Health Care Access Has Grown Worse Since 2003

BY MARY ELLEN SCHNEIDER
New York Bureau

One in five Americans postponed or skipped needed medical care last year because of cost, insurance problems, or difficulty getting an appointment, according to a report from the Center for Studying Health System Change.

Researchers, who compared nationwide survey data from the years 2003 and 2007, found that the number of Americans that reported problems with access to health care increased dramatically during the intervening period. In 2007, more than 23 million individuals (8%) said that they went without needed medical care, compared with 13.5 million (5.2%) in 2003.

There were even more problems with delaying care. In 2007, 36 million (12.3%) reported that they delayed seeking care, compared with about 23.5 million (8.4%) in 2003. The most recent figures come from the 2007 Health Tracking Household Survey, a nationally representative sample of about 18,000 individuals. The earlier data are drawn from a similar survey of about 47,000 individuals.

"The change is not only large, but it is widespread," Peter J. Cunningham, Ph.D., the study's lead author and a senior fellow at the Center for Studying Health System Change, said at a press conference.

Specifically, the researchers found that access problems were increasingly affecting people with and without insurance. In 2007, about 20% of uninsured people and 11% of insured people reported delaying care. In addition, 17.5% of uninsured people and 6.3% of insured people reported unmet medical needs.

But while more uninsured people reported access problems, the rate of increase for unmet medical needs between 2003 and 2007 was higher among people who had insurance. Of the additional 9.5 million people who reported unmet needs between 2003 and 2007, 6.7 million had health insurance, Mr. Cunningham said.

The researchers also found greater unmet medical needs among individuals with fair or poor health and among children from families with lower incomes. For example, unmet medical needs increased from 11.9% in 2003 to 17% in 2007 for people who were in fair or poor health.

The gap in access to care between low- and higher- income children grew wider in 2007 after having been virtually eliminated in 2003 following expansions of the Medicaid and State Children's Health Insurance Programs. In 2003, 2.2% of children below 200% of poverty experienced unmet medical needs, the same percentage as those children whose family incomes were at 200% of poverty or higher. However, in 2007, 5.4% of children below 200% of poverty had unmet medical needs, compared with 2.9% of children at 200% of poverty or higher. ■

Aetna Defends Its Performance-Based Physician Network System

BY ALICIA AULT
Associate Editor, Practice Trends

SAN FRANCISCO — Speaking at the insurance industry's annual meeting, an Aetna executive defended the company's performance-based physician networks, saying that they were a way to keep costs down and to let patients know which physicians offered the best and most cost-effective care.

Dr. Gerald Bishop, senior medical director for Aetna's West division, spoke at the AHIP Institute, at a conference sponsored by America's Health Insurance Plans.

Preferred provider networks have been the subject of legal challenges around the country, most recently in Massachusetts and Connecticut. Physicians have claimed that the networks use inappropriate methodology to rate their performance.

In 2007, New York Attorney General Andrew Cuomo struck a settlement with several insurers in which they agreed to publicly disclose rating methods and how much of the ratings is based on cost, and to retain an independent monitoring board to report on compliance. Aetna was one of the first insurers to sign on to that settlement, and has continued to comply, said Dr. Bishop. He noted, for instance, that Aetna reviews and updates its provider list every 2 years and notifies each physician in writing if there has been any change in his or her status. Physicians have the opportunity to appeal if there is an error.

Aetna first began developing its Aexcel network in 2002, said Dr. Bishop. The goal was to mitigate rising costs, ensure patient access to specialists, and find a way to recognize the variations in costs and practices in each individual market, he said. The company found that 12 specialties represented 70% of spending on specialists and 50% of the overall spending: cardiology, cardiothoracic surgery, gastroenterology, general surgery, neurology, neurosurgery, obstetrics/gynecology, orthopedics, otolaryngology, plastic surgery, urology, and vascular surgery.

When considering which physicians were eligible for the network, Aetna looks at the number of Aetna cases managed over a 3-year period (there was a 20-case minimum). The company also uses nationally recognized performance measures to gauge clinical performance. Physicians who score statistically significantly below their peers are excluded.

The company also uses the Episode Treatment Group methodology to evaluate 3 years of claims for cost and utilization patterns. A physician is considered efficient if his or her score is greater than the mean for that specialty and that market.

The Aexcel network now exists in 35 markets, covering 670,000 members. Aetna members in most, though not all, those areas can log onto a secure patient Web site and see costs for various procedures and information on why his or her physician has been designated a preferred provider in the network. ■

Community-Level Efforts Aim to Tackle Health Disparities

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — Simple yet targeted efforts to improve minority patients' access to health care are growing in communities across the nation.

Often, language is the first component that needs to be addressed.

The first step in Expecting Success, a national project to reduce disparities supported by the Robert Wood Johnson Foundation, was to query patients on ethnicity and language on admission to 10 hospitals serving a large number of cardiac patients.

The results were somewhat startling: One hospital that had no interpreters, found that they were admitting 500 Spanish-speaking patients a month.

"Until you ask the question, you will not know. At that institution, they are now investing in interpreters, in translated materials, they started taking this seriously," said Dr. Bruce Siegel, director of Expecting Success and a professor of health policy at George Washington University.

In suburban Washington, Adventist Healthcare system was similarly surprised by the diversity of community it serves. "Within Washington Adventist Hospital, just one of our hospitals, we have 68 different languages spoken by our staff, serving a community with about 140 languages spoken," said Adventist Healthcare President William Robertson at a meeting sponsored by the Alliance of Minority Medical Associations, the National Association for Equal Opportunity in Higher Education, and the U.S. Health and Human Services department.

Even within an ethnic group, there is a wide diversity of cultures, said Maria Lemus, executive director of Vision y Compromiso, a California-based advocacy group that aims to educate the Hispanic community about quality of care issues. While understanding the ethnic make-up of a population is important before moving forward, successful strategies ultimately rely on the strengths of local communities.

One of the group's programs, the Community Health Worker/Promotoras Network is made up of respected members of the Hispanic community who provide education and outreach to their peers. The *promotoras* concept has been around for more 50 years, having been implemented in Europe, China, Africa, Europe, and Latin America. It was adopted in California a little more than 25 years ago, she said.

Promotora is an apt term for Jerry Barnes of Columbus, Ga., who gave up a successful nursing career to work toward a healthier community. As a city council member, he was the driving force behind an effort to reduce the city's high diabetes rates.

"I had a 'eureka' moment one afternoon and thought, there are fire stations throughout the entire city. Why not make it accessible for people to stop in and have their blood sugar tested?" Mr. Barnes said. Now thanks to the impetus of Mr. Barnes and the efforts of Columbus' mayor and fire chief, residents can stop by a fire house and have their blood sugar checked between 9 a.m and 9 p.m.

Officials in San Antonio, Tex., took similar steps to ensure widely needed services are readily available when they set up a twice weekly immunization clinic at Goodwill stores. The program was so successful that immunizations are now available 5 days a week. Though home grown, these strategies can be adapted to other communities, as well, according to Ms. Lemus. ■

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