Access To Quality Health Services

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PROGRESS REVIEW

In the first session in the second series of assessments of *Healthy People 2010*, ADM John O. Agwunobi, Assistant Secretary for Health, chaired a focus area Progress Review on Access to Quality Health Services. He was assisted by staff of the lead agencies for this *Healthy People 2010* focus area—the Health Resources and Services Administration (HRSA) and the Agency for Healthcare Research and Quality (AHRQ). In his introduction to the Progress Review participants, ADM Agwunobi noted that the Access objectives address services within four components of the healthcare system: clinical preventive care, primary care, emergency services, and long-term and rehabilitative care. He stated that ensuring high standards and readily available care is essential to achieving the two overarching goals of *Healthy People 2010*—eliminating health disparities and increasing quality and years of life for all Americans. Also participating in the review were representatives of other U.S. Department of Health and Human Services (HHS) offices and agencies.

The complete text for the Access to Quality Health Services focus area of *Healthy People 2010* is available online at **www.healthypeople.gov/document/html/volume1/01access.htm**. For comparison, the report on the first-round progress review (held on June 4, 2002) is archived at **www.healthypeople.gov/data/2010prog/focus01/2002fa01.htm**. The meeting agenda, tabulated data for all focus area objectives, charts, and other materials used in the Progress Review can be found at a companion site maintained by the National Center for Health Statistics (NCHS)/Centers for Disease Control and Prevention (CDC): **www.cdc.gov/nchs/about/otheract/hpdata2010/focusareas/fa01-atqhs2.htm**.

Data Trends

Richard Klein of the NCHS Division of Health Promotion Statistics summarized the status of the 16 *Healthy People 2010* objectives in the Access focus area as follows: little progress on a large scale overall, but no notable retrograde movements; new data since the first-round Progress Review for five objectives; no updates since the baseline for five objectives; and, as reported in the earlier Progress Review, one objective (1-12; 24-hour toll-free access nationwide to poison control centers) with a target that has been met. In general, relative health disparities between population groups have remained much the same, even when their objectives have registered progress overall. However, increases in disparity were noted for Hispanics with regard to having a source of ongoing care (Obj. 1-4) and a usual primary care provider (Obj. 1-5). About three quarters of objectives and subobjectives with data beyond the baseline year are moving toward their targets. Mr. Klein then reported in greater detail on progress achieved toward meeting the targets of selected objectives in the focus area.

The proportion of persons under age 65 with health insurance varied from 83 percent to 84 percent from 1997 (baseline) to 2004. Among poor people, the proportion increased from 66 percent in 1997 to 69 percent in 2004.

Certain age groups showed improvement in coverage during that time span: an increase from 86 percent to 91 percent among persons aged 10 to 14 years and an increase from 80 percent to 85 percent among those aged 15 to 19 years. The 2010 target is 100 percent (Obj. 1-1). In 2001, the first year for which data became available on subobjectives 1-3a, b, c, and d, the age-adjusted proportion of adults aged 18 and older who had been counseled by their provider about four kinds of health behaviors varied by the targeted behavior as follows: physical activity or exercise—45 percent (target 54 percent); diet and nutrition—43 percent (target 56 percent); smoking cessation—66 percent (target 72 percent); and risky drinking—11 percent (target 17 percent). For the first three behaviors, the highest proportion of counselees was in the 45- to 64-year age group; for the fourth behavior, risky drinking, the highest proportion was in the 65- to 74-year age group (16 percent), with only 7 percent of young adults aged 18 to 24 years receiving counseling. In another component of this objective, 24 percent of females aged 15 to 44 years received counseling about unintended pregnancy in 2002, compared with 19 percent in 1995. The target is 50 percent (Obj. 1-3f). Also, 40 percent of females aged 45 to 57 years received counseling about management of menopause in 2001, the first year for which data became available. The target is 42 percent (Obj. 1-3h).

In 2003, 78 percent of the total population had a usual primary care provider, a small proportional increase from 77 percent in 1996. Among racial and ethnic groups for whom data were available in 2003, Hispanics, at 63 percent, ranked lowest in access to primary care providers. Males, at 74 percent, lagged behind females, at 81 percent, and adults with less than a high school education had a comparatively low access rate of 68 percent. In terms of disability status, 85 percent of persons with activity limitations had a usual provider, marking a comparatively large contrast with the 77 percent of persons without activity limitations who had such a provider. The target for all groups is 85 percent (Obj. 1-5). In 2001, 12 percent of the total population experienced difficulty or delay in obtaining needed health care, the same percentage as in 1996. The target is 7 percent (Obj. 1-6). Notable among the groups that experienced relatively high degrees of difficulty or delay were Hispanics (14 percent); females (13 percent, compared with males at 10 percent); the poor (19 percent); and people with activity limitations (19 percent). In the school year 2003–2004, the proportion of degrees granted by health profession schools to members of under-represented racial and ethnic groups was as follows: American Indians/Alaska Natives—0.5 percent, compared with 0.6 percent in 1996–1997; blacks—7.4 percent, compared with 6.5 percent in 1996–1997; and Hispanics—5.9 percent, compared with 5.2 percent in 1996–1997. The targets for these groups are, respectively, 1.0 percent, 13.0 percent, and 12.0 percent (Objs. 1-8a, c, d). In 2003, the rate of hospital admissions for uncontrolled diabetes in people aged 18 to 64 years was 7.8 per 10,000 people, compared with 7.2 per 10,000 in 1996. In terms of health insurance status, the rate for Medicaid patients was 30.0 per 10,000, compared with 3.9 per 10,000 for privately insured patients, and 6.7 per 10,000 for uninsured patients. These rates show a relatively large increase from 1996, when the rate for Medicaid admissions had been 23.5 per 10,000. The target is 5.4 per 10,000 people (Obj. 1-9b).

In 2002, the first year for which data became available, 30 states had in place processes to monitor and evaluate trauma system outcomes. The target is all 50 states and the District of Columbia (Obj. 1-13h). In 2001, data also became available on the age-adjusted proportion (9.6 percent) of persons aged 65 and older with long-term care needs who do not have access to home health care. The proportion of blacks in that category without such access was 17.3 percent and of Hispanics, 14.8 percent. Among the poor, 13.6 percent lacked access, compared with 7.7 percent of those with middle or high income. Persons in the category who lived outside metropolitan statistical areas (MSAs) fared relatively better (at 7.5 percent lacking access) than those within MSAs (10.4 percent lacking access). The target is 7.7 percent (Obj. 1-15a).

Key Challenges and Current Strategies

In the presentations that followed the data overview, the principal themes were introduced by representatives of the two co-lead agencies—Elizabeth Duke, Administrator of HRSA, and Carolyn Clancy, Director of AHRQ. These agency representatives set the stage for discussions among participants in the review by identifying a number of barriers to achieving the objectives and citing activities under way to meet these challenges, including the following:

Challenges

- The costs of early death and poor health among the uninsured are estimated to total between $65 billion and $130 billion. An April 2006 survey found that half of all young adults in the United States go without health insurance and that more than 15 million Americans were uninsured for 4 consecutive years.
- Almost 50 percent of bankruptcy filings are due to medical expenses. Over a 10-year period ending in the early part of this decade, healthcare costs in the United States rose an average of 8 percent yearly.
- About 20 percent of the U.S. population reside in localities federally designated as Health Professional Shortage Areas (HPSAs). Shortages in the healthcare workforce, especially in nursing, have a negative impact on continuity of care, patient waiting times, and access to after-hours care.
- Underuse of multidisciplinary teams in primary care and the continued use of a system focused on disease care rather than on health care in a broader sense create an environment that discourages any counseling dialog between providers and patients.
- From 1993 to 2003, the population increased by 12 percent. During this period, emergency department visits increased by 27 percent, and 425 emergency departments were closed, imposing increasing strain on those that remain. Hospitals that are still open have a smaller total number of inpatient beds than a decade ago. Emergency department overcrowding has also depleted the surge capacity needed to deal with a natural disaster or terrorism event.
- In some instances, expanded access to health care can result in increased rates of adverse health outcomes (e.g., diagnosis of previously undiagnosed conditions, doctor visits, hospitalizations, etc.).
- The aging of the population makes long-term care (LTC) services increasingly important. Persons with LTC needs require the help of other persons to perform activities associated with personal care and the routine needs of daily living.

Strategies and Opportunities

- The *2005 National Healthcare Quality Report* (*2005 NHQR*) is a comprehensive national overview of the quality of health care in the United States. With 179 measures to monitor progress, the *2005 NHQR* focuses on 46 core measures that represent the most important and scientifically sound measures of four components of quality—effectiveness, patient safety, timeliness, and patient centeredness. The *2005 NHQR* is a product of collaboration among agencies across HHS, in which AHRQ plays a leading role.
- The companion *2005 National Healthcare Disparities Report* (*2005 NHDR*) uses the same core measures as the *2005 NHQR* to monitor the nation's progress toward eliminating disparities in both quality and access to health care for both the general population and for congressionally designated priority populations. The *2005 NHDR* includes an additional 13 core measures of access and adds two components of quality to the *2005 NHQR's* four core measures. The additional components are facilitators and barriers to health care and healthcare utilization.
- AHRQ's initiative on health information technology (HIT) includes more than $166 million in grants and contracts in 41 states to support and stimulate

investment in HIT, especially in rural and underserved areas. AHRQ also works with HRSA to integrate HIT systems in health centers to improve patient safety.

- HRSA has been engaged since 2001 in an unprecedented expansion of the health center network. To date, 865 health center sites have been created or expanded, for a total of about 3,800 sites throughout the system. The number of patients treated each year by community, migrant, homeless, public housing, and school-based health centers increased by nearly 2.9 million, from about 10 million in 2001 to about 14 million in 2005. The latest estimate is that, in 2006, the system will serve 14.6 million patients who are mostly minorities of low income.
- HRSA's Diabetes Prevention Pilot Collaborative has significantly reduced the time required to translate scientific gains to practice, improved the success rate of treating prediabetic patients, and reduced the untoward consequences of failure to treat such patients with full success. HRSA's pilot projects typically ensure a high degree of patient involvement in their own care and provide for a team approach in their healthcare providers' followup strategies.
- With its headquarters in HRSA, the National Health Service Corps (NHSC) marks its 35th anniversary this year and is currently fielding more than 3,900 physicians, dentists, nurses, and other healthcare professionals to deliver primary health care in HPSAs to more than 5 million people nationwide. Almost four out of five NHSC clinicians remain in the communities to which they are assigned after their term of service is over, a testament to their commitment to their medically underserved patients.
- A national toll-free telephone number (1-800-222-1222) able to access 61 poison control centers is fully operational 24 hours a day in all states, Puerto Rico, and the District of Columbia. Dialing the number connects a caller to a poison control center in his or her geographic area.
- The year 2006 is the fifth consecutive year that HRSA has provided funding through the Hospital Preparedness Program to health departments in all states and territories. Currently four metropolitan areas also receive funding. This year, the program's focus is on efforts to improve the capability of local and regional healthcare systems to address a variety of public health and health promotion topics.
- AHRQ has developed an elder-care-based knowledge transfer partnership with the Administration on Aging, CDC, and the Centers for Medicare and Medicaid Services to establish and support a learning network for teams of state and local officials and program managers to increase the use of evidence-based prevention in community-based settings that are linked to public health and clinical settings.

Approaches for Consideration

Participants in the review made the following suggestions for public health professionals and policymakers to consider as steps that might enable further progress to be made toward achievement of the objectives for Access to Quality Health Services:

- To provide a sharper focus for public policy, continue research on efforts to quantify Goal 1 of *Healthy People 2010*, "Increase quality and years of healthy life," recognizing the wide range of issues of measurement and interpretation that are involved with developing summary measures of health.
- Encourage the use of health information technology, which is conditioned on continuing education to foster the acceptance and proficiency in the use of such tools.

- In all programs relating to clinical care, seek to foster and strengthen the recognition and application of sound public health concepts and practices.
- To aid in controlling and decreasing the prevalence of chronic diseases, promote the concept and application of a "medical home" for people with chronic illnesses (i.e., a customary setting for interaction with primary care providers). Make use of clinical and community linkages in these efforts.
- Encourage healthcare institutions to make greater use of financial incentives (e.g., rewards and bonuses) to effect improvement in the performance of healthcare providers they employ.
- In public information and outreach activities relating to accessibility and quality of healthcare services, highlight proven best practices in a succinct and pointed form that lends itself to wide media coverage.
- Whether healthcare professionals are in private practice or in institutional settings, seek to make them aware of the central and critical role they play in ensuring that patients have timely and effective access to health services. Work to decrease the communication gaps that exist.
- With a view to reducing and eliminating health disparities, explore in greater depth the interplay of varying factors in the lives of Hispanics in the United States—such as location, background, immigration status, folk practices, literacy, conditions of employment, income, and education—which can disadvantage them in obtaining access to high-quality health care.
- With healthcare costs rising less steeply than in the past, seize the opportunity to direct additional resources to the translation into practice of lessons learned about enhancing access to quality health services.

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[Signed August 15, 2006]

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