing evidence that access to a wide range of public health, clinical preventive, primary, secondary, tertiary and chronic care services leads to improvements in these and other important health outcomes.[6, 7] Many (but not all) of these health services, when delivered to individuals, translate into measurable improvements in the health of the community-at-large. Health services that have clear evidence of such benefits are critical to the health of communities and include: immunizations, prenatal care, and cancer-specific screening (a full list of these services is available in the *Menu*[2]). Other services, such as liver transplantation, can improve the health of individuals, but may come at a high cost to society and lack evidence of health effects on the community level. This represents a population-based perspective on the provision of individual services; however, the Board recognizes that the provision of specific services to individuals should be determined on a case-by-case basis, with

consideration given to age, gender, risk factors, specific diagnoses, medical necessity, and potential risks and benefits.

Unfortunately, access to these health-care services is not guaranteed for all U.S. residents. In Washington, residents must obtain health-care services from a variety of public and private sources and through a wide array of funding mechanisms. Under this system, having access to health care has most often been equated with having either public or private health insurance. The medical literature clearly demonstrates that lack of insurance is a risk factor for poor health outcomes. Uninsured adults are more likely to fail to receive preventive services, forego necessary medical services, and delay seeking medical care for potentially serious symptoms.[8] Uninsured adults also present with later-stage diagnoses and are more likely to die of cancer. [8, 9] The uninsured may access health services through community health centers and other "safety-net" providers, however, the availability of these charity services varies dramatically from provider to provider and from county to county.[10]

Access to health care is not guaranteed by health insurance coverage. Nationwide workforce shortages in the health-care industry and reductions in reimbursements have resulted in a decreasing number of primary-care providers willing to accept Medicaid and Medicare patients.[10] In Washington State, the availability of providers varies by type of health insurance and by county.[11] Access to health care is also determined by the type of benefits in the insurance package and the level of coverage provided, including variations in out-of-pocket expenses for consumers. Changes in coverage and cost-sharing clearly lead to changes in the use of critical health services.[12, 13]

The 2001 Institute of Medicine report, *Crossing the Quality Chasm,* had a major impact on the working definition of health-care access because it suggested that not all health-care access was equal in terms of quality and safety.[14] The medical community has responded to this challenge through research and system-level changes, including improvements in error reporting and safety monitoring. As a result, the evidence base for the provision of high quality and effective medical care continues to improve.

3. ACCESS AND PUBLIC OPINION

Most U.S. adults are dissatisfied with their ability to access affordable health care, but few believe that health care should be one of the top national priorities. In June 2002, polls by the Harvard School of Public Health and Robert Wood Johnson Foundation found that 60 percent of Americans were either "not too satisfied" or "not at all satisfied" with the availability and affordability of care.[15] When asked to rank the top health-care priorities for government to address, 22 percent reported lack of or inadequate insurance coverage, 14 percent the cost of prescription drugs, and 12 percent the cost of health-care services.[15] Despite this reported high level of dissatisfaction, following September 11, 2001, more Americans view terrorism and the economy as the most important issues for government to address. In October 2002, only 6 percent of Americans ranked health care as one of the top two priorities for the government.[16]

Although access is not a top priority nationwide, most Washington residents are willing to do their part to enact changes in the health-care system. In July 2002, a poll of 600 adult heads-of-household in Washington State found that 87 percent of respondents believed too many people in Washington could not afford the health care they need.[17]

Only 53 percent agreed that anyone in Washington who really needed to see a doctor could see one. To improve the system, 63 percent of residents would be willing to pay higher premiums for coverage, 62 percent would increase government regulation of fees charged by providers, and 59 percent would increase taxes to pay for health insurance.[17] Thus, while terrorism and the economy are higher priorities overall, many residents of Washington State are dissatisfied with the current health-care system and are willing to explore solutions to key health issues, such as access.

4. ACCESS IN WASHINGTON STATE

Washington residents have reasons to be concerned about access to health care in their state. The rate of uninsured declined in the 1990s, with a low of 8.4 percent in 2000;[18] however, this trend has not continued, with estimates of the rate of uninsured at 10.6 percent in 2002 and projections for higher rates in 2003.[19] This new trend may reflect the rising rate of unemployment for Washington (which, at 6.4 percent, is the one of the highest in the nation),[20] given that 71 percent of adults age 19 to 64 and 69 percent of children in this state are enrolled in employment-based insurance programs.[21]

When Washington's residents change or lose jobs, they often experience gaps in health coverage that are not reflected in the rate of uninsured. A recent report found that 22 percent of Washington parents were without coverage at some point during 1997 through 1999.[18] Employment-based insurance is an important source of coverage for Washington; however, one out of every five Washington workers are employed by a firm that does not offer insurance to its employees.[21] Smaller firms are less likely to offer health insurance; only 44 percent of employers with less than 50 employees did so in 2001.[18] Categorical benefits such as mental health and oral health coverage are more often viewed as discretionary. For every adult without medical insurance in Washington, there are three without dental coverage.[22]

Public health insurance programs covered 22 percent of all Washington residents in 2000,[21] and the numbers of Medicaid and Basic Health Plan enrollees have been increasing recently due the faltering economy and implementation of the State Children's Health Insurance Program (SCHIP). Unfortunately, not all of these residents have easy access to a primary care physician. An analysis of five rural counties found that while 80 percent of primary care physicians were accepting new employer-insured patients, only 46 percent, 43 percent, and 26 percent of primary care physicians were accepting new Medicaid, Medicare, and Basic Health Plan patients, respectively.[11] This disparity in access is most likely a result of Washington's very low per capita reimbursement for Medicaid and Medicare services. In 1999, Washington ranked 42 among the 50 states in Medicare reimbursement.[23] Declines in reimbursement nationwide have led many providers to forego providing charity care, which for years was "subsidized" by generous reimbursement under the Medicaid system.[10]

These gaps in insurance coverage and access to primary care physicians may result in failure to receive critical health services such as cancer screening, immunization, mental and behavioral health care, and dental services. In Washington, 19 percent of women age 50 to 69 failed to receive mammography in the past two years, and 15 percent of women age 18 to 64 failed to receive a pap smear in the past three years. [24] More than half of all residents over age 50 had never been screened for colorectal cancer.[25] In 1999,

44 percent and 31 percent of the elderly in Washington had not received the recommended influenza and pneumococcal vaccines, respectively.[26] More than 10 percent of adults in Washington have not had a dental visit in the past five years,[25] and 14 percent of children have unmet dental needs (twice the national rate).[27]

Minority groups have higher unmet health needs. In Washington, Hispanics, African Americans, and Native Americans are significantly more likely to be without health insurance than whites.[18] Koreans, African Americans, and Hispanics also have higher percentages of unmet dental needs.[28]

While private and public insurance programs have left significant gaps in access to health services that are critical to the health of Washington State, the Washington State Department of Health (WSDOH) and local health jurisdictions (LHJs) have not been able to completely fill this void. More than half of LHJs are engaged in collaborative access improvement projects; however, less than half are actively collecting or using information about trends in access to critical health services, and even fewer LHJs are able to assess the quality of the health services that are being delivered.[29] On the local level, barriers to meeting these public health standards include the lack of available data summaries from the state, growing budget constraints, and competing resources with the high-priority issues of bioterrorism preparedness and infectious disease control.

5. TRENDS IN HEALTH-CARE FINANCING AND POLICY

5.1 The Return of Medical Inflation and Budget Deficits

Following the dramatic increases in health-care expenditures of the 1980s, medical inflation remained relatively stable in the 1990s. The new millennium has been marked by a return to double-digit health-care cost increases that have been attributed to consolidation in the health-care industry, escalating prescription drug costs and use, and pent-up increases in the managed-care market.[9] According to a survey by the William M. Mercer consulting firm, the average cost of employer-based health coverage increased by 11.2 percent in 2001,[30] and employers expect premiums to increase by 13.6 percent from 2001 to 2002.[31] These cost increases also appear to be driven by an aging population with high burden of disease, consumer demands for greater access to care, and health provider demand for higher reimbursement.[9]

In Washington, 45 percent of the growth in the 2001 to 2003 state budget has been attributed to increasing health-care costs.[19] These cost increases have combined with declines in forecasted revenue to produce a $1.3 to $2.5 billion state budget deficit for 2003 to 2005.[32] The State's Health Services Account, which finances 125,000 Basic Health Plan enrollees, 350,000 children on Medicaid, and many childhood vaccines, is facing a $552 million budget deficit for 2002 to 2005.[32] These budget shortfalls do not account for a 26 percent reduction in federal SCHIP funding in 2002 (and predictions of further reductions through 2006).[33] The U.S. Office of Management and Budget (USOMB) predicts that a large number of states will face significant SCHIP funding shortfalls over the next several years and be unable to sustain their SCHIP enrollments. The USOMB projects a national SCHIP enrollment decline of 900,000 children between 2003 and 2006.[33]

5.2 A Shift Toward Tax-Financed Health Care

In the United States, private employers have been an important source of health insurance coverage for most of the past century. Private employers in Washington State continue to hold the lion's share of the health insurance market; forty-six percent of residents obtained health-care insurance through a private employer in 2000.[23] Despite the strength of employer-sponsored health insurance, tax-financed programs now cover most health-care expenditures in the United States. In 1999, 51 percent of national health-care expenditures were paid by federal, state, or local tax dollars through Medicare, Medicaid, insurance for public employees, and other government programs.[34] In 2000, these government programs provided health coverage for 41 percent of Washington residents.[23] These estimates do not include foregone tax revenue (tax breaks passed on to employers who offer health insurance) or charity services for the uninsured. Another analysis that included estimates of foregone tax revenue concluded that 57 percent of national health expenditures were paid by government funds in 1998.[34] In Washington, the proportion of health expenditures that are either partially or completely tax financed varies by county. In five rural counties, more than 70 percent of primary care patients are covered by Medicaid, Medicare, or have health insurance through a government employer.[11] Thus, in the United States we are beginning to see a shift toward a system of health care that is mostly tax-financed.

5.3 Changes in Private Health Insurance Coverage

In the current sluggish economy, many employers are no longer willing to absorb the rising costs of health care, and they are looking for ways to pass these costs on to employees. Employers are also facing new pressures, including increases in liability through new patients' rights legislation. As a result, companies are beginning to consider changes in insurance that impart more financial and coverage decisions onto employees. Nationwide, more than 70 percent of employers are likely or somewhat likely to reduce health insurance benefits or increase copayments over the next year (based on a survey of 200 employers nationwide, covering more than 1.4 million employees).[31] These changes are occurring at a time when employees are less likely to be able to stand up to employers because of low levels of unionization and increased use of part-time labor.[9]

Insurers and health plan purchasers tend to use three primary means of reducing or moderating premiums: cost-sharing (co-payments and deductibles), exclusions or limitations in coverage, and managed-care approaches.[31] While the use of managed-care approaches is waning, there is a growing interest in consumer- or market-driven health-care programs that combine cost-sharing and coverage limitations to achieve cost savings. There are several examples of this trend in private insurance already. The most common strategies use "tiered" pricing, where insurers charge different prices for each choice of physicians, hospitals, and benefits. Under this method, the monthly premium is determined by how cheap or expensive the doctors, hospitals, and benefits are in a chosen plan or network. Consumers are sometimes given a menu of health insurance options to choose from, which include a variety of levels of copayments and deductibles. Another new option for employers is the "fixed- or defined-contribution" plan (or DC plan).[31] In a DC plan, the employer gives each employee a fixed sum of money for medical expenses per year. The employee then pays for health care out of this pool (or uses personal, "out-of-pocket" funds) until a cap is reached.

Along the way, many employers and insurers are also promoting Internet-based health information systems for consumers. The idea behind these systems is that consumers would access information about health-care services and symptoms to make decisions about utilization and self-management. All of these measures are similar in that they pass more responsibility for health-care decisions and financing on to the consumer.

5.4 Changes in Government-Sponsored Insurance Coverage

One area of the health-care safety net is expected to grow over the next few years: community and migrant health centers. Instead of increasing financing for existing government programs, the President's Health Center Initiative is a plan to generate 1,200 new health center access points nationwide, which will serve an additional 6 million Americans by 2006. [35] These centers will be designed to provide culturally appropriate, high quality health care to those who are unable to pay.

A recent report from the Institute of Medicine may result in renewed efforts to test universal coverage in several states.[36] The Committee on Rapid Advance Demonstration Projects, which was convened to identify models for health system reform, recommended that three to five states be selected to embark on model projects designed to extend health coverage to all residents. The Committee suggested two possible approaches: providing tax credits to offset the costs of eligible participants' insurance premiums or expanding Medicaid and SCHIP to cover a broader range of participants. This report is expected to generate funds for health insurance demonstration projects in 2003.

6. IMPACT OF TRENDS ON ACCESS IN WASHINGTON STATE

6.1 Growth in the Uninsured

Higher health-care costs, employers passing on more of these costs to their workers, unemployment growth, and state cutbacks in government-sponsored insurance programs will all but guarantee increases in the rate of uninsured. At this point, no one knows how high the rate of unemployment will rise; thus, it is difficult to predict how much the number of uninsured will increase. The growth in uninsured in Washington State will likely be among childless adults, young adults between the ages of 19 and 34, ethnic minorities, and those with low income.[21] Midlife Americans age 45 to 64 are also particularly vulnerable to unemployment due to layoffs, reemployment in temporary or part-time work that offers no health coverage, and individual market premiums that rise steeply with age.[9]

6.2 Growth in the Underinsured and Increasing Medical Inequality

Many private health plan purchasers are considering moves away from comprehensive health-care coverage and toward consumer-driven health-care coverage. Given greater choice, the healthy consumers will be drawn to plans with lower premiums, higher deductibles, and higher cost-sharing for selected services. Some healthy consumers who are risk-averse may choose plans with higher premiums, lower deductibles, and more benefits, but, in the face of a stagnant economy, many healthy consumers may choose to bet against the risk of illness in favor of more cash on hand.

Premiums will rise for comprehensive plans, which are most often selected by consumers with chronic health conditions who use significant amounts of care. [31] Because healthy consumers choose other plans, the comprehensive plans will end up with

a disproportionately high burden of chronically ill and expensive enrollees (also known as adverse selection). [9] Those Americans with low income will be less able to purchase the more expensive and comprehensive plans; thus, medical inequality will increase, with those who can pay getting more and better services. The problem of adverse selection is already apparent in Washington State Health Insurance Pool, which provides coverage for the state's sickest, low-income residents; the Pool's board recently approved a 17.2 percent increase in premiums to cover the high cost of providing medical services for this group.[37]

6.3 Increased Consumer Self-Reliance

Some policymakers believe that consumers are ready for consumer-driven decision-making in health care, but others predict that consumers are ill prepared for such decisions and unaware of the potential for adverse consequences from their choices. Health-care consumers often do not know what type of plan they are in currently or how the choice of plan impacts their care.[9] Focus groups (from 42 companies with over 1,000 employees) found that employees generally do not understand health coverage enough to make an informed choice, do not expect to understand health information, and "accept and ignore" their knowledge deficits.[9] Most consumers want their employer to negotiate with insurers on their behalf and to be distanced from the health insurance market.[9] There is also evidence that consumers make health-care decisions "inconsistently and behave unpredictably when values, such as cost and available care, conflict."[9]

In a free-market system, the shift toward consumer-driven care would require health plans and providers to compete on the basis of cost and quality. Unfortunately, reliable cost and quality data are not yet available for public use. When this information becomes available, the largest barrier to its use will be inadequate health literacy. In 1992, between 42 and 90 million adults in the United States functioned at low or marginal literacy levels, and 75 percent of older Americans read at the 8th-grade level or below.[9] Low literacy translates directly into low health literacy, and these individuals may be unable to follow medication instructions, read and interpret information necessary for informed consent, and select appropriate health plans.[9] Most adults have trouble reading and understanding medical brochures, and most health materials are printed on the high-school or college reading level.[9] Health information is increasingly available on the Internet. While nonprofit organizations, such as the American Accreditation HealthCare Commission (URAC), now accredit health web sites based on quality and privacy, these organizations do not address health literacy issues.[38]

6.4 Effects on Utilization of Critical Health Services

Proponents of consumer-driven shifts in health care argue that these cost-saving measures will promote more efficient use of health-care resources by consumers. However, the Rand Health Insurance experiment demonstrated that people who have to pay more for health care use less of both necessary and unnecessary services.[9] Consumers with higher out-of-pocket expenses had less use of acute care, chronic care, well care, mental health care, and emergency room care services.[39] Other studies have demonstrated that cost-sharing has important negative effects on the rates of breast cancer screening, cervical cancer screening, and preventive counseling.[12] The use of other "categorical," but critical, health services, such as dental care, will also likely decrease. It is unclear

what effect these changes in health service use will have on long-term health outcomes for our communities.

7. ACTIONS OF THE BOARD TO PROMOTE ACCESS

Having recognized many of these trends in access during the mid-1990s, the Washington State Board of Health has continuously played an integral role in promoting access to a "core set of critical health services that are necessary to protect the public health."[40] The Board worked with the PHIP to develop public health standards relating to health-care access and, in 2000, adopted a *Menu of Recommended Critical Health Services for Washington State Residents*.[2] This *Menu* was generated by a team of independent medical professionals and health-care consultants using evidence from national medical research and guidelines. Each of the health services addressed diseases of high prevalence for the state-at-large, were a high national priority for health policy and research, were supported by clear evidence of effectiveness and safety, and were identified by local policymakers, providers, and the public as an important and necessary service. The Board intended for this list to be used by LHJs, policymakers, and employers to guide discussions about access to these services in the community, to set priorities, and to shape insurance coverage.[2]

The evidence base for the *Menu* continues to grow. The U.S. Preventive Services Task Force (USPSTF), whose *Guide to Clinical Preventive Services* was a critical resource in development of the *Menu*, continues to update its recommendations.[6] The USPSTF has also developed guidelines to incorporate evidence related to cost-effectiveness into its recommendations about preventive care.[41] In collaboration with the USPSTF, the Partnership for Prevention published methods for using evidence about disease burden and cost-effectiveness to prioritize preventive services on the national level.[42] These methods can be adapted to the local level and continuously updated to reflect biomedical advances.

The Phase II (2001-2003) work of the Board in the area of access called for collaborating with LHJs to develop and use localized menus; promoting the *Menu* at meetings and conferences around the state; and convening forums around the state to discuss access. To date, the Board has successfully influenced the Governor and the Subcabinet on Health to make access to critical health services one of the five strategic directions for state health policy during the 2003-2005 biennium. The Governor's Subcabinet on Health has also strengthened efforts to implement disease management programs and value-based purchasing strategies. The Board has also collaborated with Washington State Health Agency Medical Directors to jointly recommend that state agencies explore the effectiveness of mechanisms for measuring and monitoring the appropriate delivery of clinical preventive services for children.[43] The status of these and other activities of the Board are summarized in Table 1:

Table 1
Status of the Phase II (2001-03) Activities of the Board in Promoting Access

Task	Timeline
Promote Menu of Critical Health Services	
Assemble menu materials and print final report under single cover	November-01

Table 1 Status of the Phase II (2001-03) Activities of the Board in Promoting Access	
Task	**Timeline**
Promote Menu of Critical Health Services	
Revise and update relevant materials on the Board's website	November-01
Distribute final report in print and electronically	January-02
Present final report and Menu at meetings and conferences	Ongoing
Continue to discuss the use of the Menu by state purchasing and regulatory agencies as a potential basis for an insurance product, as a guide to LHJs for implementing PHIP standards, as a tool for assessing access, and for other purposes	Ongoing
Continue to promote the use of the Menu through PHIP meetings	Ongoing
Encourage Public Engagement in Access Discussion	
Continue to participate in HRSA grant oversight panel	August-02
Continue to participate in Governor's Subcabinet on Health	Ongoing
Convene public forums for discussion of HRSA planning grant findings and recommendations	Pending
Encourage LHJs to present local access issues at board meetings	Ongoing
Support Local Access Improvement/Standards Implementation	
Continue to track and provide visibility for local access improvement efforts such as those going on in Spokane, Jefferson, Thurston, Clark, and other counties	Ongoing
Explore possibility of convening a conference or other venue where LHJs can share lessons learned and best practices	TBD
Explore possibility of outside funding to support an ethnographic study, media campaign, or other activities that would increase visibility of implementation or increase awareness of local efforts	TBD

8. EXAMPLES OF ACCESS PROMOTION

Several LHJs around Washington State are proactively promoting access in their communities. The *Baseline Evaluation Report on Standards for Public Health in Washington State* reviewed access improvement efforts for all 34 local health jurisdictions (LHJs) and 38 WSDOH programs. It found that 60 percent of LHJs (serving 81 percent of the population of Washington State) had implemented or were developing collaborative efforts to reduce specific gaps in access to critical health services.[29] Several of these access improvement efforts deserve further mention and can serve as "exemplary practice" examples for other LHJs.

In Jefferson County, community leaders came together under the support of a grant by the WHF to explore local access issues and set priorities for action. This effort was lead by members of the local hospital district board of commissioners and Jefferson County Board of Health; they formed a Joint Board to meet on a regular basis over a one-year period. A workgroup was appointed by the Joint Board to research the many

complex issues involved in the financing and delivery of health-care services in the county. At the recommendation of this workgroup, an invitational health-care access summit was held in May 2001. The Joint Board is now working with local organizations to generate a list of priority health services, collect data on access, and plan future access improvement projects. The hospital district and health department continue to meet on a regular basis to coordinate their respective services and respond to urgent service gaps that have been identified by the assessment process.

In Clallam County, the local United Way organization convened a broadly representative group of community leaders in response to a growing number of health-care access problems. This Access Coalition has played an integral role in stabilizing a fluctuating pool of health-care providers. The Coalition adopted three initial goals: stabilize existing medical practices through improved reimbursement from publicly-sponsored health insurance programs, encourage volunteer efforts by health-care providers, and explore the feasibility of a community health clinic in the Port Angeles/Sequim area. To date, these efforts have resulted in the designation of a low-income Health Provider Shortage Area, several private practices obtaining eligibility as rural health clinics, and improved support for volunteer clinics in Port Angeles and Sequim. While a community clinic has not yet proven to be feasible, the Lower Elwha Klallam and Jamestown S'Klallam Tribes have both expanded their tribal clinics to meet the needs of Medicaid-sponsored community members who are unable to receive primary care from private practitioners.

Since 1994, the Thurston County Board of Health has convened a Community Health Task Force to examine access to primary medical and dental care, find solutions to access issues, and begin implementing these solutions; several access improvement efforts have resulted from these meetings. Among these, two community-based projects are centered on oral health. The Access to Baby and Child Dentistry (ABCD) program provides dental care to Medicaid-eligible children of Thurston and Mason counties from birth to six years of age. An adult oral health improvement project is providing charity dental care for over 600 residents of Thurston County. This joint effort by the Olympia Union Gospel Mission, the Oral Health Coalition, and volunteer practitioners has resulted in support for a two-chair, charity dental clinic to serve adults in the county. The Thurston County Health Department's role in these efforts has been to bring community leaders together around the issue of oral health, help generate financial support, and facilitate community awareness of the initiatives.

Another major access improvement effort for southwestern Washington State is the CHOICE Regional Health Network 100% Access Demonstration Project. This Health Resources and Service Administration (HRSA)-funded collaborative effort includes five public health jurisdictions, seven public and nonprofit hospitals, free clinics, primary care practitioners, a Latino social services agency, three mental health Regional Support Networks and state-level executives and legislative staff. The goal is to develop, advocate, and implement a demonstration project that provides 100 percent access to a uniform set of health-care services for 93,000 residents in the region by 2008, starting with those under 250 percent of the federal poverty level (FPL). The next phase of this project will be to develop long-term financing and risk management solutions.

The Spokane Health Improvement Partnership (HIP) is an alliance of more than 500 Spokane County organizations and many individuals dedicated to improving community health. HIP plays an active role in identifying unmet community needs and gaps in services that affect quality of life and community health. After helping to identify those needs, the HIP works with community groups to find the people, the resources, and the tools to provide solutions for local problems. Examples of the work of the HIP include the Disability Awareness, Surveillance, and Health Promotion (DASH) program which helps to identify priorities for community mobilization around disability issues, and the Expanded Choice Planning Team, comprising representatives of hospitals, health plan carriers, brokerage services, physicians, employers, and clinics, whose goal is to find financially stable and sustainable long-term solutions to improve access to health care for the employed uninsured and their dependents in their community. These efforts have increased Medicaid enrollment and improved continuity of care in the Spokane region.

On the national level, the "The Models That Work Campaign" of the Bureau of Primary Health Care identifies and promotes replicating innovative community-based models for the delivery of primary health care to underserved and vulnerable populations. This private-public partnership, led by HRSA, offers support to organizations and communities that are interested in increasing access to care and eliminating disparities in health status for America's neediest citizens.[44]

In Scituate, Rhode Island, an innovative group of local community and health-care leaders are developing a universal coverage health-care program for 10,000 town residents and employees. The main elements of the Scituate Health Plan are a catastrophic health plan, a tax-deferred medical savings account, and a low annual premium for each enrollee to support a local primary and preventive care system. Plan developers are currently negotiating with underwriters and expect to begin enrollment in the community in 2003.

9. CONCLUSIONS

We have defined access to health care as the ability to obtain safe, evidence-based health-care services that have a predictable benefit to the health status of the community-at-large. In Washington State, access to health care is not guaranteed for all residents. One in ten residents do not have health insurance. Those who have coverage through government programs may not have access to a primary care provider, and the utilization of many beneficial health-care services remains suboptimal.

In the short term, access to health care will likely worsen for Washington State residents, as evidenced by increasing numbers of uninsured children and adults. Increasing unemployment, shortfalls in state and federal budgets leading to reductions in covered lives under government programs, and increasing health-care costs for consumers will be the primary drivers of the higher rates of uninsured. The shift toward consumer-driven health care may result in important gaps in benefits and reduce the use of critical health services. The growth in funding for community and migrant health centers will strengthen the safety net for the uninsured nationwide; however, this program will provide coverage for less than 2 percent of U.S. residents by 2008. Sadly, it may be too little, too late.

In the United States, we are committed to providing access to health-care services through a variety of private and public programs. Since many Americans support market-based solutions to our current health-care problems, universal health coverage through a single-payer system seems unlikely in the near future. Given these conditions, we will require multifaceted approaches to access promotion that include improved public and private purchasing strategies, public education, legislative mandates, detailed data collection for progress monitoring, and community-based coalitions.

An example of this multifaceted approach to access promotion is seen in childhood immunizations. There is clear medical research to support the efficacy, safety, and cost-effectiveness of childhood vaccinations against diphtheria, tetanus, pertussis, measles, mumps, rubella, polio, influenza, hepatitis B, and varicella.[45] In 2001, an analysis of all services recommended by the USPSTF found that childhood vaccines were the highest priority for access improvement nationwide.[42] Since 1990, Washington has been a "universal vaccine distribution state", meaning that state-supplied vaccines are provided to all children regardless of their ability to pay or their health plan coverage. The state and federal funds for this program also generate infrastructure support to participating providers and clinics, including incentives, to improve rates of immunization. Other state and federal funds are allocated to promote public education about vaccine preventable illnesses. In addition, Washington has mandated that "every child at every public and private school in the state and licensed day care center" shall have either received full immunization, initiated a schedule of immunization, or provided a medical or religious exemption.[46] While not all children have received these immunizations statewide, rates of immunization are high, and all parents who desire them for their children are guaranteed access.

We recognize that some groups may interpret the information we have provided in this report differently. We also recognize that a variety of organizations, from local businesses to the Board, and individuals, from legislators to providers, have important roles to play in access promotion. To provide the many interested parties with specific recommendations for action, we have attempted to interpret the access issue on several levels.

The Board, the PHIP, the WSDOH, and LHJs must continuously strive to improve access for area residents -- as this is one of the core functions of public health. Public health departments are not a substitute for individual medical care services; instead, they are designed to provide services that benefit entire populations. In some cases, health departments do provide medical services to individuals (*e.g.* immunizations), but these services are limited and should have critical public health implications. What health departments can do about health-care access falls into the realm of planning, assessing resources, community organizing, and making referrals for individual clients.

While the *Public Health Standards for Washington State*[47] and the *Recommended Critical Health Services for Washington State Residents*[2] have provided a benchmark for LHJs, the Board, and PHIP need to consider using workgroups or convening a formal PHIP Committee on Access to Critical Health Services to discuss the feasibility of these standards, coordinate access data collection across public and private organizations, and work with LHJs to improve funding for these efforts. The recent baseline report from the

Public Health Standards Committee indicates that many LHJs have not implemented the PHIP access standards. There may be many reasons for these low levels of implementation, including lack of available data summaries from the WSDOH as required by the PHIP standards, the press for implementation of more urgent local issues such as bioterrorism defense and infectious disease control, budget reductions and threats of them, questions about the authority of LHJs to pursue such work, and questions about financial resources for these efforts. Despite these concerns, several LHJs, including Clallam, Jefferson, Thurston, and Spokane counties mentioned earlier, are implementing these standards and have developed community examples of "exemplary practice". Without a clear funding source, some LHJs may not have the resources necessary to implement all of the access *Standards* in full; however, all LHJs have opportunities to improve access by reviewing available data and resources on access in the area, using these data to build coalitions around access issues with local health leaders and areas businesses, and providing support to community groups that are interested in applying for federal, state or private funds to expand access to critical health services. Along these lines, the WHF has offered LHJs an opportunity to improve the public dialogue on access to health care by participating in a series of community roundtable discussions on health and health-care priorities.[48]

A variety of groups are collecting data on access to critical health services on different levels, including the WSDOH, LHJs, the WHF, and local health provider organizations. These groups should consider joining together in a collaborative data collection and processing effort. A coordinated effort would provide more detail about access to critical health services on the state and local level, help identify gaps in resources, and provide the data needed to compete for federal health insurance demonstration projects, access improvement grants, and state budget dollars.

Public health-care purchasing agencies should also place a high priority on access promotion in this time of shrinking resources and expanding technology. Public agencies have a unique opportunity to expand the use of the *Menu* and other evidence about efficacy, safety, and quality to guide "value-based" purchasing of health-care services for the underserved residents of Washington State. In designing benefits packages for enrollees, public agencies should consider evidence from an expanded set of critical health services that includes mental, behavioral, and dental health services.

While legislators and the general public have been focusing their attention elsewhere – on terrorism and the economy – changes in the health-care marketplace have occurred and are creating new problems for health-care access. Legislators have the authority to regulate the provision of a core set of services that are critical to the health of Washington State. The evidence base for many health services has been changing with time, and legislators should consider a periodic reappraisal of the current health mandates. New standards for quality, safety, and value should be applied to existing health-care regulations. Legislators should also consider using the *Menu* to set reasonable standards that specify a set of critical health services and a level of cost-sharing below which insurance carriers and public and private purchasers cannot go. Residents of Washington State, as they face the personal financial challenges of this economic recession, should consider two important questions: "can we afford the health-care

choices we want?" and, "are there any health-care services, other than immunizations, that government should take steps to guarantee for all residents?"

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