Access to Quality Healthcare

Description

Access to quality healthcare continues to be a global issue. In 2018, the World Health Organization (WHO) identified specific outcomes to work toward the goal of primary care for all global inhabitants (WHO, 2019a). Emergency departments (EDs) were originally designed for acute emergent visits. However, ED patient visits for nonemergent care are increasing due to gaps in primary care and healthcare costs.

In the United States (U.S.), ED visits exceed 139 million annually (Rui & Kang, 2017). In 2018, a 10-year study completed by the Healthcare Cost and Utilization Project (HCUP) revealed an increase in ED visits for all age groups and, most notably, a 20% increase for the 45 to 65-year-old age group (Sun et al., 2018). Medicaid payments for those under 18 years of age increased from 45% in 2006 to 62% in 2015 (Sun et al., 2018). Disparities in access to healthcare and costs continue to be debated. The U.S. Affordable Care Act (ACA) was signed into law in 2010 with the goal to improve healthcare access by making healthcare more affordable. The intent was to expand Medicaid and supporting innovations in healthcare delivery to lower the cost of access to healthcare. Yet, ten years later, healthcare remains unaffordable for many Americans due to high premiums and out-of-pocket expenses (Kaiser Family Foundation, 2013; Collins et al., 2017).

A review of the literature for the last five years concerning access to healthcare and ED care reveals more than 1,000 studies that focus on access to care for various diagnoses and specific populations. The barriers to access to care are multi-modal and require different strategies to eliminate. Caring for behavioral health conditions such as substance use disorder in the ED is one example of a specific challenge related to access to care. Due to the cycle of addiction, with remissions and exacerbations, many patients find themselves in the ED either by choice or necessity. Traditionally, options for access to care for substance abuse have been limited and often not covered by insurance (U.S. Department of Health and Human Services, Office of the Surgeon General, 2016). Other examples have been highlighted by the COVID-19 pandemic in 2020. Surge volumes from the pandemic have limited access to care and created shortages of personal protective equipment (Centers for Disease Control and Prevention [CDC], 2020a). Innovative strategies to address some of these barriers such as outdoor and drive through virus testing, outdoor healthcare provider visits at urgent care facilities, and expanded telehealth services emerged during the COVID-19 pandemic. Emergency nurses were on the front lines of many of these creative solutions.

Access to quality healthcare in the future is not clear or certain. Currently, EDs across the world are the access points for many to receive quality, cost-effective healthcare (WHO, 2019b). The adaptability of emergency nurses and other healthcare professionals will be key to successful access. Fortunately, emergency nurses are poised and ready for the challenge, as demonstrated daily in EDs globally. The Emergency Nurse Association (ENA) will continue to support and provide innovative education for the emergency nurse.

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ENA Position

It is the position of the Emergency Nurses Association that:

1. All people have the right to equitable access to affordable, comprehensive, quality healthcare services for critical, acute, and chronic conditions, including behavioral health and substance use disorders, regardless of socioeconomic status or geographical location.

2. Strategies be implemented to support increasing the healthcare provider workforce, including targeted funding for education and student loan repayments.

3. Advanced Practice Registered Nurses (APRNs) be allowed to practice to the full extent of their educational preparation, in addition to allowing equitable reimbursement for services provided.

4. Contributions to advocacy efforts on local, state, and national levels are aimed at improving access to affordable, comprehensive, quality healthcare for all.

5. Access to affordable, comprehensive, quality healthcare be expanded through prioritization, exploration, implementation, and reimbursement for use of emerging technologies, such as telemedicine.

6. Emergency nurses participate in the development and delivery of public information for preventive, community, and primary care resources to mitigate nonemergent use of emergency services.

Background

Access to affordable, comprehensive, quality healthcare substantially impacts physical, social, and mental health outcomes (Agency for Healthcare Research, 2016, County Health Rankings & Roadmaps, n.d., Healthy People 2030, n.d.). Lack of access to quality healthcare is one of the WHO's top ten threats to global health, as at least half of the global population does not have access to essential health services (WHO, n.d.-b). Access to healthcare varies across the globe and is dependent upon several factors.

Health equity refers to the absence of avoidable differences in healthcare, often related to social, economic, demographic, and geographic difference among populations (WHO, n.d.-a). According to the CDC, health equity is achieved when people attain full health potential regardless of other social determinants (2020, March 11). Awareness of the concept of health equity is crucial for effective healthcare policy-making; while not all people need or desire the exact same type of healthcare access, the focus of healthcare policy should include the goal of addressing barriers to healthcare access.

Ideally, individuals access the healthcare system through a primary care provider to receive comprehensive, affordable, community-based care (WHO, 2019a). Primary care providers offer a usual source of care, early detection, and treatment of disease, chronic disease management, and preventive care (Healthy People 2030, n.d.). According to the CDC as of 2018, it is estimated that 87.6% of U.S.

citizens over age 18 had a usual source of care (USC) (CDC, National Center for Health Statistics, 2017). Of those, 61.6% had a visit with that USC on an annual basis (Wolford & Stagnitti, 2019). For many individuals, the USC is the emergency department (ED), as evidenced by nearly 29% of all emergency visits in the U.S. which are nonemergent Emergency Severity Index (ESI) triage levels four or five (Rui & Kang, 2017).

The cost of healthcare or the ability to pay for care is a barrier to access for many. Globally, nearly 800 million people spend 10% of the household budget for healthcare, and of those, nearly 100 million state that the cost of healthcare forces them into poverty (WHO, 2017). In 2010, the U.S. enacted the ACA into law to expand access to healthcare (Kaiser Family Foundation, 2013). Prior to the ACA, 16% of all people in the U.S. were uninsured, and of those, 33.9% were adults ages 19–25 and 7.8% children under age 18 (Cohen et al., 2011). Cohen et al. (2018) found the following: In the U.S., 9.3% of all people were uninsured, with 10.3% of adults age 18–64 and 5.2% of children age birth to 17 uninsured. Adults ages 18–64 with insurance were primarily covered through private insurance (68.9%) and the remaining through public options (19.4%). Of those with private insurance, 45.8% were in high-deductible plans. In children ages birth to 17, the coverage rate differs somewhat, with only 54.7% covered through private insurance and 41.8% through public options.

In the U.S., 4.8% of people failed to obtain needed medical care due to costs (CDC, National Center for Health Statistics, 2017). In 2017, the combined average employee insurance premium and potential out-of-pocket expenses to meet deductibles amounted to nearly 11.7% of median income, up from 7.8% in the previous decade (Collins & Radley, 2018). High deductibles contribute to delays in seeking health care; 47% of people with deductibles of $3,000 or more reported not seeking care when needed compared to 22% who did not have a deductible (Collins et al., 2017). Higher out of pocket expenses may result in delays in accessing healthcare, further contributing to seeking care in the ED.

Having health insurance facilitates access to primary care, specialists, and emergency care. However, it does not ensure access. Access to quality providers in close proximity is a crucial factor in healthcare access (County Health Rankings & Roadmaps, n.d.). It is projected that by 2023, the U.S. will experience a shortage of nearly 100,000 physicians, with rural and other underserved areas experiencing the shortages more acutely (Association of American Medical Colleges [AAMC], 2019). Nurse practitioners (NPs) and physician assistants (PAs) provide quality care and improve access by serving underserved populations and treating patients across the health spectrum (Everett et al. 2009). A recent study revealed an increase of 43.2% of NPs practicing in rural areas from 17.6% in 2008 to 25.2% in 2016 (Barnes et al., 2018). As demand for healthcare access expands, it is important to reiterate that advanced practice registered nurses (APRN), including NPs, nurse midwives, clinical nurse specialists, and nurse anesthetists, are highly trained and able to provide a variety of services that are poised to fill the gap (Nursing World, ND; Swan et al., 2015; Jennings et al., 2015). However, the Institute of Medicine (IOM) and the Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing (2011) found many APRNs are faced with barriers to practice, including state laws, federal policies, outdated insurance reimbursement models, and institutional practices and cultures. Strategies to expand the

healthcare workforce, including educational funding, are an important consideration to expand access to affordable care.

An estimated 15% of the U.S. population live in rural areas and experience higher rates of death from five leading preventable causes including heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke compared to the urban populace (CDC, 2019). People who live in a rural setting face unique challenges in accessing healthcare, such as limited provider options or the need to travel great distances to receive services. Urban and rural EDs have seen increased visits over time across age groups; the increase in rural visits has outpaced urban visits (Greenwood-Ericksen & Kocher, 2019). To help address access gaps, community grant programs offering funding opportunities aimed to increase access to care in rural communities and to address their unique health care challenges are available (Health Resources & Services Administration, 2020).

As spending on healthcare continues to increase, policymakers look for ways to ensure access to care is cost-effective. An emerging strategy for increasing access to healthcare is that of telehealth aimed at helping to address workforce shortages and reach patients in rural and underserved areas (Enlund, 2019). Telehealth uses electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration (Health Resources & Services Administration, 2019). In many cases, telehealth is reimbursed based upon the type of visit and the insurance type (Centers for Medicare & Medicaid Services [CMS], 2020; Medicaid.gov, n.d.). Telehealth is a promising solution to the lack of sufficient behavioral health providers, yet adoption is not widespread in the U.S. (Mace et al., 2018). A University of Iowa study found that rural hospitals that used telehealth for trauma patients were able to transfer the patients for definitive care more rapidly than those who did not have telehealth access (Schnabel, 2017). Further, using telehealth in an express care setting can be completed in roughly 35 minutes compared to the average ED length of stay of over two and half hours (Siwicki, 2017). Another study found that using telemedicine in the pre-hospital setting can decrease nonemergent ED visits by 6.7% (Langabeer et. al, 2017). The COVID-19 pandemic calls for social distancing led to increased utilization of telehealth and virtual visits across the healthcare system, potentially leading the way for expanded healthcare access in the future (Hollander & Carr, 2020). In response to the need to increase use of telehealth and virtual visits during COVID-19, CMS waived some requirements that limited reimbursement, presenting an opportunity to transform payment for telemedicine in the future (CMS, 2020).

In the complex healthcare environment, ensuring access to affordable, comprehensive, quality healthcare is a daunting task. The entire ED team has a part to play in advocating for policies to support advancing education and development of APRNs, removing barriers to access, and informing the public of resources for avoiding nonemergent use of the ED.

Resources

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