
Overview

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This overview discusses articles published in this issue of the Health Care Financing Review, entitled "Access to Health Services for Vulnerable Populations." These articles focus on the following topics: access to Medicaid for pregnant women, access measures by health status, racial access questions, end stage renal disease (ESRD) patients, other special populations, and the effects of physician payment reform.

INTRODUCTION

Access to health services for vulnerable populations is the primary focus of the articles in this issue of the *Health Care Financing Review*. There are two critical elements which need to be explored. The first is how one defines access to health care. Access has been defined as "...those dimensions which describe the potential and actual entry of a given population group to the health care delivery system" (Aday, Fleming, and Andersen, 1984). Measures of access reflect, therefore, whether persons who need care are able to obtain it (Health Care Financing Administration, 1994).

The second critical element is how one defines a vulnerable population. Vulnerable population subgroups are those individuals with characteristics that put them at risk for not receiving needed care (Health Care Financing Administration, 1994). Examples of groups that have been identified by the Health Care Financing Administration (HCFA) include minorities, the frail elderly, persons in poor health, low-income per-

sons, high-risk pregnant women and their infants and children, underserved individuals, and the disabled. Some individuals, such as the low-income frail elderly, are particularly vulnerable since they possess multiple characteristics which put them at risk.

This article presents an overview of the topics presented in this issue of the *Health Care Financing Review*. As can be seen from the variety of articles, vulnerable populations can be defined in many ways. Health status, race and ethnicity, and socioeconomic status are a few of the approaches used in these articles to identify vulnerable populations. Persons in poor health are vulnerable in that they require more frequent contact with the health care delivery system. Additionally, it is widely recognized that race and socioeconomic status are associated with health status and access (Nickens, 1995; Schulman et al., 1995; Ford and Cooper, 1995). For example, black persons and persons in lower socioeconomic groups have higher mortality rates.

For the ease of discussion, the majority of the articles in this issue of the *Health Care Financing Review* can be categorized into six domains. The first five categories address access issues for specific vulnerable populations: Medicaid and pregnant women, access measures by health status, use rates for racial and ethnic minorities, access for ESRD patients, and access for additional special populations. In the sixth category, the impact of physician payment reform on access is examined. Finally, an examination of Medicare spending is presented. Per capita expenditures is a particularly useful measure to use in access studies which make comparisons between groups.

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MEDICAID AND PREGNANT WOMEN

The article by Ellwood and Kenney focuses on the effect of the Medicaid expansions for pregnant women in California, Georgia, Michigan, and Tennessee. Prior to the Medicaid expansions for pregnant women in the late 1980s, eligibility was linked to receiving Aid to Families with Dependent Children (AFDC). The income standards associated with AFDC are typically lower than the Federal poverty level. The intent of the Medicaid expansions for pregnant women was to enroll more low-income pregnant women and thereby improve access to prenatal care and birth outcomes. This study reveals some mixed results. Results show that the number of births financed by Medicaid substantially increased, but early enrollment of pregnant women who are new to Medicaid continues to be a problem.

ACCESS MEASURES BY HEALTH STATUS

Survey data contain measures of health status which cannot be obtained from claims data. Health status measures available from surveys, such as self-reported health status and activity limitations, add a unique perspective to the study of access. In this issue of the *Review*, two national surveys, the Medicare Current Beneficiary Survey (MCBS) (conducted by HCFA) and the National Health Interview Survey (NHIS) (conducted by the National Center for Health Statistics), were used to examine access to health services by Medicare enrollees.

Using the MCBS, Rosenbach, Adamache, and Khandker examined satisfaction with quality, availability, and costs of medical care, and satisfaction with the ease of getting to the doctor by self-reported health status and activity limitation. Rosenbach, Adamache, and Khandker

also examined use rates and the frequency of perceived barriers to care by self-reported health status and activity limitation. The findings from the MCBS analysis suggest that overall Medicare enrollees are very satisfied with their care. However, there are differences between health status groups in the degree of satisfaction—those in poorer health report less satisfaction and more barriers to care than those in better health.

Using the NHIS, Mentnech, Ross, Park, and Benner examined the simultaneous influence of health status, insurance status, and income on the probability of having a physician contact. Interestingly, in contrast to aged persons in very good health, insurance status and income appear to have little influence on the probability of a visit for those in very poor health. As asserted by the authors, however, it cannot be concluded from this finding that all persons in poor health enjoy equal access to health care.

USE RATES FOR RACIAL AND ETHNIC MINORITIES

Differences in use rates between white and black Medicare enrollees have been well documented. In this issue of the *Review*, Mitchell and Khandker further explore the large racial differences in the use of “high-tech” cardiac procedures, such as cardiac catheterization and revascularization. They confirm earlier findings that among patients admitted for acute myocardial infarction, black Medicare enrollees are significantly less likely to undergo these cardiac procedures. More importantly, the black-white differential remains even after controlling for comorbidities and financial resources. The authors suggest that future research should explore patient care-seeking behavior as a potential explanatory factor in the large black-white utilization differences.

Not only have researchers demonstrated that black patients have lower use rates than white patients, it has also been shown that Hispanics have lower use rates than non-Hispanic whites (Schur, Bernstein, and Berk, 1987). For example, Hispanics are less likely to receive specific preventive services (Harlan, Bernstein, and Kessler, 1991). In this issue of the *Review*, Schur, Albers, and Berk point out that although it is widely recognized that insurance coverage is a strong predictor of use, the role of cultural barriers is less clear. They argue that since different types of barriers—financial versus cultural—call for different policy solutions, it is important to explore which factors account for the lower use rates of the Hispanic population. Using data from the 1987 National Medical Expenditure Survey, the authors explore the relative influence of financial versus cultural factors on health care use for Hispanic adults.

The articles by Mitchell and Khandker and by Schur, Albers, and Berk examine financial indicators as explanatory variables in models predicting use. Mitchell and Khandker document for the first time that regardless of race, limited financial resources affect the probability of receiving a cardiac procedure. That is, Medicare enrollees residing in poverty areas are much less likely to receive cardiac procedures. Schur, Albers, and Berk show that financial resources, such as degree of insurance coverage, are stronger predictors of use than cultural influences, such as language spoken. Schur, Albers, and Berk, in particular, suggest that policies with the goal of increasing access should focus on reducing financial barriers.

ACCESS FOR ESRD PATIENTS

Kidney transplantation is regarded as the optimal treatment for ESRD. Various

methods have been used to measure access to transplantation. Regardless of the method used to measure access to transplantation, however, studies have shown that there are large racial differences. The transplantation rate is lower and the waiting times are longer for black ESRD patients compared with white ESRD patients. In this issue of the *Review*, Eggers explores a new measure of transplantation access: access to the national Organ Procurement and Transplantation Network. Through the linking of two data sources, Eggers was able to describe where in the transplantation process racial disparities are greatest. This new measure of access to transplantation reveals that while black ESRD patients have lower rates of transplantation after getting on the waiting list, they are also less likely to get on the waiting list to begin with.

While transplantation is the optimal treatment for ESRD, not all patients receive a transplant, given the shortage of available organs. Dialysis remains the only viable treatment alternative. In his article on the variations in home dialysis modalities, Kendix uses various data sources to explore the determinants of home dialysis provision among the free standing renal facilities. This is an important issue to explore since, as described later in the Thamer, Ray, Richard, Greer, Pearson, and Cotter article, home-based treatment is associated with a higher quality of life. The Kendix article demonstrates that the lower the number of facilities per square mile, the higher the probability of provision of home-based dialysis treatments. As stated by the author, this likely reflects the long travel time for facility based treatments for residents of rural areas. The Kendix article also describes another important finding: There is a negative association between the percent of blacks attending a facility and the probability of providing the home-

based dialysis modalities. The author presents several plausible explanations for the racial difference in access to home-based dialysis modalities, including the higher rate of infection among black patients receiving home-based peritoneal dialysis.

The majority of ESRD research has focused on the Medicare ESRD population. However, about seven percent of ESRD patients are not eligible for Medicare benefits. Very little research has been done to characterize this population. The purpose of the Thamer et al. article in this issue of the *Review* is to address the recommendation of the Institute of Medicine that studies be conducted to describe the demographic, health status, and access characteristics of the Medicare-ineligible ESRD population. Specifically, Thamer et al. examined claims data for California, Georgia, and Michigan Medicaid enrollees who received chronic renal dialysis and who were not covered by Medicare or private insurance. Demographics, use of dialysis services, and costs of the Medicaid-only ESRD population were compared with Medicare ESRD patients in these three States. Differences were observed between the Medicaid-only and Medicare ESRD patients in demographics, dialysis practice patterns, and resource utilization. Several findings are particularly noteworthy.

The Medicaid ESRD population is younger, more likely to be female, and more likely to be non-white compared with the Medicare ESRD population. Interestingly, in California and Georgia, Medicaid patients are less likely than Medicare ESRD patients to dialyze at home. It should be noted, however, that the article does not control for place of residence. Therefore, it is difficult to determine why Medicaid ESRD patients in these two States have a lower likelihood of receiving home-based dialysis. It could reflect less access to home-based treat-

ment modalities, but it could also reflect, as described in the Kendix article, residence in a more rural area.

OTHER SPECIAL POPULATIONS

Like the ESRD population, the disabled population is also at risk for access problems due to their poorer health status. While studies have examined access and use of services by overall reason for Medicare eligibility, very little research has focused specifically on the disabled population. In this issue of the *Review*, Rosenbach uses the MCBS to examine levels of access and satisfaction within the Medicare disabled population. This is the first attempt to compare access for those disabled due to a mental condition with those disabled due to a physical condition. There appear to be striking differences between the two vulnerable subgroups. Most notably, Medicare enrollees disabled due to a mental condition are less likely to have a private physician as a usual source of care, less satisfied with their care, and more likely to report unmet need. These troubling findings suggest that future research on access should specifically address the needs of Medicare enrollees eligible for Medicare due to a mental condition.

The articles described in this overview have examined the impact of financial resources on access. Clearly, the Medicare cost-sharing requirements may be burdensome for low-income enrollees, particularly if they lack supplemental insurance coverage. Those in poor health status, such as the disabled or ESRD populations, have an added barrier in that they require more services. To address this problem, Congress established the Qualified Medicare Beneficiary (QMB) program. Beginning in 1990, the QMB program required States to pay the cost-sharing amounts for low-income Medicare

enrollees. There is concern, however, that not all Medicare enrollees eligible for the QMB program are participating. In the article by Neumann, Bernardin, Evans, and Bayer, the MCBS was used to estimate the number of eligible elderly enrollees participating in the QMB program. Additionally, the authors describe the characteristics of participating and non-participating eligibles. Finally, the authors describe the barriers to participation in the QMB program. Several important findings have emerged from this work. First, this article validates the concern that not all eligible low-income Medicare enrollees are participating in the QMB program. On a more comforting note, however, those who do participate appear to be those most in need of the program—the low-income elderly with the highest health care utilization.

IMPACT OF MEDICARE PHYSICIAN PAYMENT REFORM

To address the need for a more rational payment system, Congress enacted the Medicare fee schedule and extra billing limitations as part of physician payment reform. As a number of articles in this issue of the *Review* point out, differences in access to health services still exist among subgroups of the Medicare population. With the implementation of physician payment reform, there was concern that disparities between vulnerable groups might worsen if those in need had difficulty obtaining care. This concern is more fully described in the article by Rosenbach, Adamache, and Khandker. In response to a Congressional mandate, HCFA began a comprehensive effort to monitor the impact of physician payment reform on access.

Several articles in this issue of the *Review* were undertaken to fulfill this Congressional mandate and address the impact of physician payment reform on

access. In the analysis conducted by Rosenbach, Adamache, and Khandker, the MCBS was used to evaluate whether implementation of physician payment reform had an impact on satisfaction. The results from this effort suggest that satisfaction did not deteriorate. In fact, in some cases satisfaction actually improved between 1991 (pre-fee schedule) and 1993 (the first full year following fee schedule implementation).

Using claims data from the Medicare administrative files, Reilly examined the impact of the fee schedule on hospitalizations for congestive heart failure (CHF). Patients with CHF are particularly vulnerable, in that they generally require close monitoring and have a high rate of hospitalization. It is believed that hospital admissions for this chronic condition are somewhat avoidable through access to ambulatory care. Reilly reasonably concludes that a decrease in access to ambulatory care associated with physician payment reform could potentially lead to an increase in hospitalizations for CHF. From the analysis of claims data, there does not appear to be any evidence that hospitalizations for CHF increased as a result of physician payment reform.

Much of the work done to date to monitor the impact of physician payment reform on access examines the issue from the beneficiary perspective. In contrast to this approach, Meadow used the physician as the unit of analysis to evaluate the impact of physician payment reform. This effort takes advantage of a unique physician identifier available on physician claims. This identifier permits an examination of utilization at the level of the physician providing services. It has been hypothesized that physicians may reduce the number of Medicare services they provide in response to Medicare fee reductions.¹ The

¹ This assumes physicians can substitute services paid for by Medicare with services paid for by other payers.

article by Meadow shows, however, that surgeons as a group had stable average case loads during the first and second years of physician payment reform. More importantly, for physicians in general the reverse pattern was observed. That is, the caseloads of physicians increased in areas experiencing fee reductions.

Each of these articles support the conclusion that physician payment reform does not appear to have had a detrimental impact on access. However, there continue to be differences in access and utilization between vulnerable groups.

MEDICARE SPENDING BY STATE AND BORDER CROSSING

The HCFA Office of the Actuary has been producing estimates of national health spending for some time. In this issue of the *Review*, the State-level estimates are updated. In addition to providing State-level estimates of per capita Medicare expenditures in this article, Basu, Lazenby, and Levit summarize out-of-State spending patterns for Medicare enrollees. This effort to measure interstate border crossing is very important to the development of State-specific spending estimates.

The articles included in this issue of the *Health Care Financing Review* highlight the need to continue to examine access to health services. It is clear that access to health services has improved since the implementation of the Medicare and Medicaid programs (as described in the Mentnech et al. article); however, substantial differences between vulnerable groups remain. In order to support the formulation of policies that address access problems, future research should continue to investigate the reasons for differences between vulnerable populations.

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