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HEALTH CARE ACCESS FOR LOW-INCOME PEOPLE: SIGNIFICANT SAFETY NET GAPS REMAIN

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Despite signs that low-income and uninsured people's access to primary health care services has improved, serious gaps in care exist, especially for specialty physician, mental health and dental care, according to the Center for Studying Health System Change's (HSC) 2002-03 site visits to 12 nationally representative communities. Key factors contributing to these gaps in the safety net include declining private physician and dentist involvement, changes in funding and facilities, and more people in need. Community leaders have developed a variety of innovative strategies to add specialty, mental health and dental services but could benefit from more support from state and federal policy makers.

Rx for More Specialty, Mental Health and Dental Services

While many communities have expanded primary health care services for low-income and uninsured people in recent years,[1] widespread access problems exist for specialty physician, mental health and dental services, according to findings from HSC's 2002-03 site visits to 12 nationally representative communities (see Data Source).

Community health centers (CHCs) and other local clinics mainly provide preventive and primary care, and hospitals often have limited capacity for mental health, outpatient specialty and dental services. Many low-income and uninsured people turn to private physicians and dentists, but access to these providers has declined in recent years. As a result, many of the uninsured and people covered by Medicaid or the State Children's Health Insurance Program (SCHIP) have significant problems obtaining specialty, mental health and dental services.

Specialty medical care. Health leaders in 10 of the 12 HSC communities reported that low-income people have great difficulty obtaining specialty care, and observers in six communities indicated that access has declined over the last two years. As a New Jersey CHC respondent lamented, "While access to primary care and acute care is good, specialty care is the missing piece in the middle. It is the worst part of the health care system." Five specialties were cited commonly across communities as being particularly difficult to gain referrals: gastroenterology, orthopedics, cardiology, endocrinology and dermatology.

Primary care providers said they spend considerable time trying to find specialty practitioners to see their patients. Capacity at safety net hospitals and community clinics for these services is limited and waits for appointments often are long. For example, in Miami, patients reportedly wait months for specialty care at the county hospital, the community's major safety net provider. Additionally, hospitals in several communities reported that specialists are reluctant to provide on-call coverage in local hospital emergency departments, a major source of care for uninsured people.

Mental health care. Access to mental health services surfaced as a significant problem in eight of the 12 communities. Comments such as "the mental health delivery system is in shambles," expressed the extent of these problems. For example, a Greenville community clinic director reported that clinic doctors are overwhelmed trying to care for physical ailments of patients with mental health conditions that are undertreated.

Dental services. In eight of the 12 communities, observers cited considerable problems with dental services, and access had worsened over the last few years in some communities. One community dental program representative noted that patients face a two-year wait for services, and a community health association reported that it takes CHCs two years to recruit new den-

Data Source

Every two years, HSC researchers visit 12 nationally representative metropolitan communities to track changes in local health care markets. The 12 communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. HSC researchers interviewed individuals in each community who are involved directly or indirectly in providing safety net services to low-income people, including representatives of safety net hospitals, provider groups, community health centers, local health departments and government officials, academics and advocates. This Issue Brief is based on an analysis of these individuals' assessments of availability of various types of services for low-income people.

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tists. In some communities, patients often end up losing teeth because emergency extractions are the only service available. Even in communities that have expanded primary dental services, access to specialty dental services, such as periodontics and endodontics, is difficult.

Why Gaps Persist

A number of factors contribute to the long-standing—and in some cases worsening—lack of specialty, mental health and dental services, including declining private physician and dentist involvement in the safety net, changes in funding and facilities, and more people in need.

Limited private provider participation. Many local health care leaders said private hospital, physician and dentist participation in the safety net "only scratches the surface of the problem," and some communities report that many providers are less willing to treat the uninsured. These findings are consistent with Community Tracking Study Physician Survey findings that show the percentage of physicians nationally providing charity care decreased from about 76 percent in 1997 to 72 percent in 2001.

Provider willingness to treat people covered by Medicaid and SCHIP also was a challenge in most communities. In many cases, physicians technically participate in Medicaid and SCHIP but reportedly restrict caseloads to existing patients or agree to see a limited number of publicly insured patients each month.

Provider involvement in care for low-income people is largely linked to their ability to finance the care through other means. Although some states and communities have charity care pools—funds set aside to reimburse providers for caring for the low-income uninsured—they often are designed to reimburse hospitals rather than private physicians and dentists. Across the communities, low Medicaid and SCHIP payment rates—especially relative to commercial payments—were cited as major obstacles to provider participation.

Administrative and regulatory burdens also were mentioned but as a secondary issue. The overall cost of practicing medicine reportedly affects participation as well. In a few communities, rising malpractice premiums were identified as a factor.

Respondents in eight of the 12 HSC communities believed shortages of specialty physicians contributed to access problems for low-income people. Some of these perceived shortages were longstanding, while others were more recent. In Syracuse, observers said an inadequate supply of specialists, particularly dermatologists and psychiatrists, was likely an issue behind gaps in access. A Phoenix respondent pointed to study findings that showed low compensation levels and large numbers of uninsured hurt Arizona's ability to recruit physicians. Respondents in that community reported insufficient numbers of dermatologists, gastroenterologists and rheumatologists.

In addition, a number of communities appear to have shortages of dentists and hygienists. Arizona and Arkansas lack dental schools, which some say contributes to the problem. Additionally, a few communities, especially Syracuse, encountered difficulties because of dentists retiring.

Funding cutbacks. Funding cuts for key mental health facilities have added to access problems in some communities. Because many mental health services for low-income people are financed by the states, directly or indirectly through Medicaid, they have been vulnerable to state budget deficits in recent years. A 2002 survey by the National Mental Health Association found that 29 states had reduced funding for mental health agencies or Medicaid mental health services. In Greenville, for instance, downsizing of the state-funded inpatient facility and other cutbacks reportedly have hindered a major mental health clinic's ability to monitor patients appropriately. And state budget cuts in Ohio led to elimination of mobile mental health outreach and assessment activities throughout Cleveland.

Since dental services for adults are an optional benefit under Medicaid, many states have cut these services in the face of budget constraints. For example, Massachusetts eliminated adult dental coverage in 2003. In the same year, five other states in which HSC communities are located reduced dental services, often limiting care to emergencies.[2]

Change in organization focus. In a few cases, organizations that traditionally provided specialty services have reduced that commitment, creating a noticeable gap. In Seattle, for example, safety net respondents described recent difficulties referring low-income patients to a quasi-public, multi-specialty provider group. Reportedly, financial difficulties led the provider to focus more on higher paying populations and to convert to a private organization. And a safety net hospital in Greenville reduced clinic sessions in the downtown area to reportedly focus on its teaching mission by concentrating on patients with particular conditions.

Increasing demand. Increased patient demand has contributed to more access problems in several communities, especially those with rapidly growing numbers of immigrants and newly unemployed workers. Indeed, the number of uninsured people nationally rose by 2.4 million between 2001 and 2002.[3] The number of people covered by Medicaid and SCHIP increased as well. Furthermore, some suggested that primary care expansions generated need for more follow-up care, leading to increased pressure on safety net providers and growing waits for follow-up appointments.

Communities Address Problems

State and local policy makers are aware of the access problems for specialty, mental health and dental services, but communities have been more active in addressing the issue. Respondents cited few state level efforts aimed at narrowing the gaps, and budget constraints have hampered states' ability to allocate funds over the last few years. Although some states have increased Medicaid payment rates, in many cases, Medicaid rates are still much lower than private insurer rates.

Meanwhile, many HSC communities systematically have tried to improve access to services, often with the help of federal or state funds. Strategies include expansions to community clinics and initiatives to promote provider volunteerism or pay providers for treating the uninsured.

Community clinic expansions. Health centers in most of the HSC communities have added mental health and dental services over the last few years. Seattle, Miami, Boston and Orange County have expanded mental health and substance abuse services through existing facilities and, in some cases, school-based clinics. And at least two CHCs in Phoenix have built dental centers, one of which is expected to add 5,000 dental visits a year. Federally qualified CHCs have largely financed growth through federal expansion grants,[4] while other centers used a mix of funding, including tobacco settlement and state funds. Most of the clinic expansion funding has been for primary care, however, and many clinics continue to struggle to provide other services.

In addition, some free clinics have added specialty services for the uninsured by recruiting more volunteer physicians and dentists. In some cases, doctors who volunteer in safety net facilities receive malpractice protection through federal or state programs. Volunteer physicians allow large clinics in Greenville and Cleveland to provide specialty sessions, as well as limited dental services. Clinic capacity is limited, however, and some specialty sessions are infrequent—one or two days a month.

Volunteer networks. To reduce safety net providers' reliance on personal relationships with private practitioners for referrals, a few communities have created more formal networks of practitioners willing to serve low-income people on a volunteer basis. Medical societies in Little Rock and Greenville, for instance, have initiatives in which physicians and dentists agree to see a

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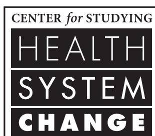

set number of uninsured patients in a given period. The idea is that, if practitioners are allowed to limit their contribution, care will be more equally distributed and no one will be overburdened, leading to more practitioners participating. However, the Greenville program has not generated much patient enrollment because of stringent eligibility requirements. The Little Rock program has recruited about 1,000 physicians and more than 100 dentists throughout the state, but respondents indicated that many uninsured people are unaware of the program.

Managed care programs. In a few communities, initiatives to manage care have helped link uninsured people to established networks of providers who are paid for their services. For example, Indianapolis and Lansing operate programs through a public-private entity or hospital system, financed by a mix of federal, state and local funds. Leaders in Indianapolis found that their program has improved access to specialty care. In Lansing, private specialists were not participating at the level expected and access was still considered a problem. Both programs have had difficulties recruiting dentists.

Lessons Learned

Across communities, low-income and uninsured people face long-standing, and sometimes worsening, difficulties obtaining specialty, dental and mental health services. Increased access to primary care services over the last few years has both illuminated the gaps in other services and likely identified needs for follow-up consultation and treatment. Safety net providers are not equipped to meet the wide range of health care needs of all low-income people, and access to private practitioners remains limited. As a result, many low-income people likely face delayed care, untreated conditions and poor outcomes.

As policy makers seek to improve access to health care services through the safety net, lessons can be learned from local experiences. Because low payment rates appear to be a major barrier, attempts to create or increase rates to private providers for treating low-income and uninsured people may have potential. But continued budget shortfalls likely will hinder state and local governments' ability to do this. In addition, policy makers could look for ways to cultivate and promote communities' creative approaches to expand sources of care for low-income and uninsured people. ■

Notes

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2. Johnson, Pat, "Medicaid: Benefits and Services (Year End Report – 2003)," Health Policy Tracking Service (Dec. 31, 2003).

3. Health Insurance Coverage in the United States: 2002, U.S. Census Bureau, Washington, D.C.

4. Hoadley, John F., Laurie E. Felland and Andrea B. Staiti, *Federal Aid Strengthens Health Care Safety Net: The Strong Get Stronger*, Issue Brief No. 80, Center for Studying Health System Change, Washington, D.C. (April 2004).

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