



Access to Care

Access to Care: The National Challenge*

Access to health care means that one can receive respectful, high-quality health care in a reasonable time. There are four components that make up the continuum of care: clinical preventive services, primary care, emergency services and rehabilitative and long-term care. These components are also the access points into health care. Therefore, to improve access to care each must be addressed. Following is a description of each component.

Preventive Care. Preventive services have a substantial impact on many of the leading causes of disease and death. People must have access to preventive services that are effective in preventing or detecting diseases or risk factors at early, treatable stages. An example of this would be blood pressure and cholesterol screening.

Primary care. Improving primary care across the Nation depends in part on ensuring that people have a usual source of care. Having a primary care provider as the usual source of care is

especially important because of the beneficial attributes of primary care. These benefits include the provision of integrated, accessible health care services by clinicians practicing in the context of family and community.

Emergency services. Prehospital emergency services, poison control centers, and hospital based emergency departments are the most commonly sought sources of emergency care. Each year, they provide prompt first-contact care for millions of people regardless of their socioeconomic status, age, or special need. For many severely ill and injured persons, these settings are a crucial link in the chain of survival between the onset of symptoms and treatment in a hospital. For persons whose health problems are less pressing, emergency services are a gateway to additional health care.

Long-term care and rehabilitative services. People with physical or mental conditions that limit their capacity for self-care need long-term care and rehabilitative services. This population covers persons of all ages, from those who were born with physical or mental limitations to those who developed such limitations later in life. About 40 percent of the people in this population are under age 65 years. The long-term care population includes individuals who need help or supervision to perform activities of daily living.

For more information on access to care, please visit the Healthy People web-site at: www.healthypeople.gov

Access to Care Health Disparities*

Barriers in access to care go beyond basic causes, such as too few health care providers or a lack of facilities. Individuals also may lack a usual source of care or may face other barriers to receiving services. Having no health insurance or being underinsured can be barriers. No facilities or no health care professionals nearby are barriers. Sexual orientation, cultural differences, language differences, not knowing what to do, and environmental challenges for people with disabilities are also barriers.

Patients with disabilities may face more barriers from facilities not physically accessible or from the attitudes of clinicians. Hispanics, young adults, and uninsured persons are least likely to have a usual source of care. Hispanic persons and those with less than 12 years of education are least likely to have a usual primary care provider. Certain people, such as those who are disabled, elderly, chronically ill, or HIV-infected, require access to health care providers who have the knowledge and skills to address their special needs.

Large differences remain in health insurance coverage for some populations. Among the nonelderly population, almost 33 percent of Hispanic persons lacked coverage in

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*From Healthy People 2010, U.S. Department of Health and Human Services

Jacksonville Access to Care Health Report Card

Healthy People 2010 Access to Care Objectives

Obj #	Objective	U.S. (1998)	FL (2001)	Duval (2001)	2010 Target
Clinical Preventive Care					
1-1	Increase the proportion of persons with health insurance. (Percent)	83.0	81.3	89.2	100
Primary Care					
1-5	Increase the proportion of persons with a usual primary care provider. (Percent)	77.0	76.1 ¹	78.4 ¹	85.0
1-6	Reduce the proportion of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family member. (Percent)	12	8.7 ^{1*}	6.1 ^{1*}	7
1-9	Reduce hospitalization rates for three ambulatory-care-sensitive conditions - pediatric asthma, uncontrolled diabetes, and immunization-preventable pneumonia and influenza. (Rate per 10,000 population)				
1-9a	Pediatric asthma	23.0	24.8 ²	14.3 ²	17.3
1-9b	Uncontrolled diabetes	7.2	6.5 ²	8.1 ²	5.4
1-9c	Immunization-preventable pneumonia and influenza	10.6	2.3 ²	3.8 ²	8.0
Emergency Services					
1-12	Establish a single toll-free telephone number for access to poison control centers on a 24-hour basis throughout the United States. (Percent)	15	Florida has ³	Florida has ³	100

¹ Behavioral Risk Factor Surveillance System, 2002

² FDOH, Agency for Health Care Administration, 2002

³ Centers for Disease Control and Prevention, 2001

* Data is percent of no access to needed medical care in past 12 months.

The availability of data related to access to care for Florida and Duval County is limited. Data were available for only five of the sixteen Healthy People objectives related to access to care. For this report, the majority of data was cited from the 2002 Florida Behavioral Risk Factor Surveillance System (BRFSS), the 2002 Duval County BRFSS, and the Department of Health's Agency for Health Care Administration.

When comparing national and state data with Duval County BRFSS data, Duval had better results related to health insurance, primary care provider, and obtaining health care (objectives 1-1, 1-5 & 1-6). However, sample size is too small to permit comparison within Duval County.

When comparing national baseline data related to hospitalization rates for ambulatory-care-sensitive conditions, the

same picture emerges. Duval has better rates than the nation in two of the three conditions (objective 1-9a and 1-9c). Only uncontrolled diabetes (obj. 1-9b) is higher for Duval than the national baseline.

Although the data looks good locally, Duval County has a way to go in reaching the Healthy People objectives. These objectives will be addressed by state and local agencies including the Duval County Health Department and its partners and collaborators.

Prenatal Care Service Utilization in Duval County

Access to prenatal care is key to moms having positive birth outcomes. Prenatal care (which includes risk assessment, treatment and education) contributes to reductions in perinatal illness, disability, and death by identifying and mitigating potential risks and helping women to address behavioral factors, such as smoking and alcohol use, that contribute to poor outcomes. Prenatal care is more likely to be effective if women receive care early in pregnancy.

In 1998, in 83% of live births, U.S. moms received prenatal care in the first trimester. Over 87 percent received prenatal care in the first trimester in Duval County in 2002. Figure 1 displays utilization of prenatal care services in Duval County by age. The data indicate that younger moms are less likely to access prenatal care in the first trimester. This is especially true of moms 17 & under where only two-thirds received prenatal care services in the first trimester.

Locally, the Friendly Access (FA) project addresses access to maternal and child care services. The purpose of FA is to create improvements in customer service and access to the maternal and child health care system of Jacksonville. FA targets the uninsured and Medicaid populations in 14 Duval County zip codes, with the highest rates of poverty and infant mortality. Priority is given to interventions that improve access to prenatal and pediatric care and reduce disparities in infant mortality.

For more information on Friendly Access, please contact Thomas Bryant III at 665-2263.

Health Disparities

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1998, a rate that is more than double the national average. For adults under age 65 years, 34 percent of those below the poverty level were uninsured. Similar disparities exist in access to a specific source of ongoing care. An average of 85 percent of adults identified a specific source of ongoing care in 1998, but that dropped to 77 percent for those below the poverty level.

Disparities are also at the local level. Health Zone 1, mostly African American, reported the highest estimated percent (16.1) of uninsured people (see map on back cover). Duval County has only a 12.0 percent uninsured rate. However, health insurance coverage is

not the only issue. When looking at hospitalization rates for ambulatory-care-sensitive (ACS) conditions, there are apparent racial disparities (see Figure 2). ACS conditions are illnesses in which early and complete primary care can reduce the severity of the condition. Whites have a much lower rate of hospitalization for two of the three ACS conditions. This suggests that African Americans have limited access to preventive care services and evidence of low-quality primary care.

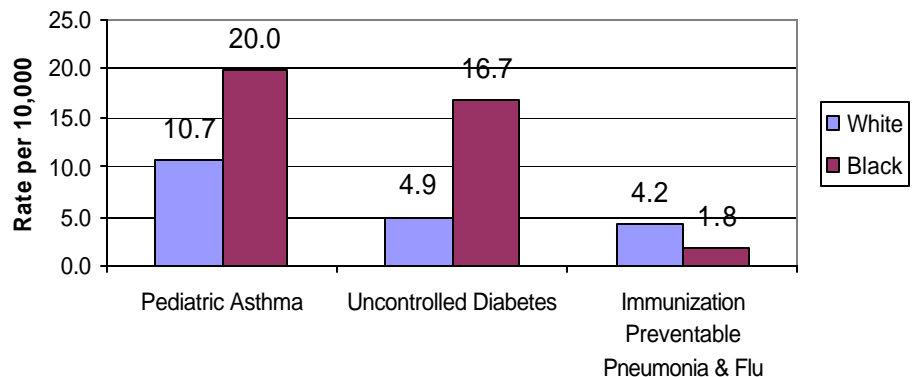
In order to address the above disparities, improving access to primary care and preventive services for the high-risk populations would decrease ACS related hospitalizations and extended illnesses.

Figure 1 Entry into Prenatal Care by Trimester and Age Group, Duval County, 2002

Age Group	First Trimester	Second Trimester	Third Trimester	No Care	% First Trimester
< 17	317	133	13	7	67.4
18-24	3474	607	103	78	81.5
25-34	5033	332	54	49	92.0
35+	1192	73	16	19	91.7

Source: FDOH, Office of Vital Statistics, 2002
Prepared by: DCHD, Institute for Health, Policy and Research Division, December 2003

Figure 2 Ambulatory-Care-Sensitive Conditions by Race, Duval County, 2002



Source: FDOH, Agency for Health Care Administration, 2002
Prepared by: DCHD, Institute for Health, Policy and Research Division, December 2003

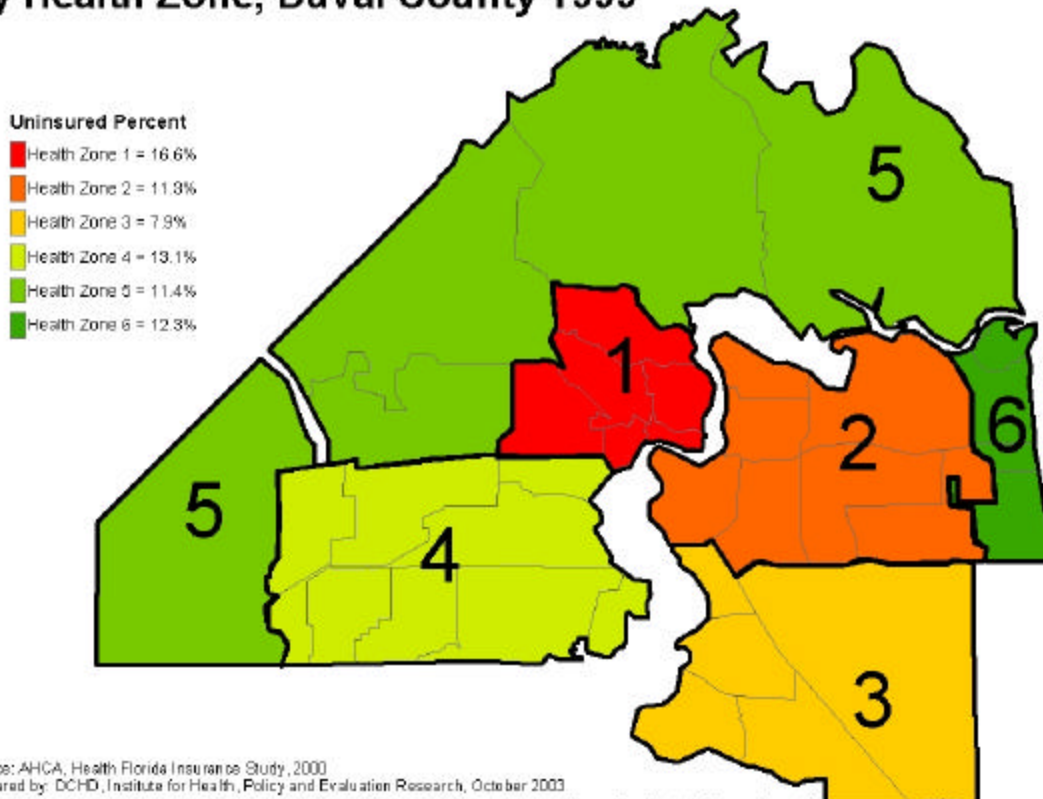
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Estimated Percent of Uninsured for the Under 65 Population by Health Zone, Duval County 1999



Source: AHCA, Health Florida Insurance Study, 2000
Prepared by: DCHD, Institute for Health, Policy and Evaluation Research, October 2003
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