

Access to Quality Healthcare

Position Statement





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Access to Quality Healthcare

Description

Access to quality healthcare continues to be a global issue. The World Health Organization (WHO) (WHO, 2020) defines quality of care as health services increasing the possibility that identified health outcomes are consistent with evidence-based knowledge, including health promotion, prevention, treatment, rehabilitation, and mitigation. Additionally, 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 but have become the safety net for those who lack access to quality healthcare. Access to quality healthcare in the future is not clear or certain. Currently, EDs around the world are the primary access points for many to receive healthcare (Udalova et al., 2022; WHO, n.d.-a; WHO, 2019b). The global increase in ED patient visits for preventable, low acuity, nonemergent conditions is due to numerous social determinants of health (SDOH), including, but not limited to, economic, environmental, or social conditions (Riwitis & Navarroli, 2023; Udalova et al., 2023; WHO, n.d.-a).

As of 2020 in the United States, ED visits exceeded 131 million annually (Cairns & Kang, 2022). In 2018, a 10-year study completed by the Healthcare Cost and Utilization Project 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). Disparities in access to healthcare and costs continue to be debated. The Affordable Care Act (ACA) was signed into law in 2010 with the goal to improve access by making healthcare more affordable. According to the Kaiser Family Foundation (KFF) (2023) the ACA Medicaid expansion extended coverage to adults by adding eligibility for those with incomes up to 138% of the federal poverty level. Additionally, states were given an enhanced federal matching rate to expand coverage, increasing coverage to adults in 40 states and Washington, DC (KFF, 2023).

Many low-, middle-, and high-income countries offer government-guaranteed healthcare, otherwise known as universal healthcare (UHC), offering access to some level of healthcare based on a government's legislation, regulation, and/or taxation. The countries that have a form of UHC coverage have emergency care visits that are often an entry point for patients because of cost and access barriers. In some of these countries, emergency services are utilized more because of ease of access and by people with lower income because services are not billed, nor do they require copayments (Eurofound, 2019). The management of these systems varies by country. There are some countries where the government manages the entire healthcare system, such as the National Health Service (NHS) for countries of the United Kingdom (UK) (Vankar, 2023). Other countries, such as Canada, use taxation and a single payer system, even though each of the 13 Canadian provinces and territories determine the care delivered (Dhalla & Tepper, 2018; Tikkanen, 2019). Citizens of countries in the European Union (EU) make contributions through their employer to use private insurance companies that are government regulated (Tikkanen, 2019).

The barriers associated with access to quality healthcare are multi-modal, vary by country, and require different strategies to eliminate barriers and improve care. While providing quality healthcare has its challenges, it should include an ongoing patient-healthcare provider relationship, especially in areas such as behavioral/mental health and reproductive health. Caring for behavioral and mental health conditions such as substance use disorder requires a solid patient-healthcare provider relationship to manage ongoing care, including medications. Unfortunately, due to the typical cycle of addiction, with remissions and exacerbations, many patients find themselves in the ED either by choice or necessity. In the U.S., options for access to care for substance use disorder have been limited, carry a heavy cost burden, and

are often not covered by insurance (U.S. Department of Health and Human Services [HHS], Office of the Surgeon General, 2016). In fact, the U.S. has one of the highest mental health burdens with a lower capacity to care for patients than ten other high-income countries (Tikkanen et al., 2020). According to Tikkanen et al. (2020), a number of other high-income countries are removing cost barriers by operating specialty clinics and waiving copayments for mental healthcare. While there are some cities and regions of the U.S. trying to improve mental healthcare, barriers remain. Patients around the world, particularly women, need quality reproductive healthcare. However, issues regarding a patient's right to choose are evident in many areas with laws restricting access to some reproductive health services.

Another example of barriers to access was highlighted during the global COVID-19 pandemic. Surge volumes from the pandemic created an even greater mismatch in supply and demand for care, with high patient volumes in emergency and inpatient settings and shortages of not only personnel but personal protective equipment (Centers for Disease Control and Prevention [CDC], 2023, July). Innovative strategies for addressing 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. However, many were disease-specific, and some were time-limited. Therefore, they are not a solution to the breadth and depth of problems limiting access to care.

Emergency Nurses Association 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 mental health, substance use disorders, reproductive health, and gender-affirming care, regardless of socioeconomic status or geographical location.
2. Strategies involving all stakeholders are needed to support growing the healthcare provider workforce, including targeted funding for nursing education, including student loan forgiveness.
3. All healthcare providers be allowed to practice to the full extent of their educational preparation and scope of practice and receive equitable reimbursement for services provided.
4. Contributions to advocacy efforts on local, state, national and international level are aimed at improving access to affordable, comprehensive, high-quality healthcare for all.
5. Access to affordable, comprehensive, high-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.
7. Emergency nurses support confidentiality between patient and healthcare providers and delivery of evidence-based healthcare with patient safety as the highest priority.

Background

Access to affordable, comprehensive, and high-quality healthcare substantially affects a number of social determinants of health (SDOH) such as physical, social, and mental health outcomes (Agency for Healthcare Research, 2016; County Health Rankings & Roadmaps, n.d.; Healthy People 2030, n.d.-a,

n.d.-b; Riwitis & Navarroli, 2023). Access to healthcare varies across the globe and is dependent upon several factors.

Health inequities are avoidable differences in healthcare, often related to social, economic, demographic, and geographic difference among populations (Riwitis & Navarroli, 2023). According to the Centers for Disease Control, Office of Health Equity (n.d.), health equity is achieved when people attain full health potential, regardless of other social determinants. 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 including, but not limited to, gender-affirming care.

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.-a). According to the CDC, in 2022 it was estimated that 87.6% of U.S. citizens over age 18 had a consistent source of care (CDC, National Center Health Statistics, n.d.-a, n.d.-b). Of those, 83.4% had a visit with their primary care provider on an annual basis (CDC, National Center for Health Statistics, n.d.-a; Schiller & Norris, 2023a). However, for many individuals, the emergency department (ED) is a primary source for healthcare, as evidenced by nearly 29% of all emergency visits in the U.S. being for nonemergent triage levels four or five (Cairns & Kang, 2022; Udaloave et al, 2022).

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). Many low-, middle-, and high-income countries rely on UHC to provide basic healthcare coverage to their citizens. A number of high-income countries guarantee government or public health coverage to all residents, with some countries such as France providing residents the option of purchasing private coverage (Gunja et al., 2023)

The U.S. enacted the ACA in 2010 to expand access to healthcare and in subsequent years has expanded coverage (KFF, 2023). Prior to the ACA, 16% of all people in the U.S. were uninsured (Cohen et al., 2011). However, Cohen et al. (2019) found that after ACA 9.3% of all people were uninsured. Additionally, Cohen and Cha (2023) found that 8.4% of the population still remained uninsured in 2022. In the U.S., 6.1% of adults aged 18 and over failed to obtain medical care between January and December 2022 due to costs (Schiller & Norris, 2023a, 2023b). Additionally, higher out of pocket expenses may result in delays in accessing healthcare, further contributing to individuals seeking care in the ED.

Having health insurance or UHC facilitates access to primary care, specialists, and emergency care. However, it does not ensure access. Access to high-quality providers in close proximity is a crucial factor in healthcare access (County Health Rankings & Roadmaps, n.d.). Around the globe people who live in rural settings face unique challenges accessing healthcare services, such as limited facility or provider options and/or extensive travel to receive care. According to the World Health Organization (n.d.-b) nearly half of the world population live in rural or remote areas, with 4 out of 5 living in extreme poverty. 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, 2023, April). Worldwide, rural areas also experience higher rates of illness and death due to poor access to healthcare, the causes of which are difficult to quantify due to measurement difficulties but logically include geographic location, level of poverty, and availability of healthcare workers. Access to healthcare for those living in rural or remote areas continues to be a challenge, primarily due to a global shortage of healthcare workers (HCW). Regardless of a country's economic standing, shortages of healthcare workers still pose a significant issue because 75% of physicians and 65% of nurses globally work in urban areas, despite the fact that half of the world's population lives in rural areas (Makuku & Mosadeghrad, 2022). In fact, the World Health Organization (2021) estimates that there will be a shortage of 18 million HCWs by 2030, primarily in rural, low- and middle-income settings. The International Council of Nurses (n.d.) estimates, the world

could see a shortfall of up to 13 million nurses. It is projected that by 2034, the U.S. will experience a shortage of between 37,800 and 124,000 physicians, with rural and other underserved areas experiencing the shortages more acutely (Association of American Medical Colleges [AAMC], 2021). The issue of HCW shortages creating lack of access to care is not isolated to one or two countries, but rather, it is an international issue of recruitment, migration, supply, and demand.

One solution to improving access to healthcare and combatting the looming shortages is to use nurse practitioners (NPs). The first U.S. NP program began in 1965 to address the limited access to care available to underserved pediatric patients in rural areas (McComiskey, 2018). Since the first U.S. programs began there has been a global increase in the use of NPs to provide care. In addition to the U.S., seven other countries, Australia, Canada, Finland, Ireland, the Netherlands, New Zealand, and the United Kingdom, utilize NPs to provide access to quality healthcare (Maier et al., 2018). According to the American Association of Nurse Practitioners (AANP; 2020), NPs provide quality care, treat patients in a variety of settings across the health spectrum, and improve access by serving underserved populations. In fact, 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 globally, it is important to understand that NPs are highly trained and able to provide a variety of services and are poised to fill the gap of access to care for underserved populations around the world (American Nurses Association, n.d.; Australian College of Nurse Practitioners, n.d.). Despite the growing trend to utilize NPs to improve access to care, there are a number of barriers to their ability to practice in the U.S. and internationally. Depending on geographic location, the barriers, often based on country, state, or local laws, might include restrictions on prescribing authority, restrictions on practice, such as ordering diagnostics, or negative physician and administrator relations. Where autonomy or respect are not evident and NPs may be forced to relocate their practice (Beadnell, 2019; Scanlon et al., 2019; Schirle et al., 2020).

Access to evidence-based reproductive healthcare is a serious concern following the *Dobbs v Jackson Women's Health Organization* ruling by the Supreme Court on June 24th, 2022 (Coen-Sanchez et al., 2022; Schreiber et al., 2023). In the U.S., legislative control of abortion may now be determined at the state level, potentially resulting in a lack of patient access and treatment of medical reproductive emergencies (Harris, 2022; Vinekar et al., 2022). This leads to conflict between the requirements of the Emergency Medical Treatment and Labor Act (EMTALA) and state level decisions due to the uncertainty of the definition of "emergency" and the need to determine a clear threat to life (Rosenbaum et al., 2022). This uncertainty may result in a delay in the delivery of lifesaving care, potentially resulting in detrimental effects on the patient's clinical status (Schreiber et al., 2023). There are a number of areas of concern. First, there is the interference of the legislature in the patient-healthcare provider relationship wherein legislators without medical education and training are making decisions about healthcare situations without the experience or knowledge required to make informed decisions. There is also the requirement to anticipate and seek clarification during an emergency situation, removing patient and practitioner autonomy and increasing risk to the patient. In addition, practice variations throughout the country result in the availability of patient care being dependent on the services they can access, which often depends on where they reside.

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 of education and development of staff roles to full scope of practice, removing barriers to access, and informing the public of resources for avoiding nonemergent use of the ED.

Resources

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