Behind the Numbers

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ACCESS TO HEALTH CARE

One of the indicators that the FCFC tracks is Access to Health Care. The current indicator is based on information in a database maintained by the Center for Healthy Communities at Wright State University. The indicator is defined as the percent of those who have had contact with a participating agency during the year who "(1) report having health insurance or (2) are included in active Medicaid applications or (3) are uninsured and referred for Medical Services (free or subsidized clinics)." Current participating agencies include the Center for Healthy Communities, Montgomery County Department of Job and Family Services and Dayton Public Schools. While a substantial minority of Montgomery County residents below the poverty line (24%) has been entered in the database at some point, there is no mechanism in place that keeps information current for people entered. Going "behind the numbers" of this indicator provides an opportunity to examine the relationship between insurance and access to health care.

First, in order to gain a better understanding of this indicator, it is useful to start with its associated outcome, Healthy People. (See page 4.) By "Healthy People" the FCFC means four things:

- Everyone makes choices—for themselves or for those entrusted to their care—which promote better health.
- Everyone gets the information and support they need to avoid preventable health problems.
- Both physical and mental wellness are valued.
- Everyone has access to an adequate level of health care, including prenatal care, from birth through death.

The current indicator under discussion is designed to help measure that 4th aspect – "access". More than a decade ago, the Institute of Medicine defined "access to health care" as "the timely use of personal health services to achieve the best possible outcomes."[1] There is substantial evidence that "timely use of personal health services" makes a difference in health outcomes. Andrulis (1998) cites several quantitative studies that traced correlations between access and outcomes for breast cancer, asthma, hypertension, HIV/AIDS and incidence of low birth weight babies.[2] A substantial body of more recent work documents the impact of increased access to care. In Alberta, Canada, poor and non-poor children were found to have similar rates of asthma-related emergency room visits under a system of universal health care that paid for both outpatient and hospital services.[3] In a broader study of all health outcomes, Seid et al. (2006) examined the impact on health-related quality of life as measured by a standard 22-item scale (PEDsQL4.0) of realized access to services among children enrolled in California's expanded State Children's Health Insurance Program (SCHIP).[4] That study concluded that "realized access to care is associated with statistically significant and clinically meaningful changes in health- related quality of life in children enrolled" in California's SCHIP.

Given that "Access to Health Care" matters in health outcomes, what are the barriers to access to health care? Researchers split the barriers into 3 groups: personal/family, structural and financial. Many studies have documented the importance of the financial aspects. Spillman (1992) documented substantially less use of non-emergency and in-patient care for uninsured children.[5] Several studies of CHIP expansion have documented the increases in access to care associated with increased public insurance for children. Szilagyi et al. (2006) conclude that "enrollment in New York's SCHIP was associated with improvements in access to asthma care, quality of asthma care, and asthma-specific outcomes."[6] Damiano et al. (2003) examined the impact of Iowa's SCHIP program using a pre-test post-test panel survey methodology. "Unmet need was significantly reduced among those needing services: medical care (27% before, 6% after), specialty care (40% before, 13% after), dental care (30% before, 10% after), vision care (46% before, 12% after), behavioral and emotional care (42% before, 18% after), and prescription medications (21%

[1] Millman ML, ed. Access to Health Care in America. Institute of Medicine. Washington, DC: National Academy Pr; 1993.

[2] Andrulis, Daniel 1998 "Access to Care Is the Centerpiece in the Elimination of Socioeconomic Disparities in Health" Annals of Internal Medicine September 1998 | 129(5) pp 412-416.

[3] Sin et al. 2003 "Can Universal Access to Health Care Eliminate Health Inequities Between Children of Poor and Nonpoor Families? - A Case Study of Childhood Asthma in Alberta" Chest. 2003;124:51-56.

[4] Seid et al. 2006 "The Impact Of Realized Access To Care On Health-Related Quality Of Life: A Two-Year Prospective Cohort Study Of Children In The California State Children's Health Insurance Program" Journal of Pediatrics 2006;149:354-61.

[5] Spillman B. The impact of being uninsured on utilization of basic health care services. Inquiry. 1992; 29:457-66.

[6] Szilagyi et al. 2006 "Improved Asthma Care After Enrollment in the State Children's Health Insurance Program in New York" Pediatrics Vol. 117 No. 2 February 2006, pp. 486-496 (doi:10.1542/peds.2005-0340).

ESTIMATE OF UNINSURED POPULATION IN MONTGOMERY COUNTY

	Children (0-17)		Adults (18-64)	
Caucasian	4,287	4.5%	33,680	10.3%
African-American	3,087	9.4%	14,962	20.0%
Other	129	5.3%	3,707	24.4%
TOTAL	7,503	5.7%	52,349	12.6%

Source: Health Policy Institute of Ohio based on 2004 Ohio Family Health Survey

before, 13% after). Overall health status was rated significantly better (i.e., excellent: 37% before, 42% after)." [7]

How many Montgomery County residents have financial barriers to health care? The best evidence comes from the massive Ohio Family Health Survey of 2004 which surveyed close to 40,000 Ohio households. Based on that survey, the Health Policy Institute estimates that approximately 60,000 Montgomery County residents had no insurance in 2004 (see Table above). The 'no insurance rate' among children (5.7%) is substantially less than among adults 18 to 64 (12.6%) because of the expansion of the CHIP program in the late 1990s. African-American children and adults have 'no insurance rates' twice as high as Caucasian children and adults.

Not all people without insurance have trouble accessing health care. Some households with sufficient income do choose to go without health insurance. Based on the overall Ohio distribution of adults with no insurance among income levels, approximately 36,000 adults in Montgomery County do not have the financial wherewithal to pay for routine health care.[8]

UNINSURED ADULTS IN MONTGOMERY COUNTY (18-64) BY ESTIMATED INCOME RELATIVE TO POVERTY

Less than 100% of Poverty	17,274	33%
100% – 150%	9,423	18%
151% – 200%	8,900	17%
201% – 300%	8,376	16%
Greater than 300%	8,376	16%
TOTAL	52,349	100%

Coverage in Ohio 2004: The Roles of Public and Private Programs in Assuring Access to Health Care, Results from the Ohio Family Health Survey ODJFS. In 2005, the U.S. Census Bureau's poverty threshold for a family of four with two children was $19,806.

There are some free and subsidized health clinics in Montgomery County and there are efforts underway to increase access to needed prescriptions (Unified Health Solutions and Community Health Connections). There are, however, other barriers to accessing that free and subsidized care. Some of those barriers are structural. Research suggests that transportation issues make geographic proximity extremely important for neighborhood health centers. Missed appointments at neighborhood health centers were closely tied to how far away a health center was (Lasser et al., 2005). Some of those barriers are associated with personal/family characteristics. Functional health literacy is receiving increasing attention. A recent study documented much lower rates of adherence to prescribed medication regimes among low income populations.[9] At the same time, institutional racism also plays a role. Research suggests the "minority patients seen in primary care settings report more difficulty getting an appointment and waiting longer during appointments."[10]

At this point, two important strategic planning efforts are underway in Montgomery County that may impact access to health care. First, the Montgomery County Commissioners have appointed a task force to look directly at health care access with the goal of coordinating more closely the safety net system. Second, the Combined Health District has embarked on a strategic planning exercise which will also have implications for health care among the uninsured population. Both these planning exercises may result in substantial changes in how health care access is ensured for Montgomery County residents. In addition, both may suggest new indicators of health care access that should be utilized as those changes take place.

[7] Damiano et al. (2003) "The Impact of the Iowa S-CHIP Program on Access, Health Status, and the Family Environment" Ambulatory Pediatrics, Volume 3, issue 5 (September - October, 2003), p. 263-269.

[8] Assuming that any household at 200% or less of the poverty line will have difficulty paying for health care.

[9] Lasser et al. 2005 "Missed Appointment Rates in Primary Care: The Importance of Site of Care" Journal of Health Care for the Poor and Underserved 16 (2005): 475–486.

[10] Cooper et al. "Designing and Evaluating Interventions to Eliminate Racial and Ethnic Disparities in Health Care" Journal of General and Internal Medicine 2002 17 (477-486).