CHAPTER

3

ACCESS TO HEALTH SERVICES

Introduction

Until the breakup of the Soviet Union, only two major industrialized countries —South Africa and the United States—did not provide universal access to health services. Neither South Africa nor the United States has a national health system, such as Canada's, or a national health service, such as Great Britain's, to provide a basic set of services to their entire populations. In the free market economy of the United States, health services are among many goods and services that individuals are generally expected to provide for themselves. Despite years of debate about whether its citizens have a right to health services, the U.S. system ensures only the right to emergency care in most hospitals under certain circumstances. Medicare beneficiaries are also entitled to inpatient hospital care, hospice services, and home health care.

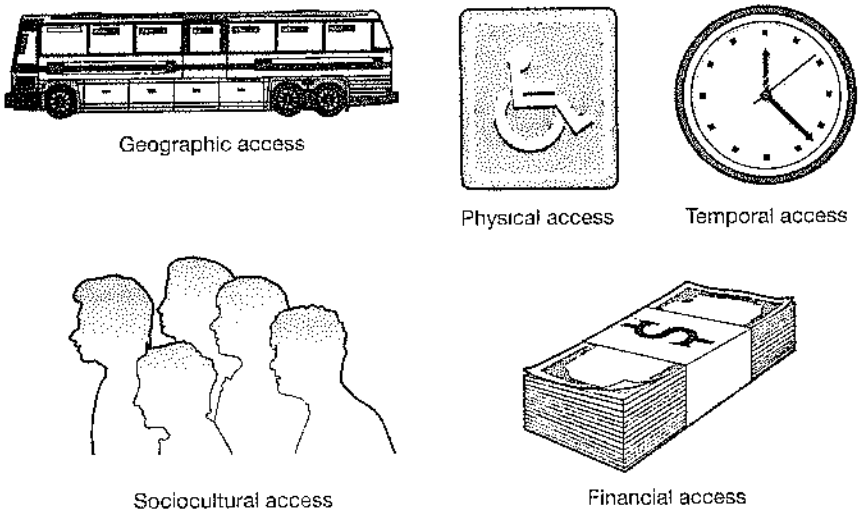
This chapter discusses how people in the United States, in the absence of a national health system or service, obtain access to care and also focuses on the care seeker's access to a provider. Issues of access among providers also exist (e.g., a generalist's access to a specialist, or a provider's access to backup support, rehabilitation, or long-term care services for patient referrals) but are beyond the scope of this book.

Defining Access

The term *access* connotes different things to health services analysts. To Penchansky and Thomas (1981), access is the measure of fit between characteristics of providers and health services, and characteristics and expectations of clients, incorporating five reasonably distinct dimensions: availability, accessibility, accommodation, affordability, and acceptability.[1] Access may describe the entry into or use of services. Access may also be defined by factors influencing entry or use of services. For purposes of this discussion, the latter definition of access is used.

Access to care has a direct bearing on the two other important dimensions of the health services system: cost/expenditures and quality. Increasing access to health services can actually decrease unit costs in some instances but inevitably increases expenditures. Limited or no access to care can decrease

EXHIBIT 3.1
Dimensions of Access to Health Services



a person's health status and quality of life, but excessive access can also be detrimental.

As Exhibit 3.1 indicates, access to care has many dimensions: geographic, physical, temporal, sociocultural, and financial. *Geographic access* is influenced by where the care seeker lives in relationship to where the provider practices. A full range of medical services is unlikely to be available in a coastal village in Alaska, a mountain mining town in Nevada, or a rural farming community in the Midwest, for example, even though the physician to patient ratios suggest that physician supply is adequate to serve these populations. Medical care is most likely to be found where a population base and related services to support it exist. Those who live outside such areas may have to travel considerable distances, often over difficult terrain and through imposing weather, to reach care. Transportation is a factor in geographic access. Public transportation systems do not serve all areas where people live, and private transportation may not be available to the care seeker.

Physical access to care is influenced by the care seeker's physical mobility and mental competence in reaching a provider, as well as by the ease of access to the provider's facility. Today's system of health services usually requires the care seeker to go to the provider. In-home services, although growing, still do not typically include home visits by physicians for routine care. Ease of access to a provider's facility has been assisted by the Americans with Disabilities Act of 1990, which recommends appropriate access and imposes sanctions for noncompliance. Another potential way to increase access to a provider is through the use of telemedicine and through remote monitoring

of chronic diseases. Such mechanisms have not yet begun to reach their full potential (Barton et al. 2007).

Temporal access may be inhibited when, because of an inflexible work schedule, the unavailability of care for young and old dependents, or other time constraints, a care seeker is unable to obtain care during the hours it is provided. Temporal barriers may also include waiting or queue times between the request for an appointment and the provider's availability.

Multicultural societies such as the United States also experience *sociocultural* barriers to access. The provider and care seeker may speak different languages or may come from different cultures that value health services in disparate ways and have conflicting customs and beliefs. These differences may inhibit a person from seeking needed care because of the frustrations inherent in communicating or may prevent the care seeker from obtaining the full benefits of the recommended treatment because of misunderstandings.

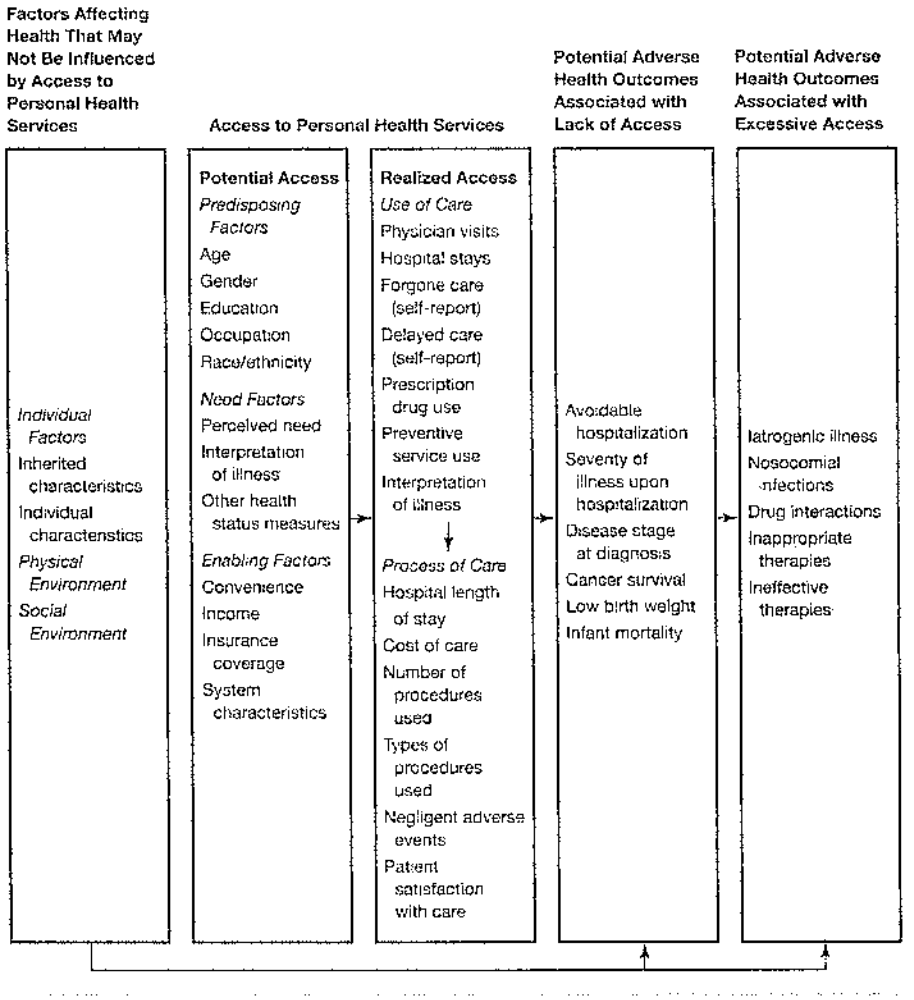
Financial access to health services in the United States is largely governed by the individual's access to health insurance coverage —either private insurance or public or social insurance.[2] Health insurance, addressed more fully in Chapter 6, became the dominant payment mechanism for health services in the last half of the twentieth century. This trend stems from the growth of private health insurance coverage during and immediately after World War II and the establishment of public or social health insurance in the mid-1960s. In addition to private and public health insurance, financial access to health services is attained by private payment, by qualifying for government-sponsored programs, or through the provision of charity care.

Given these varying dimensions of access, what factors affect a person's ability to access health services in the U.S. system? This question may be explored by examining the model in Exhibit 3.2. This model was adapted from one developed by the former congressional Office of Technology Assessment (OTA), based on work done by Ron Andersen, LuAnn Aday, and other researchers in the utilization of health services.[3] Factors affecting health that may not be influenced by access to personal health services are considered briefly. Three types of factors—predisposing, need, and enabling—that potentially affect access are then examined. Finally, the potential adverse health outcomes associated with lack of access to care and unconstrained access to care are considered.

Factors Affecting Access to Health Services

Some factors affecting an individual's health status may not be influenced by access to personal health services. Exhibit 3.2 identifies three such factors:

EXHIBIT 3.2
Factors Affecting Access to Health Services



SOURCE: This exhibit was adapted from an exhibit in *Does Health Insurance Make a Difference?* from the Office of Technology Assessment, 1992

(1) individual factors, (2) the physical environment, and (3) the social environment.

Individual factors include inherited (i.e., genetic) characteristics and individual behaviors that reflect a person's beliefs, attitudes, and values. Another individual factor, *health literacy*, has only recently begun to be examined. Some databases (see the statistical section on the World Health Organization's website) note that the United States has a 100 percent literacy rate, which is seriously overstated. A person's ability to read and understand prescription dosages and times and conditions of usage will affect the outcome of treatment. A language barrier may affect a person's ability to comprehend the proposed treatment plan.

Physical environmental factors include air and water quality, as well as the presence or absence of disease vectors. A person's friends and social relationships are examples of societal environmental factors that may not be influenced by access to personal health services.

Predisposing Factors

As shown in Exhibit 3.2, predisposing, need, and enabling factors affect potential access. These factors vary in their importance in affecting access, and they do not operate independently; rather, their effect on access is interactive.

Predisposing factors are an individual's demographic characteristics: age, gender, education, occupation, and race/ethnicity. The two ends of the age spectrum—the young and the old—often require increased access to services. Because these age groups are often dependent on others to secure their care, access may be directly affected by their ability to get assistance in obtaining care.

Gender also influences access to care. For example, women of childbearing age are likely to access health services more frequently than their male counterparts. Gender may also affect participation in clinical research studies. Criticism was directed in the early 1990s at the National Institutes of Health (NIH) for supporting large-scale research studies that limited their investigations to male subjects, even though the studied condition affected both genders (Finnegan 1996). The NIH has made strides in correcting this imbalance.

Educational levels influence access. People with higher educational levels access health services more frequently.

A person's occupation may affect access in several ways. First, a hazardous occupation, such as mining, puts one at greater risk for injuries and some types of illness (e.g., black lung disease), thereby requiring more frequent contact with the health services system. Second, a person's occupation has a direct influence on income and health insurance status, two enabling factors covered later in this discussion.

Finally, a person's race and ethnicity may affect access in several ways. Some diseases—Tay-Sachs disease or sickle-cell anemia, for example—affect only certain racial or ethnic groups. Racial and ethnic groups may also face cultural barriers or discriminatory practices that affect their ability to access health services.

Need Factors

A range of need factors—perceived health, interpretation of illness, and other health status measures—affect access to care. Numerous studies have shown that individuals who perceive their health status as fair or poor are more likely to access care (McCall et al. 1991; Short and Lair 1994/95), assuming they

have the financial means to do so. Patients' understanding and interpretation of their illness affects access. Bhandari (2006) noted that the way people report their health status is directly related to their use of medical services, with those in progressively better health status categories visiting doctors less frequently, staying fewer nights in the hospital, and taking prescription medications less frequently. Health status measures, such as levels of disability and functioning, also affect access to care.

Enabling Factors

The third category of factors affecting potential access—the enabling factors—constitutes the major focus for the remainder of this section. Enabling factors include convenience, income, insurance coverage, and system characteristics. Convenience embodies temporal, geographic, and physical dimensions of access, as discussed earlier. People's incomes directly affect their financial access and frequency of access to health services and also influence whether they have private health insurance coverage. Private and public insurance coverage is the major route of financial access to health services in the United States. Although health insurance is explored comprehensively in Chapter 6, an overview of its effects on access follows. This section concludes with a discussion of other characteristics of the U.S. health services system affecting access—principally, the availability of governmental and other programs that provide access to special populations. Following the discussion of these enabling factors, the problems of people who lack financial access to care are addressed.

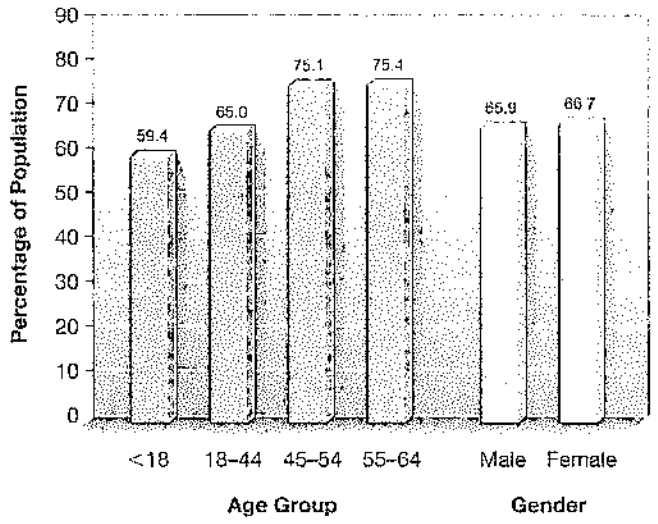
Financial Access to Health Services

Private insurance and public or social insurance are first discussed as means of financial access to health services. Private payment (out-of-pocket payment) for health services is then addressed. Finally, the important role of government-sponsored programs, such as the U.S. Department of Veterans Affairs (VA) and the military system of health services, is described.

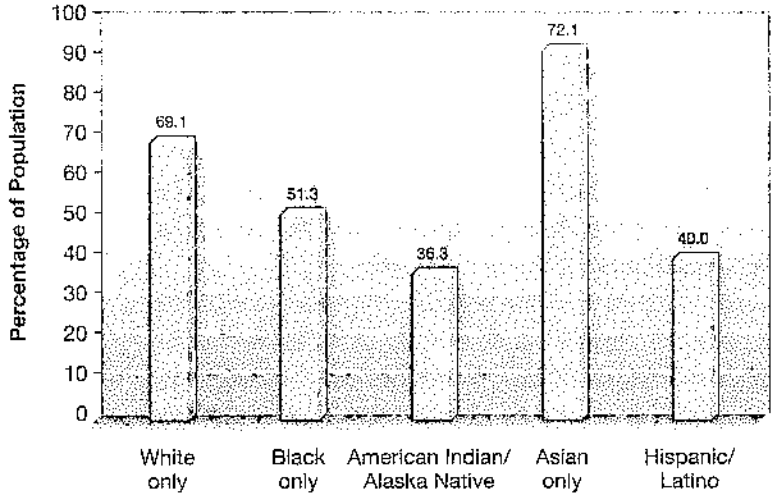
Private Health Insurance

Private health insurance is the greatest source of health insurance coverage for people younger than 65 years. Medicare, discussed in the next section, provides public or social insurance for most people age 65 years and older, as well as for people with certain types of disabilities, including end-stage renal disease (ESRD). In 2007, 67.5 percent of the population younger than 65 years reported some form of private health insurance coverage (NCHS 2009). Exhibit 3.3 shows the percentage of the population with private health insurance by age, gender, race/ethnicity, and various poverty levels. Children younger

(a)



(b)



(*continued*)

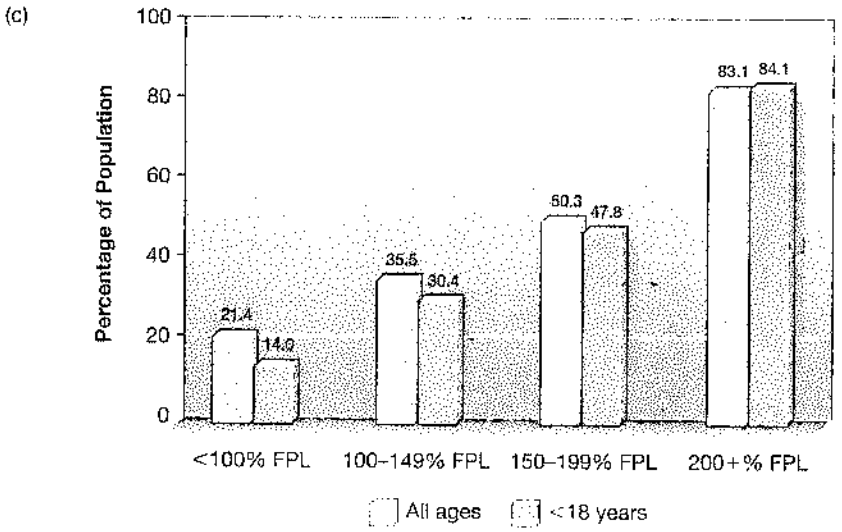
EXHIBIT 3.3 Private Health Insurance Among Persons <65 Years Old, 2006

(a) By Age Group and Gender. *(b)* By Race/Ethnicity. *(c)* By Federal Poverty Level (FPL).

than 18 years who are below the federal poverty level had the lowest insurance coverage rates of any of these demographic groups.

Two types of private health insurance are available in the United States: individually purchased policies, which are usually limited in coverage and relatively expensive to purchase, and insurance provided as one of the benefits of employment. Employer-sponsored health insurance is generally more comprehensive in scope because the risk of insuring is spread over a group of employees and because those in the workforce are generally healthier than those of working age who are not in the workforce and are not the dependents of an insured worker. Group insurance is thus less expensive per person

EXHIBIT 3.3
Continued



SOURCE: These exhibits were created using data from *Health, United States, 2008*, published by the National Center for Health Statistics in 2009.

than individual policies. In most cases, employers and employees share the cost of this insurance. Many employers are beginning to shift a greater proportion of these costs to their employees.

Individual policies are purchased by people who can afford them, those who may be self-employed, who work in industries such as mining or fishing in which insurance is difficult to obtain, or who otherwise do not have access to a group health insurance policy. Individual high-deductible policies may also be purchased by people who do not anticipate much utilization of health services but want the security of catastrophic coverage. Individual policies often impose stringent limitations for preexisting conditions. They are, however, becoming of greater interest as individuals explore new insurance products such as consumer-directed health plans (see Chapter 6).

About 61 percent of the nonelderly who have health insurance are likely to have insurance as a benefit of employment, either as the employee or as the dependent of an insured employee. Health insurance provided as a benefit of employment varies by size of firm, type of industry, the employee's work status (full-time or part-time), and other factors. Midsize to larger firms (100 or more employees) typically offer one or more types of health insurance coverage to their full-time workers, whereas smaller firms (25 or fewer employees) may not offer health insurance as a benefit. Certain industries, such as farming, logging, floral businesses, and interior design—viewed as high risk by in-

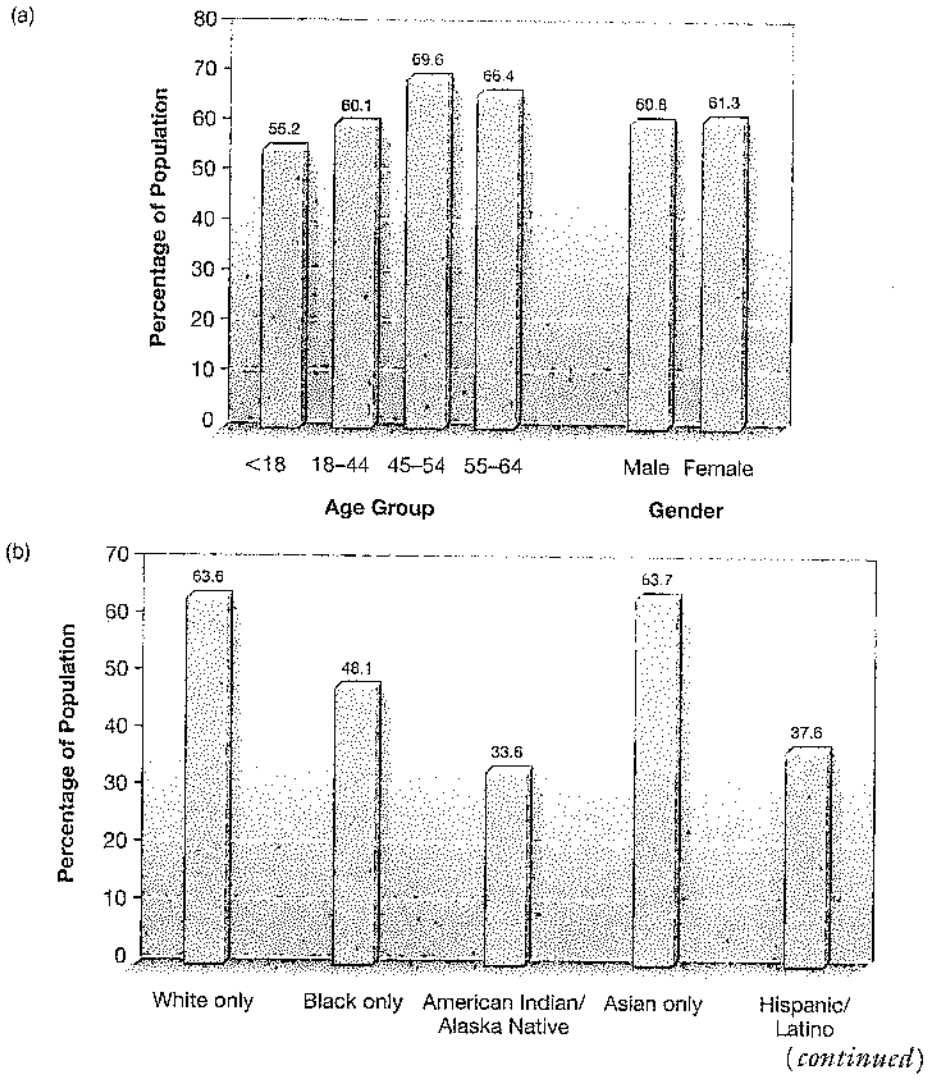


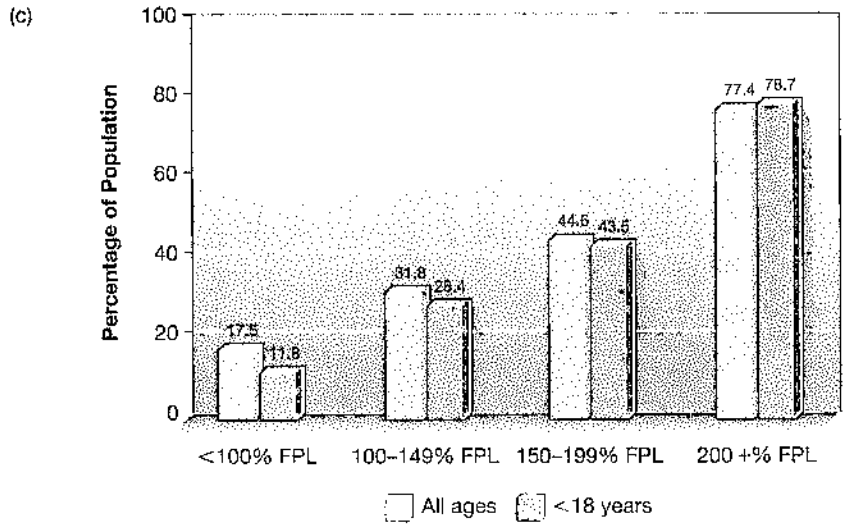
EXHIBIT 3.4
Private Health Insurance Obtained Through the Workplace, <65 Years Old, 2006
(*a*) By Age Group and Gender.
(*b*) By Race/ Ethnicity.
(*c*) By Federal Poverty Level (FPL).

(continued)

surers because of the potential for physical injury or the perceived high-risk lifestyles of the employees—may typically not offer health insurance as a benefit (Zellers, McLaughlin, and Frick 1992). Many employers, regardless of firm size, do not offer health insurance to contingent, seasonal, or part-time workers.

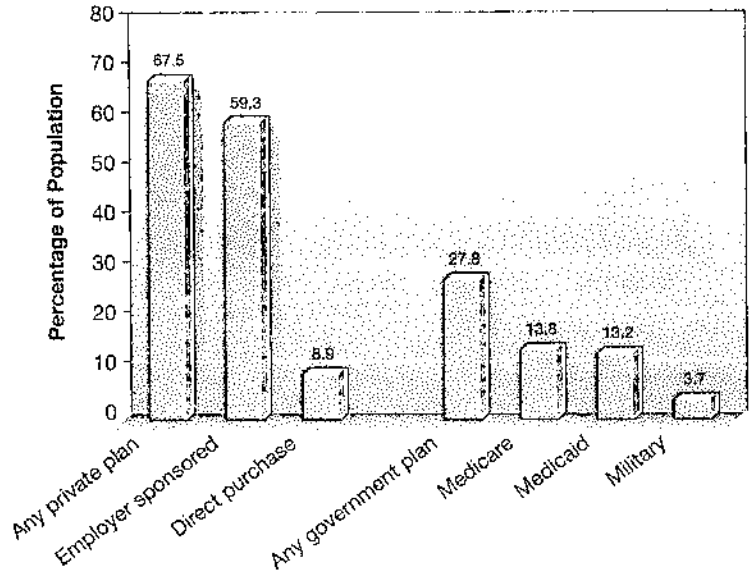
Private health insurance coverage for the nonelderly varies by race/ethnicity: a greater proportion of whites than nonwhites are insured (Exhibit 3.4). As a bridge to the next section on public health insurance, Exhibit 3.5 shows the percentage of the U.S. population that had any kind of health insurance coverage in 2007.

EXHIBIT 3.4
Continued



SOURCE: These exhibits were created using data from *Health, United States, 2008*, published by the National Center for Health Statistics in 2009.

EXHIBIT 3.5
Health Insurance Coverage, All Ages, 2007



SOURCE: This exhibit was created with data from *Statistical Abstract of the United States, 2008*, published by the U.S. Department of Commerce.

Public or Social Health Insurance

Many consider Medicare and Medicaid, two government-supported programs initiated as amendments to the Social Security Act (titles XVIII and XIX, respectively) in 1965 and implemented the following year, to be public insurance programs. Both are entitlement programs, meaning eligible persons have a legislative entitlement to all the covered services they require. Only the Medicare program really fits an insurance model and was designed to conform to the structure of private health insurance. Because the programs are so frequently compared—and confused—both are discussed in this section.

The Medicare and Medicaid programs, a legacy of President Lyndon Johnson's Great Society, resulted from compromises following the failure to enact some form of national health insurance (Anderson 1968). Medicare was intended to provide mandatory hospitalization benefits (Part A) to qualified beneficiaries and optional physician services and outpatient coverage (Part B) to beneficiaries who could afford the monthly premium. Medicare beneficiaries initially were persons 65 years and older, which was retirement age in that era; later amendments included people with ESRD (1972) and long-term disabilities (1973).

The Medicaid program, a welfare program, was established to pay for a mandated set of health services to low-income children and their caretakers who were the recipients of, or eligible to receive, public assistance funds from the Aid to Families with Dependent Children (AFDC) program or the Supplemental Security Income (SSI) program.[4] The Medicaid program has been amended over time to include people who have developmental disabilities (1972) and to expand eligibility to other low-income groups, including children, pregnant women, and the elderly. The Personal Responsibility and Work Opportunity Reconciliation Act (PL 104-93) of 1996 replaced the AFDC program with the Temporary Assistance for Needy Families (TANF) program.

Although the Medicare and Medicaid programs were established in the same congressional session and were intended to provide health services access to the two ends of the population spectrum—the elderly and children with their adult caretakers—the programs differ widely in their requirements for eligibility, covered benefits, financing, and proportion of the population each covers. These differences are illustrated in Exhibit 3.6 and discussed in more detail in Chapter 6.

Private Payment for Health Services

Private, out-of-pocket payment for health services is another way in which a person obtains financial access to care. Private out-of-pocket payment includes payment for all health services expenditures by uninsured people who can afford to do so. It also includes payment for health services not covered by

EXHIBIT 3.6
Comparison of Medicare and Medicaid Programs

	Medicare	Medicaid
Eligibility	Age 65+ Disabled persons End-stage renal disease Lou Gehrig's desease Retired railroad employees	Categorical welfare (TANF, SSI)* Persons living with AIDS Low-income pregnant women Low-income children Low-income elderly
Financing	Part A: Employer/employee contributions Copayments and deductibles Part B: Premiums Deductible General revenue (federal funds) Part C: Medicare Advantage (formerly Medicare+Choice) Capitation payment funded by Part A Trust Fund and Part B account Part D: Outpatient prescription drug coverage Premiums and general revenue (federal funds) Individual cost sharing	50% federal funds (at minimum) 50% or less state funds Limited copayments (cost sharing)
Benefits	Part A: Hospital inpatient Skilled nursing facility care Home health care Hospice Part B (optional): Physician services Outpatient services Part C: Medicare Advantage (formerly Medicare+Choice) Part D: Outpatient prescription drug coverage	Hospital (inpatient and outpatient) Rural health clinic Laboratory X-ray Skilled nursing facility, age 21+ Home health care EPSDT Physician services Family planning Nurse midwife (where permitted)
Population Covered	43.2 million persons, including 5 million persons with disabilities (2007)	55.6 million persons (2007)
Means Test	None required	Income and asset limits

* Medicaid eligibility may differ from state to state, depending on how the state redefines the linkage between welfare programs and Medicaid eligibility as a result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

NOTES: TANF = Temporary Assistance to Needy Families; EPSDT = Early and Periodic Screening, Diagnosis, and Treatment Program; SSI = Supplemental Security Income.

private, public, or social health insurance and payment for the deductibles, copayments (set dollar amounts), and coinsurances (percentages of total charges) that various insurance companies require. (Premiums are not usually considered out-of-pocket payments in the calculation of the National Health Accounts.) Out-of-pocket payments constitute an important revenue source for financing health services. In 2007, 12 percent of health services revenues came from private out-of-pocket payments (see Chapter 7).

Government-Sponsored Programs That Provide Access to Health Services

A range of government-supported health programs provide direct access to health services for special populations. A select set of these programs, including the VA system, Department of Defense programs (including TRICARE), the Indian Health Service, and the prison health services system, are discussed in the sections that follow.

U.S. Department of Veterans Affairs System

The VA health services system, established in 1921 as the U.S. Veterans Bureau (Shonick 1995) to provide inpatient, outpatient, and long-term care services to veterans with conditions connected to their military service, provides care through a system of 153 hospitals and 895 community-based outpatient clinics (U.S. Department of Veterans Affairs 2008). Some states have several VA hospitals; others, such as Alaska, have none.

VA health services facilities provide care to an important segment of the U.S. population and serve as training sites for medical students and residents. In 1972, in what was perceived as an era of physician shortages, the VA linked with other organizations to establish eight new medical schools to increase the supply of physicians.

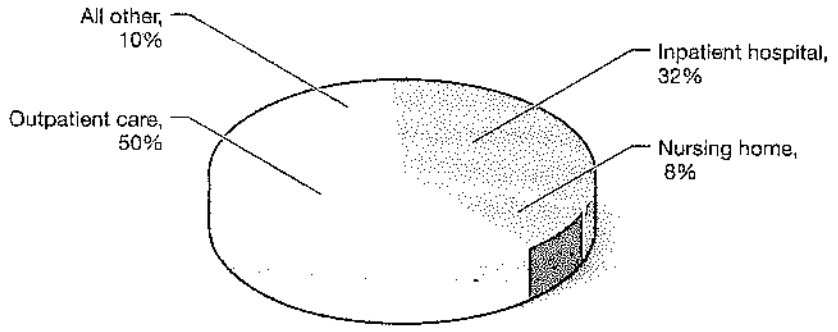
Congress periodically questions the future of the VA system. Proposals to expand VA services to include dependents of veterans, to serve other community members, or to dismantle the VA system have been discussed at the congressional level but have not yet reached legislative status. Any potential changes to the VA system need to take into account the new population of veterans from the wars in Iraq and Afghanistan.

In 2007, the VA expended $33.8 billion for the care of veterans. Exhibit 3.7 shows the percentage distribution of these funds, half of which were expended on outpatient care.

Department of Defense Health Services

The Department of Defense (DOD) is an important provider of health services to active military members and their dependents. The U.S. Army, Navy, and Air Force each operates its own medical services, and the DOD operates eight "tri-service" joint medical facilities. TRICARE serves more than 9.2 million beneficiaries in 63 military hospitals and 413 clinics around the world

EXHIBIT 3.7 VA Expenditures for Health Care, 2007



SOURCE: This exhibit was created from data from the *National Health Expenditures Report for 2007*, published by the Centers for Medicare & Medicaid Services in 2008

that are referred to as military treatment facilities (TRICARE 2008; USGAO 2005a). Contractual services are negotiated with the private sector in places where no military facilities exist. A medical school to train physicians for military service—the Uniformed Services University of the Health Sciences—was established in 1972 in the Washington, DC, area.

Military dependents and retirees, and their dependents and survivors, receive health services through TRICARE, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), an insurance program whose origins date back to the Emergency Maternal and Infant Child Care Program (EMIC) established in 1943 (Shonick 1995). The DOD requires considerable cost sharing of its TRICARE enrollees and uses managed care as one way to project and better manage expenditures for military dependents and retirees. The DOD FY 2007 budget for its Unified Medical Program was $42.2 billion to provide care to 89,400 military and 44,100 civilian beneficiaries (TRICARE 2008).

Indian Health Service

The Indian Health Service (IHS), first established as a unit of the War Department in 1802 (Shonick 1995), and now a part of the U.S. Department of Health and Human Services (HHS), provides health services to an estimated 1.5 million of the estimated 2.6 million American Indians and Alaska Natives enrolled in more than 557 tribes, villages, bands, and pueblos throughout the United States. The IHS maintains 49 hospitals and 364 health centers in a number of states for its beneficiaries, but it also contracts with the private sector to provide services to those who live outside the service areas of these facilities (IHS 2002; USGAO 2005b). Through the Indian Self-Determination and Education Assistance Act of 1975, many tribal authorities have assumed responsibility for providing health services, contracting with IHS for the funds to help them develop and implement tribal-specific health plans. Larger cities

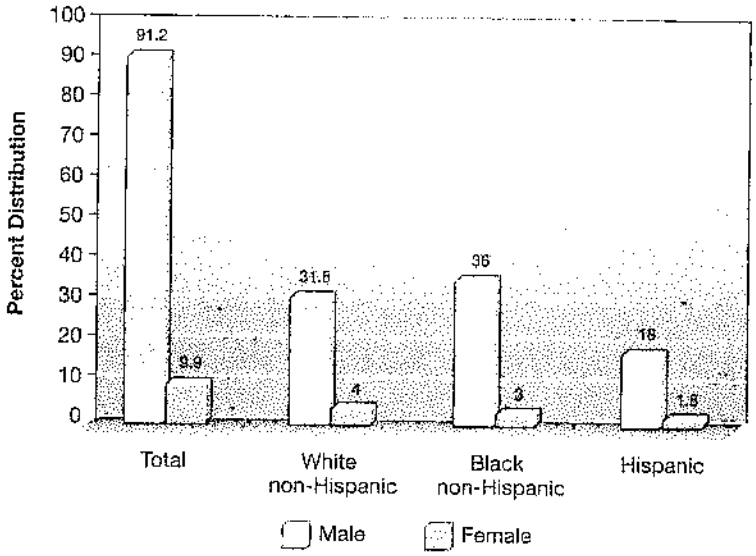


EXHIBIT 3.8 Inmates in State or Federal Prisons and Local Jails by Gender, Race, and Ethnicity, 2006

SOURCE: This exhibit was created using data from *Health, United States, 2008*, published by the National Center for Health Statistics in 2009.

may have an urban Indian center where services are available to American Indians who live away from their home reservations.

Prison Health Services

No group within the U.S. population has a constitutionally established right to health services. Prison inmates, however, are described by some as having the nearest thing to a constitutional right to care of any population group. This description stems from the provision of services that has resulted from inmate lawsuits claiming the right to care under the auspices of the Eighth Amendment to the U.S. Constitution, which prohibits "cruel and unusual punishment." Exhibit 3.8 shows the distribution of the 2.2 million U.S. prisoners in 2006 by gender and by race/ethnicity.

Inmates in federal and state prison systems receive government-funded health services that vary in extent and coverage by individual facility.[5] Prisons may have staff physicians on site, contract for physician services on an as-needed basis with nearby communities, maintain on-site clinics staffed by mid-level practitioners, provide care through the use of telemedicine, or arrange for health services in other ways. Few prisons maintain full-scale inpatient hospital facilities; they typically obtain such services from nearby communities on an as-needed basis. Dental services may also be provided according to a variety of arrangements.

Correctional facility administrators are concerned about the increasing demand and expenditures for health services because of the aging of the

prison population and because more inmates are receiving and serving longer sentences. Additional concerns include the number of inmates who are positive for human immunodeficiency virus (HIV) or have acquired immunodeficiency syndrome (AIDS), the increase in tuberculosis and other communicable diseases, the prevalence of chronic diseases in an aging population, the prevalence of mental illnesses, and other serious health problems in an incarcerated population.

Potential Adverse Outcomes Associated with Lack of Access or Unconstrained Access to Health Services

The access-to-health-services model (Exhibit 3.2) incorporates the potential adverse health outcomes associated with lack of access and excessive access. Having financial access to health services directly affects care-seeking behavior. A lack of health insurance is associated with reduced access to medical care, a lower prevalence of recommended preventive services, potentially avoidable hospitalizations, and subsequently higher mortality independent of other risk factors (Franks, Clancey, and Gold 1993). Uninsured adults and children have fewer provider visits than people with insurance. Uninsured adults use about half of the nonemergency ambulatory visits, two-thirds or fewer emergency department visits, and a much smaller fraction of inpatient hospital days—12 percent for men and 20 percent for women—than their insured counterparts. Although uninsured children appear to use emergency care on a par with insured children, they still use only 70 percent as much nonambulatory care and are only 25 percent as likely as children with insurance to enter a hospital (Spillman 1992). Children with health insurance gaps are at increased risk of having more than one care site (Kogan et al. 1995), thus jeopardizing continuity of care. They are less likely to receive medical care from a physician, even when it seems reasonably indicated, and are at risk for substantial avoidable morbidity (Stoddard, St. Peter, and Newacheck 1994).

Exhibit 3.9 shows that 52.5 percent of those without insurance for all or part of the previous 12 months postponed seeking care, and 42.4 percent went without care because of financial reasons; in contrast, only 4.1 percent of people with insurance postponed care and 3.7 percent went without care because of financial reasons. In a seminal 1992 report, the congressional OTA reported that the uninsured are more than three times as likely as those with private insurance to experience a lower utilization of services, potentially worse health services, and adverse outcomes. The OTA also reported that people with public insurance (Medicaid in particular, even though it is not an insurance program) are up to two and a half times more likely than those with pri-

EXHIBIT 3.9
Reduced Access to Medical Care During the Previous 12 Months Because of Cost, by Selected Characteristics, 2006

	Percentage of Population		
	Insured Continuously All 12 Months	*Uninsured for Any period*	*Uninsured for >12 Months*
Did not get medical care due to cost	2.1	19.4	23.0
Delayed medical care due to cost	4.1	26.4	26.1
Did not get prescription drugs due to cost	3.7	21.8	21.6

SOURCE: This exhibit was created using data from *Health, United States, 2008*, published by the National Center for Health Statistics in 2009.

vate insurance to experience potentially inadequate health services and four times more likely to have an adverse outcome.

Since these seminal studies were reported, others have continued to document the effects of lack of health insurance on health status. A study by Ayanian and colleagues (2000) showed that a significantly higher proportion of those who were uninsured for more than one year could not see a physician because of the cost and had had no routine checkup within the previous two years compared with those who were uninsured less than one year or who had not lost insurance. The Institute of Medicine (IOM) examined the matter and has issued reports on the problems of the uninsured in the United States. Members of an expert panel examined findings from more than 130 research studies. In the report *Care Without Coverage: Too Little, Too Late*, issued in May 2002, the IOM reported that adult health status changes when adults remain uninsured: adults in late middle age (especially between ages 55 and 65) and adults with low incomes are especially susceptible to deteriorating health if they never had or have lost health coverage (IOM 2002a). A study by Baker and colleagues (2002) corroborates the IOM findings: adults age 51–61 years who lost all health insurance were at increased risk of major declines in overall health and had increased risks of developing a new mobility difficulty within two years of losing their health insurance coverage. The Kaiser Family Foundation (2002), the American College of Physicians (ACP) (2004), and the Institute of Medicine (2009) all report on the health consequences of being uninsured. The uninsured receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive

fewer drugs and less surgical intervention. Uninsured children are 25 percent more likely to miss school (Kaiser 2002). The ACP report listed 15 adverse health consequences experienced by the uninsured. The IOM report concluded that health insurance is integral to individuals' personal well-being and health.

The destabilization of the U.S. economy that became alarmingly evident in the fall of 2008 suggests that a larger proportion of the population may delay seeking care because they have lost their employer-sponsored health insurance because of unemployment or have had related events that have compromised their financial access to health services. Destabilization is not a phenomenon unique to the United States: the global economy and that of many individual countries have also been affected, and although their various health services differ, a reduction in financial resources affects every resident of a country.

Although it seems a smaller problem compared with the magnitude of the uninsured population whose access to care is limited, unconstrained access to care may also contribute to, rather than alleviate, health problems. Iatrogenic (physician-induced) illness and nosocomial (hospital-acquired) infections may occur as a result of treatment. Adverse drug interactions are more likely when a patient's treatment by a range of providers is not coordinated. Despite their widespread use, not all therapies have been proven to be effective. Between one-quarter and one-third of care given to insured people in the United States falls in the inappropriate or equivocal area in which medical benefit does not exceed its risk (Brook 1991). In her book *Overtreated: Why Too Much Medicine Is Making Us Sicker and Poorer* Shannon Brownlee (2008) points out that Dr. David Eddy, a reputed heart surgeon and health economist, estimates that "as little as 15 percent of what doctors do is backed up by valid evidence."

Andrew Booth, with contributions from others, provides a resource guide that analyzes 18 studies to assess what proportion of medical practice is evidence based (Booth et al. n.d.).

The evidence-based movement's aim is to root out ineffective treatments and practices because vigorous scientific analysis does not always occur before a promising practice becomes widely disseminated. The evidence-based approach needs to be distinguished from a movement that occurred between 1987 and 1996, first called "medical futility" (Helft, Siegler, and Lantos 2002) and now referred to as "potentially ineffective care." These terms generally refer to care offered a person with a terminal illness or devastating injury whose health status is unlikely to improve despite any heroic intervention. In such situations, patient comfort and relief from pain become the focus of treatment.

Access to Health Services for the Uninsured

An estimated 96 percent of people 65 years and older have financial access to health services through the Medicare program, and nearly 84 percent of the population younger than 65 years access health services through private health insurance, Medicaid, Medicare (for people with disabilities younger than 65 years and those with ESRD), private out-of-pocket payments, or government-sponsored programs such as the VA system (USDHHS 2002; Iglehart 2002).

How do people not covered by these programs—an estimated 16 percent of the population younger than 65 years—get health services when they need them? Who are the uninsured? Why are some people uninsured? This section addresses these questions.

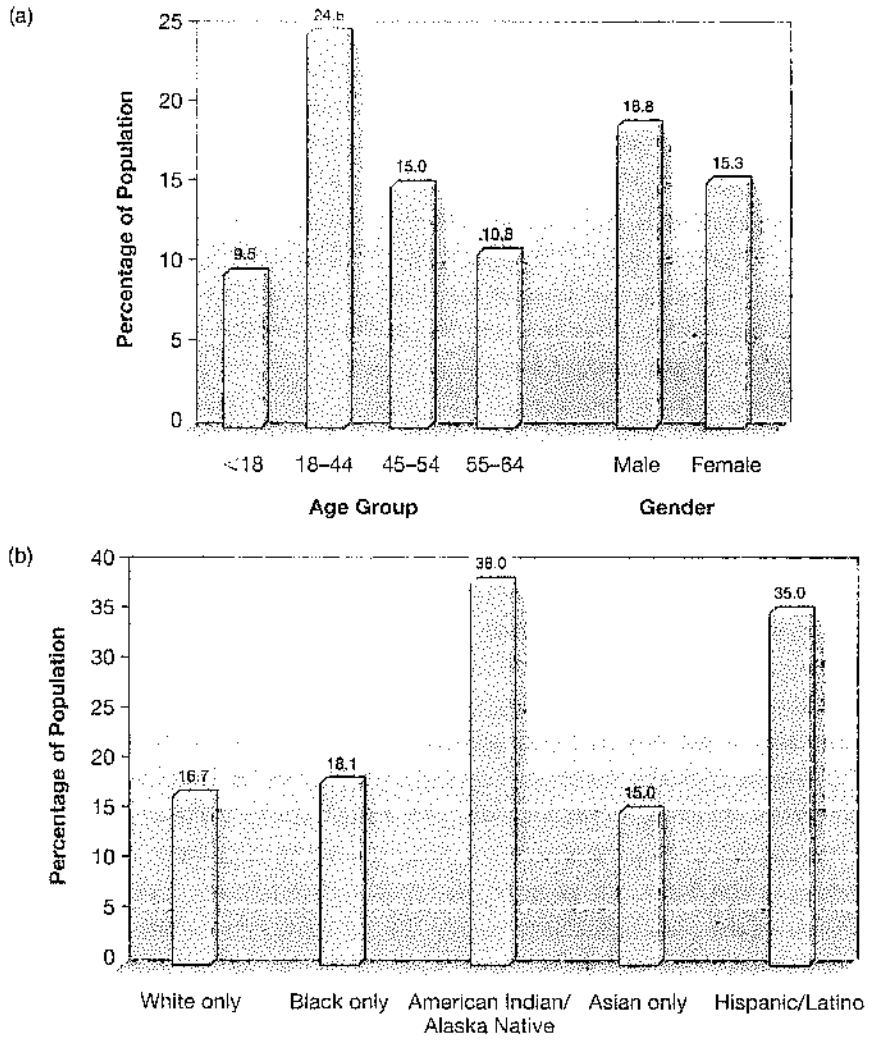
People who have no health insurance, limited ability to pay out of pocket, and limited or no access to other governmental health programs may access care from public hospitals and clinics; neighborhood, community, and migrant health centers; or clinics established by charitable organizations or other volunteers that provide low-cost sliding scale fees or no-cost care. Although many of these facilities and the providers who staff them offer comprehensive care, patients may not always be able to avail themselves of it. Thus, such sites may serve as stopgaps, providing urgent or emergency outpatient care, rather than the comprehensive care a person with insured access to the system typically receives. Persons seeking care in hospital emergency departments are likely to get such care if their situations are truly emergent or may be referred to more appropriate care, in large part because hospitals participating in the Medicare program are required to provide emergency care, regardless of the patient's ability to pay. Such patients constitute a significant economic burden to hospitals, particularly public hospitals, whose provision of charity care (also called uncompensated care or bad-debt care) may jeopardize their ability to remain financially viable.

Physicians and other providers often provide free or pro bono care to a limited number of patients. Clinics, particularly in inner-city areas, may be established as free clinics, providing basic care to all who seek their services, to the extent that their resources permit them to do so. Such clinics may be staffed by volunteer providers, with supplies and other services donated by community members or underwritten by community institutions. Helpful as these free clinics are, they cannot begin to replace a regular source of care for everyone who needs it.

Demographic Characteristics of the Uninsured

Who are the uninsured? Exhibit 3.10 shows the proportion of the population that is uninsured, by age, gender, race/ethnicity, and poverty level status. The

EXHIBIT 3.10 No Health Insurance Coverage Among Persons <65 Years, 2006
(a) By Age Group and Gender. *(b)* By Race/Ethnicity. *(c)* By Federal Poverty Level (FPL).



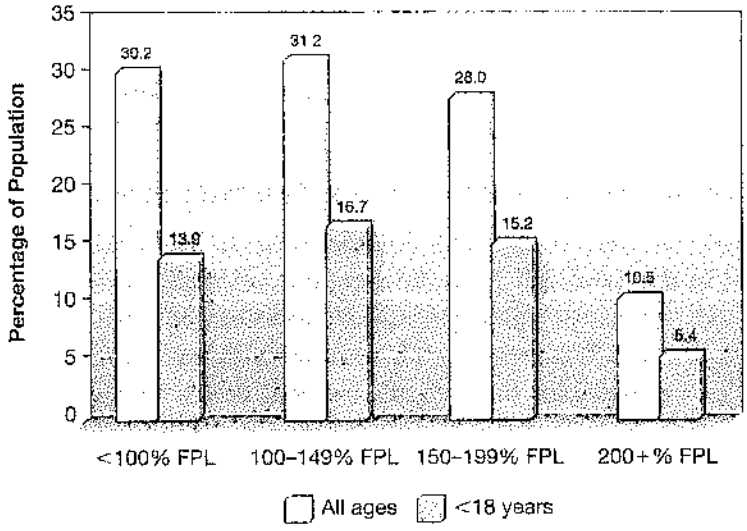
18- to 44-year-old age group has the highest proportion of uninsured persons. American Indians and Alaska Natives have the highest proportion of uninsured persons (38 percent), followed closely by those of Hispanic/Latino ethnicity at 35 percent. Rates of no insurance decrease with increases in income.

Reasons People Lack Health Insurance

People lack health insurance for many reasons. They may not have access to employer-sponsored health insurance because their employer does not offer it, they are not in the workforce, or they cannot afford the premiums. They may not be able to afford the premiums of an individual health insurance policy.

EXHIBIT 3.10
Continued

(c)



SOURCE: These exhibits were created using data from *Health, United States, 2008*, published by the National Center for Health Statistics in 2009.

They may not qualify for Medicare or Medicaid or be eligible for other government-supported health programs, such as military care.

One sometimes-overlooked reason that people lack health insurance is that they decline employer-sponsored coverage. In an early study, Cooper and Schone (1997) found an 8.2 percentage point decrease in the number of workers who accepted health insurance between 1987 and 1996. They attribute this decline to a number of factors, including declining real incomes, especially among workers who are the least likely to have coverage (e.g., healthy young men in the workforce); increasing costs of insurance; rising employee contributions to health insurance premiums; and expansions in Medicaid coverage.

Bernard and Seldon (2006) found that on average, in 2001 and 2002, 11.3 million U.S. residents were uninsured despite having an offer of employment-related insurance through their jobs or that of an immediate family member. Some who declined employer-sponsored health insurance had public coverage, but 6.3 percent of adults and 7.3 percent of children eligible for employer-sponsored health insurance had no health insurance coverage during the study period. Other findings from their work include the following:

- Children in low-income families were less likely to have coverage than other children. Most children whose parents decline private coverage end up with public care, whereas the adults remain uninsured.

- Decliners were more likely to report poor health but less likely to have a high-cost medical condition than those with health insurance coverage.
- Families declining coverage were more likely to have financial barriers to care.
- Families that decline employee health coverage rely heavily on public funding and uncompensated care.

Initiatives to Expand Financial Access to Health Services

Despite the fact that arranging for financial access to health services has largely been left to the individual, with the exception of Medicare beneficiaries who are ensured access, the public periodically expresses concern that more than one-sixth of the U.S. population has no health insurance and thus has limited access to care. Recommendations for national health insurance were introduced as early as the Roosevelt administration in 1935 (Litman and Robins 1991) and again in 1993 with the unsuccessful Health Security Act (HSA). Such proposals failed for a variety of reasons—not the least of which is the likely increase in federal expenditures needed to support them. A range of other proposals, each of which is briefly described in the sections that follow, have been offered in the last several decades, including:

- expanding the Medicare program to include other beneficiaries;
- expanding the Medicaid program to include even more of the uninsured;
- providing health insurance coverage to special populations, such as children;
- creating a single-payer system similar to that in Canada;
- reforming the health insurance industry;
- creating risk pools for the uninsurable; and
- establishing statewide health insurance programs.

At the federal level, the Medicaid program has been expanded to cover more of the uninsured (see Appendix 6.2 in Chapter 6), the State Child Health Insurance Plan (SCHIP) was established in 1997 and reauthorized as CHIP in 2009, some states have created risk pools for the uninsurable, and a number of states have established statewide health insurance programs. These changes are addressed in Chapter 6.

Expanding Medicare

The 1993 HSA was one of several proposals to expand eligibility to Medicare. The HSA proposed adding a Part C to Medicare that would provide coverage to many of the uninsured. Expenditure projections and a distaste for a larger governmental role in health services contributed to the defeat of this bill. A different Part C, the Medicare+Choice plan (discussed in chapters 6 and 19), was added to Title XVIII by the 1997 Balanced Budget Act and has since been replaced by the Medicare Advantage program established by the 2003 Medicare Prescription Drug Improvement and Modernization Act (MMA). Enrollment in Medicare Advantage remains relatively modest—8.2 million enrollees as of June 2007—

even though some Medicare Advantage plans offer more coverage than fee-for-service Medicare may provide (Merlis 2007).

Expanding Medicaid

Although a broader expansion of Medicaid eligibility has been discussed at the national level, the only action on this idea is occurring at the state level. After years of grassroots development, the state of Oregon was granted a waiver from the Health Care Financing Administration (HCFA—now the Centers for Medicare & Medicaid Services [CMS]) to initiate the Oregon Health Plan, which enrolls people whose incomes are below 100 percent of the poverty level into the Medicaid program, even if they are not categorically eligible. Oregon proposed even more comprehensive coverage through its state plan, but Oregon voters rejected this expansion in the fall 2002 elections. In January 1994, the state of Tennessee replaced its Medicaid program with TennCare to cover more of the low-income uninsured. Managed care organizations and behavioral health organizations provided care to enrollees through three products: TennCare Medicaid, TennCare Standard, and TennCare Assist (TennCare 2003).

TennCare had many problems in terms of payments to specialists, enrollment, and other issues. It was replaced by CoverTN in March 2007. Its premiums are shared by the state, businesses, and employees. The program currently has 16,000 members and 6,504 businesses enrolled. New benefits that began January 1, 2009, include increasing the number of annual preventive medicine visits, adding specialist physician visits, and removing the cap on payment for diabetic medicines and supplies (Robert Wood Johnson Foundation 2008a).

The Oregon and Tennessee programs are only two examples of Medicaid expansions. A number of other states have established similar expansions or are piloting such expansions.

Providing Health Insurance Coverage for Children

In 1997, Congress added Title XXI to the Social Security Act, creating the SCHIP, which provided $40 billion in matching funds to states over ten years to support health insurance coverage for children. States could choose to expand their Medicaid programs, start or augment a separate insurance program for children, or devise a hybrid of these strategies (Demkovich 1997a).

Twenty-one states chose to expand their Medicaid programs, 12 to have separate SCHIP programs, and 21 to operate combination programs. Despite slow enrollment starts in many SCHIP programs, 7 million children were enrolled in the SCHIP program in 2007 (Ryan and Mojerie 2008). Since 1997, Congress has changed how the SCHIP funds are allocated; between 2002 and 2004, states experienced a 26 percent decline in the amount of federal funds available to them (Ryan 2002). Congress and President George W. Bush disagreed about how SCHIP was to be reauthorized, so the president authorized an extension through March 2009. Congress, after President Barack Obama's inauguration in 2009, reauthorized this legislation as CHIP.

Creating a Single-Payer System

Canada's health services system, in which the government serves as the single payer for care, has been proposed as a model for the U.S. system to emulate. The Canadian system achieves a comparable—and some would claim a higher—health status at significantly lower per capita expenditures. The likelihood that the United States will follow Canada's lead seems slim for several reasons. One reason is the difference in the roles of the health insurance industry in the two systems: in the United States, the health insurance industry has been a dominant influence on how the system has developed, whereas the Canadian system has no major counterpart to the U.S. industry. Additionally, the Canadian system, under considerable pressure to change because of increasing expenditures and an oversupply of physicians, imposed controls on physician training and practice sites, the availability of hospital beds, and other services in the late 1990s (though since then education slots available for nursing and medical students have been added [Canadian Institute for Health Care 2002]). In the early years of the twenty-first century, an improving economy and belt tightening by the Canadian federal government led to the development of budget surpluses. Canada, however, has been affected by the worldwide economic instability that began in the fall of 2008.

Reforming the Health Insurance Industry

The unsuccessful 1993 HSA proposed several reforms to the health insurance industry, such as establishing uniform billing and streamlining other administrative procedures. Although Congress did not enact the sweeping reforms proposed by the HSA, incremental changes in the industry are occurring. The 1996 Health Insurance Portability and Accountability Act (HIPAA) makes it easier for insured people to retain coverage when they leave a job (portability); establishes federal insurance requirements for carriers offering coverage in the individual, small-group, and large-group markets; and imposes specific insurance reforms on self-funded health insurance plans (see Chapter 6).

Creating Risk Pools for Uninsurables

Thirty-five states have established subsidized health insurance plans for people with chronic conditions or other risk factors that have made them uninsurable (Rau 2008). Health insurance from a state risk pool is likely to be limited in scope and more expensive than commercial insurance. It is less likely to cover dependents than private health insurance but may fill a crucial health insurance need for those who can afford it.

Establishing Statewide Insurance Programs

Several states have established or are considering the establishment of statewide health insurance programs. Washington's Basic Health Plan, established in 1988, began as a three-county demonstration insurance plan for low-income residents and expanded statewide in 1993. As of June 2009, the Washington Basic Health Plan covered nearly 100,000 Washingtonians. Recent state budget cuts have

precipitated monthly premium increases for 2010 (Washington Basic Health Plan 2009). The 2006 Massachusetts legislature passed a universal insurance program that the governor signed into law. As of August 2008, more than 400,000 people had enrolled in this plan (Massachusetts Division of Health Care Policy and Finance 2009). Other states have followed suit, but some states may have to table further action until the U.S. economy recovers.

Other Proposals

New proposals for group purchasing—association health plans, health insurance purchasing cooperatives, and multiple employer welfare arrangements—are emerging (see Chapter 6). How these proposed new products will survive in a complex market remains to be seen. Analysts suggest that these new products warrant cautious and careful consideration but are not likely to produce a significant overall reduction in premiums or an increase in insurance coverage (Hall, Wicks, and Lawlor 2001). Many of these products appear to be eclipsed by newer initiatives, including the interest in consumer-directed health plans (see Chapter 6).

A Focus on Health Disparities

Differences in health status occur for a variety of reasons. The determinants of health (see Chapter 2) affect each person differently. Some believe income differences are the most influential factor in differences in health status, or health disparities. Other factors that might influence disparities in health status include demographic factors, such as race/ethnicity and age.

A national focus on health disparities centers on those disparities that can be corrected through improved access or other interventions. The *Healthy People 2010* objectives (and prior and subsequent versions of the objectives) aim to reduce disparities that are amenable to change (USDHHS 2000a). In 2006, the Agency for Healthcare Research and Quality summarized its findings about health disparities. Exhibit 3.11 shows the differences by racial and ethnic groups and by income in diminishing disparities. These differences clearly need to be effectively addressed if the disparities in health status and in health care are to be resolved.

This chapter has focused principally on disparities related to financial access to health services. Exhibit 3.10 is particularly telling regarding the part of the U.S. population that is uninsured.

EXHIBIT 3.11 Summary of Agency for Healthcare Research and Quality's (AHRQ) 2006 National Healthcare Disparities Report

For most core quality measures, Blacks (73%), Hispanics (77%), and poor people (71%) received worse quality care than their reference groups. For most measures for poor people (67%), disparities were *increasing;* for most measures for minorities, significant changes in disparities were not observed.

Increasing disparities were especially prevalent in chronic disease management. Compared to their reference groups:

- Blacks had 90% more lower extremity amputations for diabetes.
- Asians were restrained in nursing homes 46% more often.
- American Indians and Alaska Natives were hospitalized from home health care 15% more often.
- Hispanics had 63% more pediatric asthma hospitalizations.
- Poor people were 37% less likely to receive recommended diabetes care.

All of these disparities were *increasing* over time. Better and improving quality, however, was also observed for at least one measure for every population.

For most core access measures, Hispanics (83%) and poor people (100%) had worse access to care than their reference groups. Disparities were *increasing* for most measures for Hispanics (80%) and for poor people (100%).

Better access was only observed for Asians compared with Whites, although improving access was observed for at least one measure for every population.

SOURCE: These data came from the *2006 National Healthcare Disparities Report* published by AHRQ.

Summary

Access to health services has several dimensions—geographic, physical, temporal, sociocultural, and financial—that can ensure or inhibit access to care. Potential access is affected by predisposing factors (age, gender, education, occupation, and race/ethnicity); need factors (perceived health, interpretation of illness, and other health status measures); and enabling factors (convenience, income, insurance coverage, and system characteristics). Of the enabling factors, financial access to care in the United States is usually predicated on insurance coverage, either private or public, or personal income (ability to make out-of-pocket expenditures for care). For those who do not have health

insurance, government health programs, such as those sponsored by the VA, DOD, and IHS, provide care to eligible populations. People ineligible for health insurance or these governmental health services programs may be able to access care through low-cost or no-cost clinics.

As much as 20 percent of the U.S. population may have limited or no financial access to health services in a given year. This population is at greater risk of morbidity and mortality and frequently presents on an emergency basis with poorer health status than those people who have no financial impediments to receiving care.

Major changes in health insurance, the primary health services financing mechanism in the United States, seem unlikely, given the defeat of the HSA. Instead, incremental reforms, such as those incorporated in the HIPAA of 1996, appear to be the most likely to effect change.

Notes

1. Penchansky and Thomas (1981) define the dimensions of access as follows: Availability is the relationship of the volume and type of services (and resources) to the client's volume and type of needs. It refers to the adequacy of the supply of physicians, dentists, and other providers; facilities, such as clinics and hospitals; and specialized programs and services, such as mental health and emergency care. Accessibility is the relationship between the location of clients and healthcare facilities, taking into account client transportation resources, travel time, and cost. Accommodation is the relationship between the manner in which the supply resources are organized to accept clients (including appointment times, hours of operation, walk-in facilities, and telephone services), the client's ability to adjust to these factors, and the client's perceptions of their appropriateness. Affordability is the relationship between prices of services and providers' insurance or deposit requirements to the client's income, ability to pay, and existing health insurance. The client's perception of worth relative to total cost is a concern here, as is the client's knowledge of prices, total cost, and possible credit arrangements. Acceptability refers to the relationship between clients' attitudes about the personal and practice characteristics of providers to the actual characteristics of existing providers as well as to provider attitudes about acceptable personal characteristics of clients.
2. Insurance coverage does not, however, guarantee access to care. If providers are unavailable or if they will not accept the insurance company's payment for services, an insured person still may not have access to health services.

3. The OTA's version of the chart, which did not include the final column on potential adverse outcomes associated with excessive access, was based on Aday, Andersen, and Fleming (1980); Weissman and Epstein (1992); Mechanic (1989); and studies reviewed for the interim report.
4. The SSI program is a federal cash assistance program for low-income aged and disabled people that has standard eligibility requirements. It was established to replace state-provided cash assistance programs to low-income and aged and disabled people.
5. The focus of this discussion is on prisoners with long-term sentences. Jail inmates who may be awaiting trial or a hearing or who are serving out a short sentence may not be eligible for other than emergency services.

Key Words

Aid to Families with Dependent Children (AFDC)
Americans with Disabilities Act of 1990
association health plans
bad-debt care
behavioral health organizations
Centers for Medicare & Medicaid Services (CMS)
charity care
Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)
coinsurance
copayment
CoverTN
Emergency Maternal and Infant Child Care Program (EMIC)
end-stage renal disease (ESRD)
entitlement program
Health Care Financing Administration (HCFA)
health disparities
Health Insurance Portability and Accountability Act (HIPAA)
health insurance purchasing cooperative
health literacy
Health Security Act (HSA) of 1993
iatrogenic illness
Indian Health Service (IHS)
Indian Self-Determination and Education Assistance Act of 1975
Institute of Medicine (IOM)
managed care organization
Medicaid
Medicare (Parts A and B)
Medicare+Choice plans
Medicare Prescription Drug Improvement and Modernization Act (MMA)
multiple employer welfare arrangements
nosocomial infection
Office of Technology Assessment (OTA)
Oregon Health Plan
out-of-pocket payment
portability of health insurance
preexisting condition
private health insurance
public/social health insurance
single-payer system

Supplemental Security Income (SSI)
TennCare
uncompensated care
Uniformed Services University of the Health Sciences (USUHS)
uninsurable
uninsured
U.S. Department of Defense (DOD)
U.S. Department of Health and Human Services (HHS)
U.S. Department of Veterans Affairs (VA)
Washington Basic Health Plan