Access to Quality Health Services

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Co-Lead Agencies: **Agency for Healthcare Research and Quality**
Health Resources and Services Administration

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Goal

Improve access to comprehensive, high-quality health care services.

Overview

Access to quality care is important to eliminate health disparities and increase the quality and years of healthy life for all persons in the United States. The public health system is important because it educates people about prevention and addresses the need to eliminate disparities by easing access to preventive services for people less able to use existing health services. It ensures the availability of primary care through direct funding of clinics and providers or by providing public insurance.

Issues

Access to high-quality health care across each of the components in the continuum of care must be improved to realize the full potential of prevention. It is increasingly important that health care communication and services be provided in a culturally and linguistically sensitive manner. Adequate access to health care and related services can increase appropriate patient use of the health care system and, ultimately, improve health outcomes.

Clinical preventive care. Improving access to appropriate preventive care requires addressing many barriers, including those that involve the patient, provider, and system of care.[1,2] Patient barriers include lack of knowledge, skepticism about the effectiveness of prevention, lack of a usual source of primary care, and lack of money to pay for preventive care.

Health provider barriers include limited time, lack of training in prevention, lack of perceived effectiveness of selected preventive services, and practice environments that fail to facilitate prevention. Although consensus is growing regarding the value of a range of preventive services, providers identify lack of time and reimbursement as specific barriers to more consistent delivery of counseling about behavioral risk factors.[3] Computerized or manual tracking systems, patient and clinician reminders, guidelines, and patient information materials can help providers improve delivery of necessary preventive care.[4]

System barriers can include lack of resources, lack of coverage or inadequate reimbursement for services, and lack of systems to track the quality of care.[2] Systems interventions that can increase delivery of health care include providing feedback on performance to providers, offering incentives for improved performance, and developing and implementing systems to identify and provide outreach to patients in need of services.[1]

Measuring and reporting how well preventive care is provided under different systems are essential first steps in motivating those systems that are not performing well to develop the information, tools, and incentives to improve care.[5] Appropriate data systems are needed to allow providers and administrators to identify those services and populations most in need of better delivery. To be effective, preventive care also must be linked to systems to ensure appropriate followup services or counseling for patients identified through risk assessment or screening.

Primary care. Improving primary care across the Nation depends in part on ensuring that people have a usual source of care. This is because of the beneficial attributes of primary care. These benefits include the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.[6]

Trends

A significant measure of the access problem is the proportion of people who have health insurance. Following declines in the proportion of people with health insurance during the 1980s, the proportion has remained essentially level, at about 85 percent from 1989 to 1997 for persons under age 65 years.[7] Approximately 44.3 million persons lacked health insurance in 1998[8], continuing an increase in the number of uninsured persons. At the same time, the proportion of adults with a usual source of care—an important predictor of access to needed services—fell from 83 percent to 78 percent between 1987 and 1992 before rising to 85 percent in 1998.[9] In addition, having health insurance does not guarantee that health care will be accessible or affordable. Significant numbers of privately insured persons lack a usual source of care or report delays or difficulties in accessing needed care due to affordability or insurance problems.[10]

Disparities

Limitations in access to care extend beyond basic causes, such as a shortage of health care providers or a lack of facilities. Individuals also may lack a usual source of care or may face other barriers to receiving services, such as financial barriers (having no health insurance or being underinsured), structural barriers (no facilities or health care professionals nearby), and personal barriers (sexual orientation, cultural differences, language differences, not knowing what to do, or environmental challenges for people with disabilities). Patients with disabilities may face additional barriers arising from facilities that are not physically accessible or from the attitudes of clinicians. Hispanics, young adults, and uninsured persons are least likely to have a usual source of care.[7] Hispanic persons and those with less than 12 years of education are least likely to have a usual primary care provider.[11] Certain people, such as those who are disabled, elderly, chronically ill, or HIV-infected, require access to health care providers who have the knowledge and skills to address their special needs.[12]

Opportunities

Increasing recognition of the critical role of preventive services across the continuum of care has led to the development of tools and projects designed to help providers and patients shift to a prevention-oriented health care system. HEDIS reports on the delivery of many clinical preventive services provided by participating health maintenance organizations (HMOs). The 1999 reporting set for HEDIS contained several measures of clinical preventive services, including childhood immunizations, adolescent immunizations, smoking cessation advice, influenza vaccinations for older adults, breast cancer screening, cervical cancer screening, and prenatal care in the first trimester.

Under development is the CDC Guide to Community Preventive Services, due to be released in 2001.[13] The guide will assess the effectiveness of preventive services and interventions in community settings and at the clinical systems level. It will cover 15 topics in three areas: changing risk behaviors, reducing specific diseases and injuries, and addressing environmental challenges.

Into the next decade, Healthy People will continue to promote communitywide efforts to provide clinical preventive services, using local leadership such as health departments and community institutions to increase the accessibility of these services. Healthy People also will work to strengthen the capacity of States and localities to collect health data and conduct community health assessments for small geographic areas.

REPRODUCTIVE HEALTH–RELATED OBJECTIVES

Access to Quality Health Services

Goal:

Improve access to comprehensive, high-quality health care services.

Number Objective Short Title

Clinical Preventive Care

1-2. Health insurance coverage for clinical preventive services

1-3. Counseling about health behaviors

Primary Care

1-7. Core competencies in health provider training

HEALTHY PEOPLE 2010 OBJECTIVES

Clinical Preventive Care

1-2. (Developmental) Increase the proportion of insured persons with coverage for clinical preventive services.

Potential data source: Medical Expenditure Panel Survey (MEPS), AHRQ.

Insurance coverage for clinical preventive services improved substantially during the 1990s, but significant variations remain in the services covered, depending on the plan and type of insurance. In 1988, among employers who offer health insurance, only 26 percent of their employees were covered for adult physical examinations, 35 percent for well-child care (including immunizations), and 43 percent for preventive screening tests.[14] In contrast, a 1997 national survey of over 3,000 employers found that 88 percent of employer-sponsored plans covered well-baby care, 89 percent covered adult physical examinations, 92 percent covered gynecologic examinations, and 89 and 91 percent covered Pap tests and mammograms, respectively. Coverage was highest in HMO plans and lowest in indemnity insurance plans.[15]

Including effective clinical preventive services among the services routinely covered by insurance is an effective way to emphasize the importance of clinical preventive services as an integral part of health care.[16] The Balanced Budget Act of 1997 (Public Law 105-33) added colorectal cancer screening among other new preventive benefits under the Medicare program and expanded Medicare coverage of mammography and cervical cancer screening. Although health insurance coverage by itself is not sufficient to eliminate existing gaps in the delivery of preventive services, it is an important factor influencing who gets recommended services.[17,18] Selected clinical preventive services have a positive influence on

personal health, and many are cost-effective in comparison with the treatment of disease.[19,20] Insurance coverage is especially problematic for counseling services, in part, because of the difficulty in proving the benefits of some counseling interventions. For example, only 22 percent of employer-sponsored plans cover medications or counseling for smoking cessation.[15] The effectiveness of smoking cessation counseling, however, is supported by strong evidence, with more intensive interventions having the greatest impact and most favorable cost-effectiveness ratios.[21]

1-3. Increase the proportion of persons appropriately counseled about health behaviors.

Target setting method: Better than the best.

Data sources: National Survey on Family Growth (NSFG), CDC, NCHS; National Health Interview Survey (NHIS), CDC, NCHS.

Target and baseline:

Objective	Increase in Counseling on Health Behaviors Among Persons at Risk With a Physician Visit in the Past Year	1995 Baseline	2010 Target
		Percent	
1-3a.	Physical activity or exercise (adults aged 18 years and older)	Developmental	
1-3b.	Diet and nutrition (adults aged 18 years and older)	Developmental	
1-3c.	Smoking cessation (adult smokers aged 18 years and older)	Developmental	
1-3d.	Reduced alcohol consumption (adults aged 18 years and older with excessive alcohol consumption)	Developmental	
1-3e.	Childhood injury prevention: vehicle restraints and bicycle helmets (children aged 17 years and under)	Developmental	
1-3f.	Unintended pregnancy (females aged 15 to 44 years)	19	50
1-3g.	Prevention of sexually transmitted diseases (males aged 15 to 49 years; females aged 15 to 44 years)	Developmental	
1-3h.	Management of menopause (females aged 46 to 56 years)	Developmental	

Females Aged 15 to 44 Years With a Physician Visit in the Past Year, 1995	1-3f. Counseled About Unintended Pregnancy Percent
TOTAL	19
Race and ethnicity	
American Indian or Alaska Native	DSU
Asian or Pacific Islander	DSU
Asian	DNC
Native Hawaiian and other Pacific Islander	DNC
Black or African American	24
White	19
Hispanic or Latino	20
Not Hispanic or Latino	DNA
Black or African American	24
White	19
Education level (females aged 22 to 44 years)	
Less than high school	15
High school graduate	20
At least some college	19
Sexual orientation	DNC
Select populations	
Age groups	
15 to 24 years	22
25 to 34 years	23
35 to 44 years	10

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

Substantial gaps remain in the delivery of appropriate screening and counseling services related to health behaviors. Unhealthy diets, smoking, physical inactivity, and alcohol use account for a majority of preventable deaths in the United States.[22] Data indicate that risk assessment and counseling interventions are delivered less frequently than other preventive interventions (for example, cancer screenings).[7] In addition, the attention physicians give to specific health-risk behaviors appears to be influenced by the socioeconomic status of their patients.[23] Although time is an important constraint in the health care setting, evidence demonstrates that brief clinician counseling is effective in getting patients to stop smoking and reduce problem drinking.[19,24] In addition, brief counseling interventions aimed at high-risk individuals can increase condom use and prevent the spread of sexually transmitted diseases.[25]

Clinician counseling should be tailored to the individual risk factors, needs, preferences, and abilities of each patient.[19] For some preventive interventions, such as hormone therapy in postmenopausal women, the optimal strategy depends on how individual women value potential benefits and risks. Counseling of perimenopausal and postmenopausal women should encourage shared decisionmaking based on individual risk factors and patient preferences.[19]

Primary Care

1-7. (Developmental) Increase the proportion of schools of medicine, schools of nursing, and other health professional training schools whose basic curriculum for health care providers includes the core competencies in health promotion and disease prevention.

Potential data source: Adaptation of the Prevention Self-Assessment Analysis, Association of Teachers of Preventive Medicine (ATPM).

Significant changes in the health care system and in the expectations of consumers are influencing the education of health care providers in the United States. For example, many medical schools are assessing the content of their predoctoral and postgraduate curricula.[26] Medical educators and medical schools are recognizing that physicians will need to be prepared to provide population-based preventive health care as well as high-quality medical care to their patients.[27] This challenge exists for other health professionals, including nurses, nurse practitioners, physician assistants, and allied health personnel. This link between medicine and public health is essential to provide the highest quality health care possible to the U.S. population.

A core set of competencies for medical students in health promotion and disease prevention was developed by a task force established by the Association of Teachers of Preventive Medicine (ATPM) and the U.S. Department of Health and Human Services' Health Resources and Services Administration. The competencies, derived from the ATPM *Inventory of Knowledge and Skills Relating to Health Promotion and Disease Prevention*,[28] cover four categories: clinical prevention, quantitative skills, health services organization and delivery, and community dimensions of medical practice. Together, they address a wide spectrum of topics. This set of competencies will provide medical educators with measurable education outcomes in prevention education. The core competencies will be evaluated for potential adaptability to health provider education curricula in schools of nursing and health professional schools. The core competencies also will be reviewed for potential expansion to cover emerging issues and competencies in evaluating and responding to environmental health concerns and natural and man-made disasters. Because health care providers will have to address new health issues, policies, technologies, and practice guidelines over their careers, continuing education programs also need to be updated periodically.

Terminology

Access: According to the Institute of Medicine, "The timely use of personal health services to achieve the best possible health outcomes."[29] This definition includes both the use and effectiveness of health services. The concept of access also encompasses physical accessibility of facilities.

Activities of daily living (ADL): Personal care activities, such as bathing, dressing, eating, and getting around (with special equipment, if needed) inside the home.

Ambulatory care: Health care that does not require the patient to stay in a hospital or other facility, such as care provided on an outpatient basis.

Ambulatory-care-sensitive conditions: Conditions resulting in hospitalization that could potentially have been prevented if the person had improved access to high-quality primary care services outside the hospital setting.

Asymptomatic: Without symptoms. This term may apply either to healthy persons or to persons with preclinical (prior to clinical diagnosis) disease in whom symptoms are not yet apparent.

Clinical care: The provision of health care services to individual patients by trained health care professionals.

Clinical preventive services (CPS): Common screening tests, immunizations, risk assessment, counseling about health risk behaviors, and other preventive services routinely delivered in the clinical setting for the primary prevention of disease or for the early detection of disease in persons with no symptoms of illness.

Continuum of care: The array of health services and care settings that address health promotion, disease prevention, and the diagnosis, treatment, management, and rehabilitation of disease, injury, and disability. Included are primary care and specialized clinical services provided in community and primary care settings, hospitals, trauma centers, and rehabilitation and long-term care facilities.

Core competencies: A defined set of skills and knowledge considered necessary in the educational curricula for training health care providers. Examples of core competencies include skills in prevention education; skills in using sources of health data to identify what clinical preventive services should be delivered to the individual patient based on that person's age, gender, and risk factor status; an understanding of the U.S. public health system (local and State health departments) and its role in monitoring and maintaining the health of the community; and skills to evaluate and translate medical and scientific research reports into clinical practice.

Health insurance: Any type of third party payment, reimbursement, or financial coverage for an agreed-upon set of health care services. Includes private insurance obtained through employment or purchased directly by the consumer, or health insurance provided through publicly funded programs, including Medicare, Medicaid, CHAMPUS/CHAMPVA, or other public hospital or physician programs.

Health intervention: Any measure taken to improve or promote health or to prevent, diagnose, treat, or manage disease, injury, or disability.

Health outcomes: The results or consequences of a process of care. Health outcomes may include satisfaction with care as well as the use of health care resources. Included are clinical outcomes, such as changes in health status and changes in the length and quality of life as a result of detecting or treating disease.

Long-term care (LTC): A broad range of health and social services delivered in institutions, in the community, and at home. Long-term care services include institutional services, such as those delivered in nursing homes, rehabilitation hospitals, subacute care facilities, hospice facilities, and assisted living facilities; services delivered in the home, such as home health and personal care, hospice, homemaker, and meals; and community-based services, such as adult day care, social services, congregate meals, transportation and escort services, legal protective services, and counseling for clients as well as their caregivers.[30]

Managed care: According to the Institute of Medicine, "a set of techniques used by or on behalf of purchasers of health care benefits to manage health care costs by influencing patient care decisionmaking through case-by-case assessments of the appropriateness of care prior to its provision."[31]

Patient barriers: Any mental, physical, or psychosocial condition that prevents an individual from accessing needed health care. Examples include attitudes or biases, mental disorders or illnesses, behavioral disorders, physical limitations, cultural or linguistic factors, sexual orientation, and financial constraints.

Persons with long-term care needs: Persons who need the help of other persons to perform activities of daily living (personal care activities) and instrumental activities of daily living (routine needs).

Primary care: According to the Institute of Medicine, "The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."[6]

Primary care provider: A physician who specializes in general and family practice, general internal medicine, or general pediatrics, or a nonphysician health care provider, such as a nurse practitioner, physician assistant, or certified nurse midwife.

Primary prevention: Health care services, medical tests, counseling, and health education and other actions designed to prevent the onset of a targeted condition. Routine immunization of healthy individuals is an example of primary prevention.[19]

Provider barriers: Any mental, physical, psychosocial, or environmental condition that prevents or discourages health care providers from offering preventive services. Examples of provider barriers include a poor practice environment, lack of knowledge, and lack of efficacy studies.

Quality: According to the Institute of Medicine, "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[29] Simply stated, it is doing the right thing, for the right patient, at the right time, with the right outcome.

Secondary prevention: Measures such as health care services designed to identify or treat individuals who have a disease or risk factors for a disease but who are not yet experiencing symptoms of the disease. Pap tests and high blood pressure screening are examples of secondary prevention.[19]

System barriers: Conditions within a health care system that prevent people from accessing needed services or prevent health care providers from delivering those services. System barriers include physical, cultural, linguistic, and financial barriers as well as the availability of health care facilities or providers with special skills, such as eye, ear, nose, and throat specialists.

Tertiary prevention: Preventive health care measures or services that are part of the treatment and management of persons with clinical illnesses. Examples of tertiary prevention include cholesterol reduction in patients with coronary heart disease and insulin therapy to prevent complications of diabetes.[19]

Usual source of care: A particular doctor's office, clinic, health center, or other health care facility to which an individual usually would go to obtain health care services. Having a usual source of care is associated with improved access to preventive services and followup care.

Vulnerable and at-risk populations: High-risk groups of people who have multiple health and social needs. Examples include pregnant women, people with human immunodeficiency virus infection, substance abusers, migrant farm workers, homeless people, poor people, infants and children, elderly people, people with disabilities, people with mental illness or mental health problems or disorders, and people from certain ethnic or racial groups who do not have the same access to quality health care services as other populations.

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