

Access to Health Care

Problem:

Residents unable to access appropriate health care and resources due to cultural and socio-economic barriers.

Access to health care for all is important in order to eliminate health disparities and increase the quality and years of a healthy life. Despite strong health outcomes in Washington County compared to state and national indicators, there are populations within the county who are not routinely accessing health care services. These groups face multiple cultural and economic barriers which limit access to quality, routine and culturally appropriate care. The populations affected include populations of color, low income individuals and families, and those living in poverty. Even a lack of transportation hinders outcomes, as individuals are more likely to delay medical care.

Strong predictors of access to quality health care include having health insurance, a higher income level, a higher education level, and a regular primary care provider or other source of on-going health care. Use of clinical preventive services, such as early prenatal care, annual physicals or preventive screenings, can serve as indicators of access to quality health care access.

Without access to quality health care and medical knowledge, any number of negative circumstances may arise. Some examples include: individuals are forced to utilize urgent care and emergency room clinics for treatment; many will self-medicate or not medicate at all; chronic diseases will continue to increase in both quantity and acuity (more likely to be hospitalized and die from a preventable disease); non-English speaking individuals may remain medically isolated; individuals may accrue substantial medical debt for necessary services; and myths about and distrust of Western medicine may grow.

In summary, inadequate or no access to a continuum of care not only affects the individual but affects everyone in the community directly or indirectly through increased medical provider fees, higher health insurance premiums, and higher taxes.

While Minnesota consistently ranks as one of the healthiest states in the country, Minnesota's populations of color do not share equally in favorable health outcomes. Literature suggests race is a social determinant of health and that health disparities result primarily from social, economic, and environmental factors. According to the U.S. Census Bureau, the nation's population will experience a dramatic demographic shift during the next half century. Similar to U.S. trends, Minnesota's population is expected to grow increasingly diverse over the next several decades. It is estimated that by 2025, about 17% of Minnesotans will be people of color. Disparities are evident in a number of health outcomes. In Minnesota, the percentage of women who receive prenatal care varies widely by race, from 64% among Native Americans to 90% among Whites. Cancer is more prevalent among African Americans (527.8 cases per 100,000 population) than Hispanics (332.1 cases per 100,000 population).¹



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For populations of color and/or for those of lower socio-economic status, the barriers to obtaining health care access and knowledge can be particularly unequal when compared to the overall population of Washington County. For those populations new to the United States, perhaps the most pervasive access obstacle is the inability to speak English fluently (if at all) and navigate the complexities of the health care system. For Washington County, the 2006 American Community Survey estimated that 4.7% of the population was Asian, 3.1% was African American, 2.7% Hispanic/Latino and 0.5% American Indian.² Of the population 5 years old and over, 9.4% spoke a language other than English in the home: 35% of those spoke Asian and Pacific Islander languages, 29% spoke Spanish, 25% spoke other Indo-European languages, and 12% spoke other languages.

Culturally appropriate resources and education materials are usually limited or non-existent. Furthermore, the immigration status of the individual upon entering the U.S. determines insurance eligibility and many may not qualify. Also, the very definition of disease and health varies widely among groups. Without culturally sensitive systems and resources in place, many populations continue to be without medical “homes” and turn to their culture and religion, as the two are intimately linked to social support and community participation.

The inability to find work or a job with health benefits, coupled with the high costs of medical care and general living expenses, present challenging budgetary decisions for low income groups and for those living in poverty. According to a Commonwealth Fund supported study, researchers found that by 2004, more than 45 million Americans lived in families with high financial burdens, spending more than 10 percent of their after-tax income on health care. This represents an increase of nearly 6 million people over 2001 data. According to the 2006 Census Bureau survey, 5% of county residents lived in poverty. Four percent of related children under 18 were below the poverty level compared with 5% of people age 65 years and older. In 2007, an average of 2,731 county residents participated in the Women, Infant and Children (WIC) program per month, a 5% increase over the previous year. Hispanic/Latino, Asian, and Black/African Americans comprise 12% each of this total.³

Health insurance coverage is also used as a measure of access to health care because the deficiency of any health insurance coverage has been established as a major barrier to receiving most health care services. People without health insurance coverage, estimated to be about 47 million Americans,⁴ are more likely than their insured counterparts to forego needed medical care or prescription drugs and are more likely to not have a medical “home.” In the past year, the uninsured were three times as likely to have not visited a doctor’s office, but were just as likely as insured persons to use the emergency department.⁵

Hispanic/Latino Minnesotans in 2007 were three times as likely as white Minnesotans to lack health insurance coverage (19% compared with 6.4%).⁶ In addition, rates of uninsurance for African American Minnesotans (14.7%) and American Indians (16%) were also higher than the white population (see Figure 2). Compared with the overall population in Minnesota, in 2007, the uninsured were more likely to be young adults between 18 and 34 years of age, Hispanic/Latino or African American, not married, incomes below 300 percent of poverty, less than a college education and rate their health status as fair. In 2007, 63% of the state’s population was covered by a group policy, 5% had individual policies, and 25% were utilizing public assistance. African Americans, American Indians, and Hispanics accounted for 39%, 52%, and 34% of those individuals utilizing public services, respectively.⁶ Rates of uninsured for Washington County residents by race are not available.

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Although health insurance greatly reduces the amount that those enrolled pay for their medical care, out-of-pocket expenditures for non-covered services, co-payments, deductibles, and caps on total amounts paid by insurance may impose a considerable financial burden, even for the insured. Annual premiums for private health insurance can be expensive, and for people with employer-sponsored coverage, worker contributions averaged \$627 for a single-person plan and \$2,973 for a family plan in the U.S. in 2006.⁵ According to *Financial Burden of Health Care, 2001-2004*, “financial burdens have increased to the point at which private insurance is no longer able to provide financial protection for an increasing number of families.”⁷ Health insurance premiums alone were the source of high financial burdens for 30% of poor and 22% of low-income privately insured people in the U.S. in 2004.⁷ Insurance alone is not sufficient to ensure access to all health care services. Few insurance policies cover all needed or desired services, and many policies exclude coverage for pre-existing conditions.

Accessing dental care may be more difficult than accessing medical care because a smaller percentage of Americans have dental insurance than medical coverage. On average, Americans paid about one-half of the cost of dental care out-of-pocket in 2003.⁵ Barriers to accessing dental care include paying for care, navigating government assistance programs, finding a dentist who will accept Medicaid and Medical Assistance, transportation, and cultural or language barriers.

Local data is not available on the number of residents lacking dental insurance. However, it is estimated that more than 20 million children in the U.S. are not covered by dental insurance.¹¹ Dental care is the most prevalent unmet health need among children. Tooth decay is the most common childhood chronic disease. Oral diseases have been linked to ear and sinus infections, weakened immune systems, diabetes, and heart and lung diseases. Lack of preventative dental services and treatments has the potential to affect speech, nutrition, growth, and quality of life.¹¹ Poor children are more likely than higher income children to experience both tooth decay, cavities, and lack of a usual source of dental care. They are also more likely to experience more restricted activity days due to dental disease than higher income children.¹²

The rising cost of living, including medical expenses, food prices, and housing costs, affect everyone. A recent study by Harvard University researchers found that the average out-of-pocket medical debt for those who filed for bankruptcy was \$12,000. The study noted that 68% of those who filed for bankruptcy had health insurance. In addition, the study found that 50% of all bankruptcy filings were partly the result of medical expenses. Every 30 seconds in the U.S. someone files for bankruptcy in the aftermath of a serious health problem.

A survey of Iowa consumers found that in order to cope with rising health insurance costs, 86% said they had cut back on how much they could save, and 44% indicated that they have cut back on food and heating expenses.⁸ The median monthly housing costs for mortgaged owners in Washington County in 2006 was \$1,728, nonmortgaged owners \$479, and renters \$926. Thirty-six percent of owners with mortgages, 10% of owners without mortgages, and 45% of renters in Washington County spend 30% or more of household income on housing.²

Across the nation, gaps in income, education, and literacy levels across populations exist. Such gaps often lead to stigma, prejudice, and devalued community support among individuals and groups. Unstable housing

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situations, insecure finances, unstable employment, inadequate or no transportation, and restricted amounts of resources in medically underserved areas are realities for some county residents. One example of this gap is the unemployment rate, as most workers receive medical insurance from their employer. The unemployment rate for the county in 2007 was 4% which equated to approximately 9,124 people.⁹

Assuring access to health care for all will continue to be an issue as the county continues to expand and grow in both number and diversity. The challenges to health care providers will be to reach out to populations of color and low income groups, assure that services are provided in culturally appropriate ways, and coordinate resources and referrals in a culturally competent manner. Providers will need to hire staff who reflect the cultural diversity of the clients being served and by providing cultural competency and diversity training to all staff. Interventions that aim to reduce disparities among vulnerable populations might be most effective if they simultaneously target socioeconomic disadvantage and unhealthy behaviors. Acknowledgment of existing racism is also essential in order to provide culturally sensitive services. Interventions at the individual, community and societal level are needed with all population groups.

“Racial, ethnic minority and language-minority groups face well-documented problems getting access to health care. Lacking health insurance is paramount: approximately half of the nation’s forty-seven million uninsured people are people of color. But achieving health care equity will require more than just placing an insurance card in every hand; structural, cultural, and linguistic obstacles can disproportionately harm health care access for many communities of color.”¹⁰

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Community Feedback

Access to quality and affordable health care and knowledge was a concern in numerous community forums and surveys. Most focus groups said an absence of or inadequate health insurance coverage was a concern. Access issues were routinely mentioned regarding medical, mental health and dental health services. The topic received the most response from participants in the Women, Infant and Children (WIC) program in the community health assessment WIC survey. Responses varied from concerns about costs of prescriptions to being uninsured to transportation issues. Affordability and access to health insurance were the most common topics mentioned under “*Concerns for Access to Services*” in the community health assessment on-line survey. Access to health care (including mental health) services and disparities were among the top five major concerns of the general public who responded to the survey.

The Mental Wellness Initiative-Washington County focus group listed “*cultural issues for access and the need for more resources to deal with growing culturally diverse population*” as a trend among those they have served in the past five years. An Adult English as a Second Language (ESL) focus group included the following responses under language barrier concerns: “*medical information is sometimes difficult to understand, forms are difficult to complete, and there is growing population of languages other than Spanish in the county.*”

Key informant interviews with a Spanish bilingual cultural liaison in School District #622 (North St Paul) and an employment counselor in the Washington County Workforce Center provided more insights regarding the specific needs of the Latino community. Illiteracy (in both English and Spanish), language barriers, high health care costs, high medication costs, undocumented status, and insufficient transportation are some of the primary obstacles to obtaining quality medical care and knowledge. Both informants expressed the need for more community outreach and education, particularly in prenatal classes, and encouraged increasing staff diversity and bilingual capabilities.

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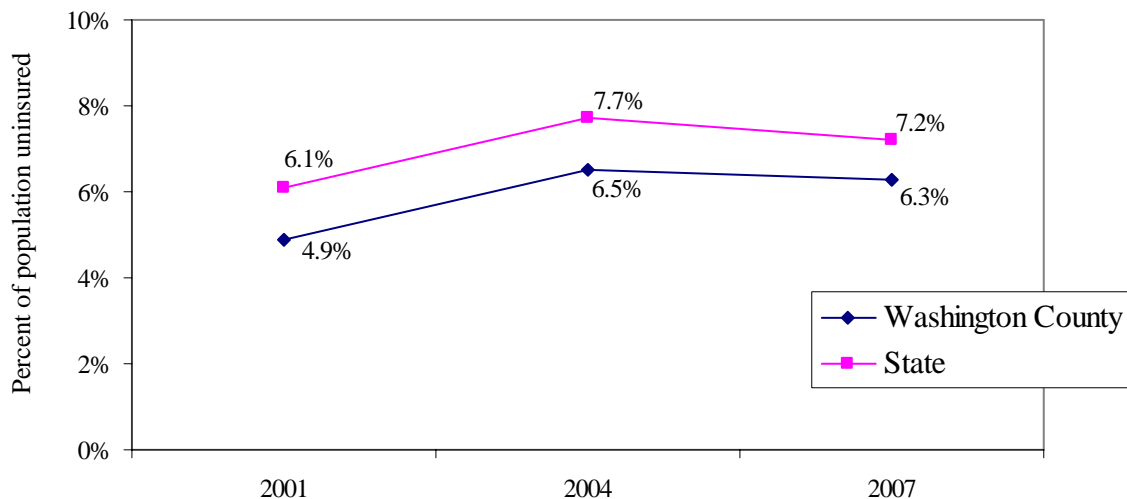
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Key Data

Figure 1.

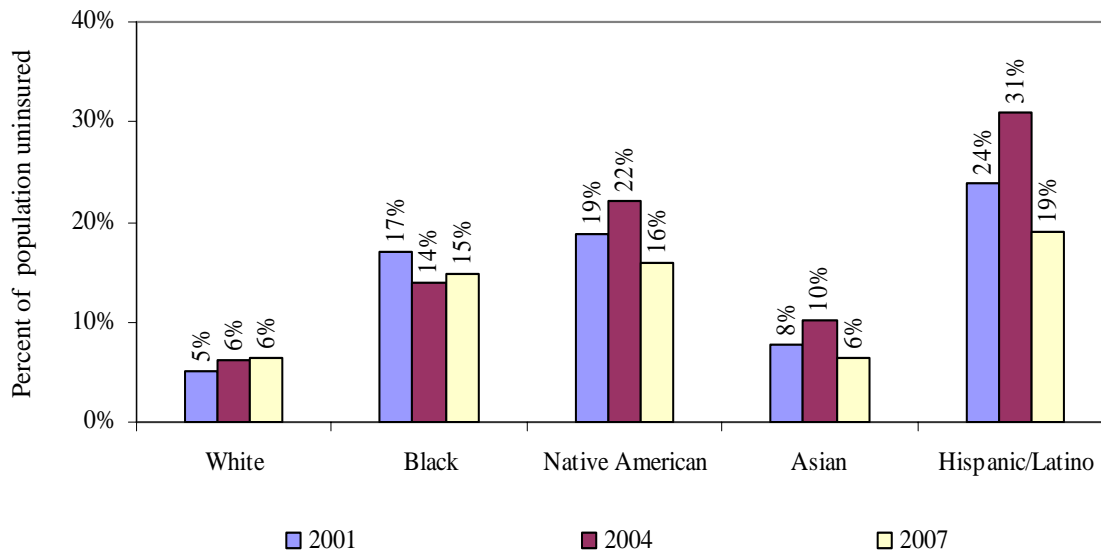
Uninsurance Rates, Washington County & Minnesota, 2001, 2004 & 2007



Source: Minnesota Health Access Surveys, 2001-2007, Minnesota Department of Health

Figure 2.

Uninsurance Rates, Minnesota, by Race/Ethnicity, 2001, 2004 & 2007



Source: Minnesota Health Access Surveys, 2001-2007, Minnesota Department of Health

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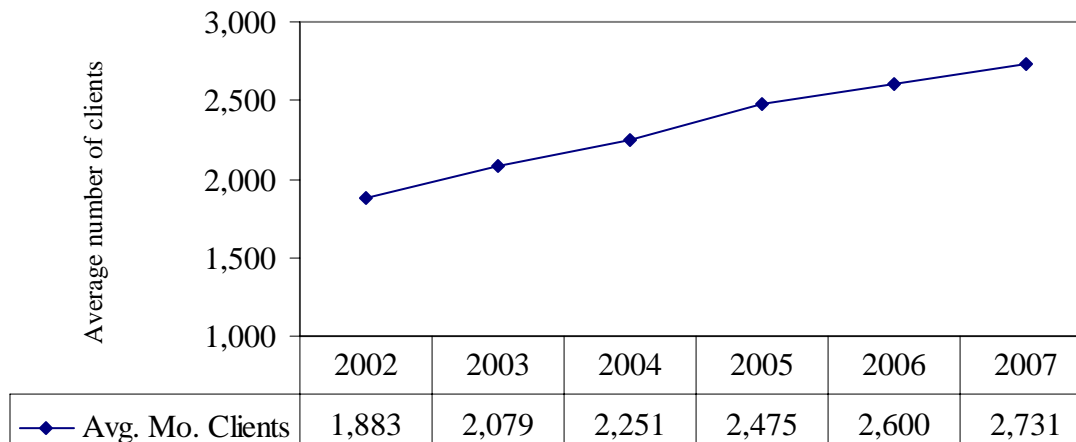
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Key Data

Figure 3.

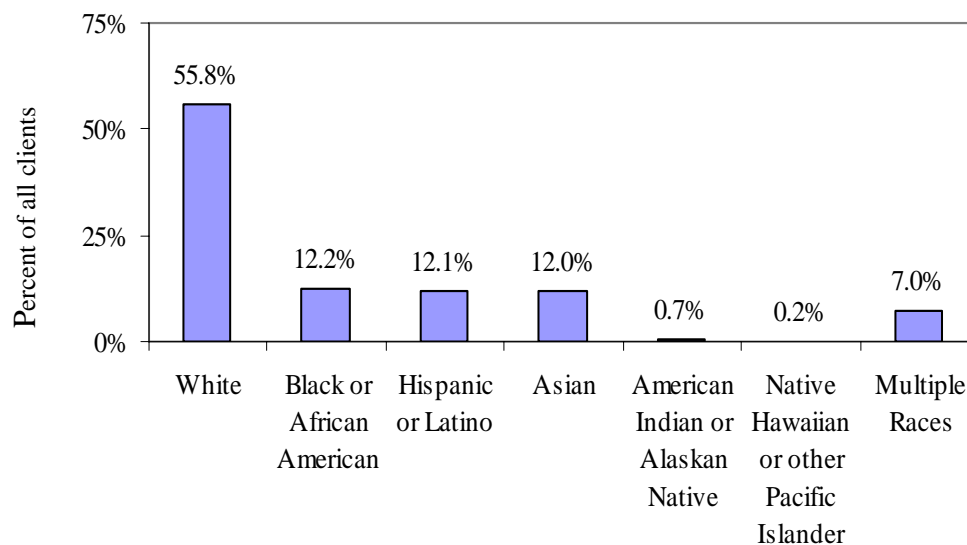
**WIC Average Monthly Participation Rate
Washington County, 2002-2007**



Source: Women, Infant and Children (WIC) program, Washington County Department of Public Health and Environment

Figure 4.

**WIC Participation by Race/Ethnicity, All clients
Washington County, 2006**



Source: Women, Infant and Children (WIC) program, Washington County Department of Public Health and Environment

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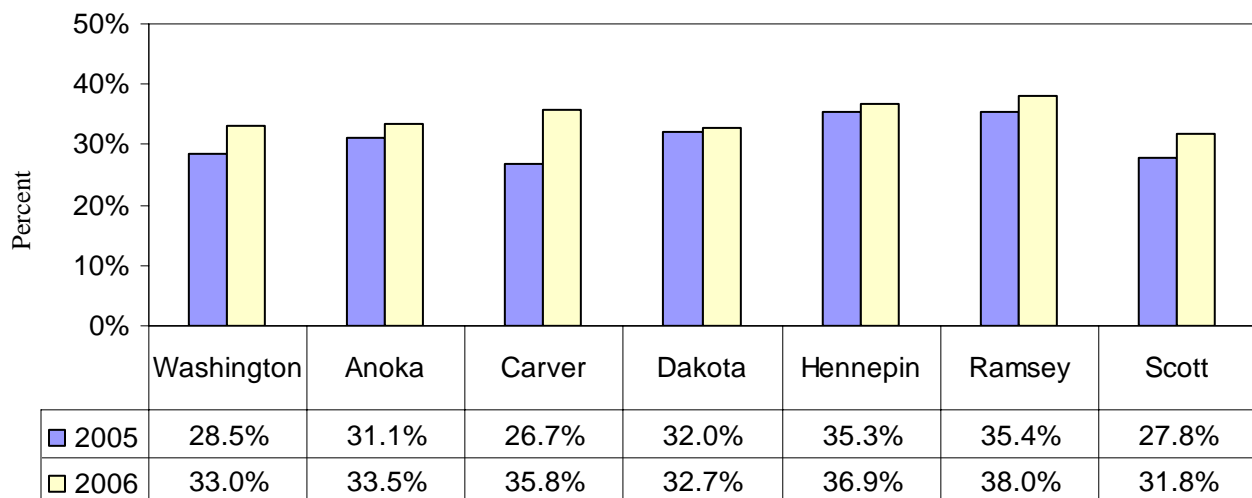
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Key Data

Figure 5.

Households Paying 30% or More of Household Income on Housing, Metro-Area Counties, 2005 & 2006



Source: American Community Survey 2005 and 2006, U.S. Census Bureau

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Community Assets

- ◆ Quality primary care facilities (hospitals and clinics)
- ◆ Programs to help families with childhood behavior problems, substance use during pregnancy, developmental and physical disabilities, and health care access
- ◆ Programs to assist families in caring for elderly and disabled adults and navigation of services for independent living, assisted living, and long-term care
- ◆ Child and teen check-ups that provide outreach for preventative health care to all Medical Assistance eligible children in the county
- ◆ Reduced cost or free immunization clinics for the uninsured, underinsured, and Medical Assistance eligible children in the county
- ◆ Women, Infant, and Children program provides nutritional education and food vouchers/formula to income eligible families
- ◆ School nurses
- ◆ Known areas in which culturally diverse groups live, collaborate, advocate, and own businesses
- ◆ Numerous faith communities providing support services
- ◆ Portico HealthNet, available within Stillwater School District, offering short-term low-cost health insurance

Community Gaps and Risks

- ◆ Transportation options are limited
- ◆ Limited availability of multicultural or multilingual services at healthcare provider locations
- ◆ Limitations in health care coverage for children and adults
- ◆ Limited availability of affordable housing
- ◆ High costs of medications, premiums, co-pays, and deductibles as well as out-of-pocket costs for the underinsured and uninsured
- ◆ Difficulty navigating a complex health care system
- ◆ Existence of prejudice and racism
- ◆ Cultural beliefs and practices
- ◆ Economic stresses of rising housing, transportation, food and energy costs

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Summary

Access to health care is important to eliminate health disparities and increase the quality and years of healthy life for everyone. Having health insurance, higher income levels, and use of regular primary care providers or other source of ongoing health care are all predictors for access to quality health care.

In addition, disparities in health status between the white-only population and populations of color and American Indians in Minnesota have existed for some time, and are, in some cases, getting worse. These disparities are a result of a complex interplay of many factors including access to health care, genetics, racism, social conditions, and health behaviors. Effectively addressing these disparities requires a comprehensive, community driven, sustained approach.

Washington County has experienced changes in diversity and growth in immigrant and refugee communities. Information is limited about the health and demographics of this population. However, information suggests that these communities have unique health concerns and experience unique barriers to accessing health care services. Closing the gap in health disparities between minority and non-minority populations poses a significant challenge for Washington County.

Sources

- ¹ America's Health, 2006, United Health Foundation
- ² American Community Survey, 2006, U.S. Census Bureau
- ³ Women, Infant & Children (WIC Program), 2006, Washington County Public Health & Environment
- ⁴ Kaiser Family Foundation, 2008
- ⁵ Health-United States, 2007, National Center for Health Statistics, Centers for Disease Control and Prevention
- ⁶ Health Insurance Coverage in Minnesota, 2007, Minnesota Health Access Survey, Minnesota Department of Health
- ⁷ Financial Burden of Health Care, 2001-2004, Commonwealth Fund, Health Affairs, January/February 2008
- ⁸ Facts on Health Care Costs, 2008, National Coalition of Health Care
- ⁹ Minnesota Department of Employment and Economic Development
- ¹⁰ Smedley, Brian D. Moving Beyond Access: Achieving Equity In State Health Care Reform, *Health Affairs*, 27, no. 2 (2008): 447-455.
- ¹¹ Dental Coverage and the Care for Low-Income Children: The Role of Medicaid and SCHIP, The Kaiser Commission on Medicaid and the Uninsured, The Kaiser Family Foundation, July 2008
- ¹² U.S. General Accountability Office, *Dental Disease is a Chronic Problem Among Low-income Populations*, 2000