

# Emergency Department Utilization Among the Poor: The Need to Improve Access to Quality Primary Care

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## **Emergency Department Utilization Among the Poor: The Need to Improve Access to Quality Primary Care**

### **Introduction**

Mrs. Jackson is a diabetic, African-American grandmother living in inner-city Chicago. Although cared for by her granddaughter Jackie, Mrs. Jackson is suffering from severe complications of diabetes. Her primary care provider, Dr. Marino, had been her physician for over twenty years, but he never managed to get Mrs. Jackson's diabetes under control. A graduate of medical school in the Philippines, Dr. Marino never finished his residency at a Chicago hospital and failed a peer review by the Department of Public Aid's Medical Quality Review Committee. The Jackson family, like many other poor families in the area, had no way of knowing this information and continued to utilize his services. When Mrs. Jackson first contracted an infection in her right foot, Dr. Marino vaguely referred her to another physician; he did not specify the physician, just the specialty. Jackie was forced to consult the phone book in search of podiatrists. Before an appointment could be made, however, Mrs. Jackson's condition worsened, and Jackie was forced to take her grandmother to the emergency room (ER). When Mrs. Jackson was finally seen in the ER, she was told that her foot would have to be amputated. Dr. Marino never followed up with his patient after this time, so her regular care after the surgery began to take place at an outpatient clinic at Mount Sinai. At this clinic, Mrs. Jackson was frequently looked after by interns and residents who knew very little about her health history, let alone what influences her socioeconomic status or ethnicity had had on it. She eventually secured a regular doctor at Mount Sinai and was scheduled to meet with Dr. Gurevich every Thursday. Jackie, however, was unable to keep up with her grandmother's regular doctors'

appointments because of the cost of transportation and, as a result, had to devise a schedule in which she took her grandmother to the podiatrist's appointment one week and Dr. Gurevich's appointment the following week. After making the expensive trip to Dr. Gurevich's office at Mount Sinai one week, Jackie was dismayed to discover that the physician had already left the hospital for the day. Determined to have her grandmother seen by a doctor, Jackie wheeled her to the emergency department. The medical records for this visit have never been located, but its effects have forever altered Mrs. Jackson's life. At that point in time, Mrs. Jackson was in the beginning stages of having a dangerous reaction to the blood-thinner Coumadin. The emergency department found her levels to be twice the desirable limit but made no arrangements for Mrs. Jackson to be monitored closely in the days that followed. Presumably, no one ever communicated this issue to Dr. Gurevich or ensured that Mrs. Jackson herself comprehended the gravity of the problem. As a result, Mrs. Jackson was hospitalized for Coumadin poisoning a few days later. A week after this stay, she was re-hospitalized for a recurrence of the original infection, and the remainder of her right leg was amputated (Abraham, 60-77).

Mrs. Jackson's story is all too familiar for many of America's poor and uninsured. Unable to gain access to a primary care provider, these individuals must rely upon the disjointed, curative care of an emergency room physician during episodes of illness. As more patients crowd into hospital emergency departments, they stretch the limits of its available resources, resulting in longer wait times and more medical missteps, like the one that almost cost Mrs. Jackson her life. Those low-income individuals who are able to secure a regular source of care are subject to the miscommunication and misunderstanding that often characterize their relationship with primary care professionals.

Inappropriate use of emergency departments and inadequate access to high-quality primary care are two interrelated issues that characterize health care for America's poor. A thorough rectification of this issue must not only discourage patients from ER misuse and enhance the accessibility of primary care but also increase the size and competence of the primary care workforce. The implementation of such programs and policies must occur if poor individuals are to gain the agency required to escape the cycle of poverty.

### **Emergency Department Care**

In 1986, Congress passed the Emergency Medical Treatment and Active Labor Act, requiring emergency departments to provide care to individuals irrespective of their ability to pay (Suruda et al., 20). This makes the emergency room the only viable alternative for the poor and uninsured who cannot afford to maintain a regular source of care.

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*Utilization by the Poor and Uninsured*

Mrs. Jackson's granddaughter Jackie often found herself relying upon emergency department services when a primary care provider failed to deliver the healthcare her grandmother needed. This behavior is a common one documented in the medical literature. Leiyu Shi<sup>1</sup> found that individuals that lack access to high quality primary care show a greater reliance on emergency department services (Shi, Stevens, and Politzer, 2006). Lacking health insurance coverage is also associated with increased usage of the emergency department. Uninsured children are 1.2 to 3.2 times more likely to be seen in the emergency department (Suruda et al., 25). One survey of inner city emergency room patients at San Francisco General Hospital found that 1/3 of those waiting had problems that were inappropriate for emergency

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<sup>1</sup> Leiyu Shi has done much research on patterns of health care utilization of the poor and uninsured and is widely regarded as an expert in the field.

department care. One-third of the individuals surveyed also reported their own problem to be “not serious” (Grumbach, Keane, and Bindman, 374). Two-thirds of these patients had no regular source of care. Additionally, of those patients with non-urgent conditions, 45% cited access barriers to primary care services (Grumbach, Keane, and Bindman, 375). Uninsured patients were most likely to give this reason.

Mrs. Jackson’s ethnicity also makes her pattern of emergency room utilization all the more familiar to minority individuals. Ethnic minorities are more likely to rely upon the emergency department as a regular source of care and to utilize it for illnesses deemed non-urgent. One study found African Americans to account for 47% of inappropriate ER users<sup>2</sup>; compared to 30% of whites (Guttman, Zimmerman, and Nelson, 1097). This disparity also exists between minority and non-minority children. African American and Hispanic children accounted for 34% and 30%, respectively, of inappropriate ER users as compared to 25% of white children (Guttman, Zimmerman, and Nelson, 1097).

Overrepresentation of ethnic minorities among the poor and uninsured must account for a portion of these differences in ER misuse. Deficiencies in health education and literacy as well as variations in ER utilization across rural and urban areas may also contribute to the racial differences in inappropriate ER use.

Mrs. Jackson’s story provides some insight into the patterns of rural and urban ER misuse. A resident of an African American enclave in urban Chicago, Mrs. Jackson was surrounded by a larger number of hospitals and emergency room physicians than are her

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<sup>2</sup> The use of the emergency room for problems that are not urgent is characterized as inappropriate or as a misuse of ER facilities. The use of these terms is not a reflection of a fault of the patient but rather a representation of the fact that their health needs are not actually an emergency. While it is difficult to determine all of the reasons behind the usage of the emergency department for the treatment of this condition, it is most certainly not only the patient’s responsibility. This is an important distinction to bear in mind when considering utilization of the ER.

contemporaries in rural areas. In urban areas, the density of emergency physicians is 14.5 per 100,000 individuals in the population (Ginde, Sullivan, and Camargo, 356). This figure is only 2.5 in small rural areas (Ginde, Sullivan, and Camargo, 356). Poor individuals living in urban areas, therefore, have increased access to a greater number of emergency departments than do poor rural individuals. This information, however, does not readily translate into greater emergency department use in urban areas. In 2001, of the states with the greatest per capita emergency department visits, two were largely rural: West Virginia and Mississippi (Sullivan et al., 699). Additionally, 28% of higher volume ERs, those seeing greater than 28,000 patients in a year, were in rural settings (Sullivan et al., 699). There has been no indication, however, that greater use of an ER translates into greater *misuse*, and, as such, it has yet to be definitively determined if there is a difference in inappropriate ER usage between urban and rural populations.

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In effect, many uninsured and poor patients have begun to utilize the emergency department as their primary source of care. Despite appearing convenient for these individuals, the emergency department cannot substitute for quality primary care services. The misuse of the emergency room is financially costly and, as evidenced by Mrs. Jackson's nearly fatal poisoning, detrimental to the health of all patients seen in the emergency department.

### *Cost of Emergency Department Care*

Emergency department care is more costly than comparable care from a primary care physician (Gill, Mainous, and Nsereko, 337). The cost of care in the ER is triple that of comparable treatment in a physician's office (Williams, 642). In a 1996 study, the average total charge for an emergency room visit was \$383.29 (Williams, 643). For non-urgent visits, this cost

was \$124.02 (Williams, 643). The high cost of ER care for non-urgent conditions can be partially attributed to the misuse of the ER itself. Inappropriate ER usage places a greater financial burden on the hospital's other patients; per-visit charges would likely be lower if a greater percentage of emergency department visits were covered by third-party payers (Williams, 644).

The crowding and long wait times associated with emergency department misuse also create undue health costs for those individuals who actually do require emergency treatment. Once every minute, an ambulance is diverted from a crowded emergency department (Horwitz, Green, and Bradley, 133). This costs the individual on board precious minutes of potentially life-saving treatment. Nationwide, less than 1/5 of hospital emergency departments were able to treat 90% of their emergency and urgent patients within an hour, and only half were able to keep the visit shorter than six hours for at least 90% of patients who were admitted to the hospital (Horwitz, Green, and Bradley, 138). Greater wait times and visit lengths reduce the quality of care provided to patients and significantly increase health risks for patients with serious illness (Horwitz, Green, and Bradley 133).

In addition to compromising ER efficiency and increasing total health costs, misuse of the ER creates great costs for the poor and uninsured. While many of these patients do not bear a financial burden for the care received in the ER, they do incur significant health costs as a result of their ER use. Long waiting times, a focus on curative care, and the discontinuity in providers have serious health consequences for individuals that rely on the emergency department as their primary source of care.

Waiting times for patients with noncritical conditions were found to be as long as 17 hours in an emergency department as San Francisco General Hospital (Grumbach, Keane, and

Bindman, 372). Fifteen percent of these patients left without ever seeing a physician. These individuals were two times more likely to report deterioration in their health status than those patients that waited to see a doctor (Grumbach, Keane, and Bindman, 372).

Seeing a physician in the ER, however, is no guarantee that one's health needs will be met. While they are required by law to treat all patients, emergency room physicians are only responsible for curing the illness with which a patient presents. Therefore, patients who rely upon the ER as their regular source of care will receive neither preventive services nor long term management of chronic diseases. Women, for example, who cited the ER as their primary place of care, were less likely to receive important preventive care services, such as a breast exam, mammogram, or Pap smear (Bindman et al., 272). When one considers that the poor are especially likely to suffer from chronic illness such as diabetes, the importance of health maintenance cannot be overstated, but overcrowded ERs cannot possibly be held accountable for the provision of such services.

A related consideration is the actual *care* given to the patient. During the time I spent working as a patient care assistant in the emergency room of my local hospital, I witnessed a considerable amount of open antagonism towards under- and uninsured patients. It was commonplace for some members of the healthcare staff to check a patient's insurance status before triage as a means of gauging his or her honesty or worth. While they would eventually treat the patient's illness, they often showed no respect for his or her concerns or feelings about the disease or treatment. This behavior severely damages the trust necessary for a good patient-practitioner relationship, thereby further undermining the health of these individuals. The importance of trust is a point that I will return to later in my consideration of primary care.

The final way in which emergency department care is detrimental to the health of those who use it regularly can be found in the discontinuity of care that it perpetuates. This is illustrated quite clearly in Mrs. Jackson's case by the lack of documentation of one of her ER visits and the absence of communication between the physician that saw her that day and her regular care doctor. In her case, the consequences to her health were quite severe. While serious incidents such as this may not be a typical result of discontinuity of care, emergency department care is, by its very nature, disjointed and fragmented. On any given visit, there is no guarantee that patients will see the same physician or nurses that they did previously. Therefore, at every visit, patients are entrusting their health to someone who knows very little about them beyond the information available in their medical record. The provider will not know personal history and will understand very little about the manner in which that patient's socio-economic status and ethnicity contribute to his or her conceptions of health and illness.

In contrast to the care received at the ER, continuity of care improves health through the relationship that develops between the patient and provider. These benefits are largely attributed to a provider's greater knowledge of the patient (Inkelas et al., 1917). This stability is especially important for the poor, whose health outcomes are largely dependent not just upon the treatment received but also on the comprehension of outstanding socio-cultural factors. High quality primary care is most strongly associated with the continuity of care described here, and it is the consideration of the reality of primary care for the poor to which we will now turn.

## **Primary Care**

Primary care is defined as the provision of first contact care and is typified by continuity, longitudinality, coordination, and comprehensiveness (Inkelas et al., 1917; Seid and Stevens,

1759). A primary care provider is responsible for a patient's routine care, such as check-ups, preventive screenings, health maintenance, and chronic disease management. A patient's relationship with his or her primary care physician is characterized "by practitioners providing support and empathy, co-participatory communication, mutual trust, and a physician's whole person knowledge of the patient" (Forrest et al., 270). These qualities distinguish one's relationship with a primary care provider from that shared with other physicians.

When Mrs. Jackson's primary care is considered in light of this definition, it becomes clear that it was riddled with flaws. While her relationship with Dr. Marino was continuous for a significant portion of her life, it lacked the coordination and communication needed to prevent Mrs. Jackson from suffering the debilitating consequences of diabetes. Nor could her subsequent relationships with primary care providers be characterized as high quality under these conditions.

Although she was going to the same outpatient clinic at Mount Sinai for care, she was initially seeing a different provider every time, thereby compromising the continuity needed for support, communication, and trust to develop. Dr. Gurevich's relationship with Mrs. Jackson could also not be described as understanding or supportive given her disregard for the difficulties Jackie had in obtaining transportation to and from her grandmother's appointments. She also failed to communicate appropriately with the ER to prevent Mrs. Jackson's Coumadin poisoning.

Mrs. Jackson's case illustrates the importance of not only having a primary care physician but also developing a trusting relationship with a high quality primary care physician. Many poor and uninsured individuals, however, cannot even claim to have a primary care provider.

#### *Utilization by the Poor and Uninsured*

Access to high quality primary care can be divided into two complementary categories (Seid and Stevens, 1760). The first of these is potential access, having the means to secure a source of care if one so chooses. This indicator would reflect health insurance status and the availability of a regular source of care. A second consideration is realized access, which concerns the actual use of care once one has attained potential access. While the first of these categories is most commonly thought to reflect access to care, especially for the poor and uninsured, it is important to recognize the criticality of the second as well.

Patients facing high health care costs tend to decrease the use of both necessary and unnecessary services, including care from a primary care physician (Pham, Alexander, and O'Malley, 663). Therefore, it is not surprising that many individuals cite financial barriers to the access of primary care services. A phone survey found the poor most likely to report lacking a regular source of care for financial reasons (Hayward et al., 436). A different study of patients seen in the ER without a regular source of care found the uninsured to be disproportionately represented in the 45% of patients who reported access barriers to primary care services (Grumbach, Keane, and Bindman, 374).

Insurance status is also a significant predictor of an individual's access to primary care (Seid and Stevens, 1760; Atlas et al., 325). Privately insured individuals are much more likely to report having a specific primary care clinician than their uninsured or publicly insured counterparts (Inkelas et al., 1919).<sup>3</sup> Sixteen percent of individuals that took part in a phone survey reported that they did not have a regular source of care; this response was most common among the uninsured (Hayward et al., 435). This difference is also reflected in children's access to well-child care from a primary care physician. Only 35.3% of the 11.7% of children who do

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<sup>3</sup> Publicly insured, in this context, is referring to Medicaid or Medicare patients.

not have health insurance receive primary care compared to 64.1% of privately insured children (Ascota et al., 111).

The availability of primary care providers also restricts access of the poor and uninsured to regular health care services. There is a documented lack of low-cost primary care physicians and a shrinking number of providers who are willing to serve the uninsured or publicly-insured populations (Shi, Stevens, and Politzer, 206). A 2009 National Association of Community Health Centers Report found that 60 million Americans lacked access because of the shortage of primary care physicians (Sherman, Muscou, and Dang-Vu, 945). This shortage is often felt most strongly in rural areas (Hayward et al., 436).

There is not just a difference in access between urban and rural populations; problems of access are also reported disproportionately across different ethnic groups. Latinos are the least likely to report having insurance and a regular doctor and are, consequentially, the ethnic group most likely to lack access to high quality primary care (Seid and Stevens, 1769). Asian/Pacific Islanders and African Americans are more likely to have access than Latinos but less likely to do so than whites (Seid and Stevens, 1769). Additional studies have confirmed these results (DeVoe et al., 788; Shi and Stevens, 195). Minority children are also less likely to have a usual source of care compared to white children (Raphael et al., 242).

Many studies have shown that poor individuals are not only less likely to have access to the care in general but are also less likely to receive high quality primary care in comparison with their more affluent counterparts. A study that assessed patient-physician connectedness, a common indicator of the quality of primary care, found that this measure was the greatest for whites who spoke English as their primary language (Atlas et al., 331). Whites are also more

likely to see the same clinician during primary care visits to a particular clinic, thereby promoting the continuity and quality of the care received (Shi et al., 141). Similarly, minority children who have attained access to primary care have shorter visits, receive less preventive counseling, and experience fewer referrals to specialty care (Raphael et al, 242). The attainment of a regular source of care, then, is not the only problem facing the poor and uninsured, especially minorities. The quality of the care gained is also a concern that must be addressed.

### *Benefits of High Quality Primary Care*

#### *Health Benefits*

Primary care is often—and should be—the first source of healthcare for patients. The services rendered by primary care providers range from well-patient care and the receipt of preventive services to specialist referral and the management of chronic illnesses. Because of this breadth, access to these services, or the lack thereof, has a large impact on health outcomes (Atlas et al., 325). A regular source of care is associated with greater receipt of preventive services, less missed or delayed care, reduced emergency department usage, more effective treatment and management of chronic conditions, and better overall health (Shi, Stevens, and Politzer, 211). Continuity of care has also been associated with better compliance for appointment keeping and use of medications, better pregnancy outcomes, and reductions in hospitalizations among elderly men (Bindman et al., 269). Eighty-five percent of women with a regular source of care receive preventive services for which they are eligible, such as a breast exam, mammogram, and Pap smear, compared to only 42% of uninsured women without a regular place of care (Bindman et al., 273). This finding has also been confirmed by other studies (DeVoe et al., 787; Ettner, 1748; Shi and Stevens, 195). A regular source of care is

particularly important for children to ensure the receipt of annual check-ups and immunizations (Inkelas et al., 1917).

Many patients, although receiving primary care services, experience episodic care from different physicians within a clinic or practice (Atlas et al., 325) While access to any primary care physician is important for improvements in health outcomes, continuity of care, particularly the establishment of a trusting relationship with a single practitioner, is even more strongly predictive of increased well-being. Individuals that score higher in terms of patient-physician connectedness are more likely to complete recommended testing for preventive screenings and receive guideline-recommended care (Atlas et al., 331). Continuity of care with a specific physician is significantly associated with a decreased likelihood of ER usage (Gill and Mainous, 333). Greater trust in one's physician's judgments about the severity of an illness may be responsible for this relationship between continuity of care and decreased ER usage and hospitalization (Gill and Mainous, 333). Having a specific clinician is also associated with higher patient-rated access to care (Raphael et al., 1918). A continuous relationship with a specific provider is especially important for people with chronic illnesses and mental health problems, which disproportionately affect the poor and uninsured (DeVoe et al., 786). Additionally, a study by Shi found that access to and continuity with a single primary care provider can reduce the adverse impact of income inequality on health (Shi et al., 143). The downward spiral of Mrs. Jackson's health as she lost and regained different primary care physicians also illustrates the importance of a long-term relationship with a single provider.

Access to a primary care physician and, more importantly, the development of a trusting, long-term relationship with a single provider can significantly improve health outcomes for the

poor and uninsured. The financial benefits associated with access to high quality primary care are also important.

### *Financial Benefits*

Access to high quality primary care is known to reduce health care spending (Seid and Stevens, 1759). This is partially due to fewer hospitalizations and decreased emergency department usage associated with having a regular source of care. The receipt of preventive services and well-patient care also facilitates early diagnosis and management of illnesses that would otherwise require costly medications, specialists' visits and hospitalizations.

Physicians' decisions affect how 90% of every health care dollar is spent (Pham, Alexander, and O'Malley, 663). Given this power, physicians have a responsibility to consider how their choices affect the out-of-pocket costs of their patients. Primary care physicians are much more likely to think about these costs when making treatment decisions than are medical specialists, such as emergency room physicians. Eighty-five percent of primary care providers consider costs to the patient when prescribing generic over name-brand drugs compared to 74.5% of specialists (Pham, Alexander, and O'Malley, 663). This difference remains when choosing inpatient vs. outpatient care settings and when selecting diagnostic tests (Pham, Alexander, and O'Malley, 663). As a whole, physicians were more likely to consider out-of-pocket costs when treating patients of known lower socio-economic status (Pham, Alexander, and O'Malley, 667). These results are indicative of the health savings associated with high quality primary care and are suggestive of the value of enhancing access to these services, particularly for the poor and uninsured.

### *Community Health Centers and Free Clinics*

Recognition of the importance of primary care to uninsured and poor individuals has led to the creation of community health centers (CHC). CHCs provide primary care services at low to no cost to people living in rural or inner-city underserved areas (Shi, Stevens, and Politzer, 206). In 2004, there were 900 CHCs in the US with 3600 primary care delivery sites, serving 13.1 million individuals on a budget of approximately 1.6 billion dollars (Shi, Stevens, and Politzer, 206). The majority of those served are low-income, uninsured, or Medicaid enrolled individuals. These patients are also more likely to be of poorer health than non-CHC patients. Uninsured CHC patients are more likely to have diabetes than their national counterparts, and Medicaid-insured CHC patients are more likely to have asthma (Shi, Stevens, and Politzer, 208). The existence of these chronic illnesses in a disproportionately large percentage of poor and uninsured populations reflects the need for continuity in primary care services. Ninety-seven percent of uninsured CHC patients report having a regular source of care as compared to 64.9% of uninsured patients nationally (Shi, Stevens, and Politzer, 208). Access to care is also as good or better for uninsured and publicly-insured CHC patients compared with patients nationally regardless of race, education, or socio-economic status (Shi, Stevens, and Politzer, 208). CHCs may, then, be filling a gap in health care coverage for those individuals with the greatest health needs. Free clinics, such as that of Rockbridge County, may also serve a similar function.

CHCs and free clinics, however, cannot possibly provide primary care services to all of those in need. The US Health Resources and Services Administration reports that there are currently 6080 Primary Care Health Professional Shortage Areas (HPSAs), with 65 million people living in them (Sherman, Moscou, and Dang-Vu, 945). Undoubtedly, rural and inner-city poor and uninsured populations are disproportionately affected by this shortage. Without access to high quality primary care services, they are left with little choice but to use emergency

departments for healthcare needs as they arise. The costs of reliance on the ER for care and the benefits associated with the receipt of high quality primary care are strongly suggestive of the importance of enhancing access to primary care while deterring ER usage for uninsured and poor individuals.

## **Policy Recommendations to Enhance Access to and Usage of High Quality Primary Care**

### *Universal Healthcare: Is It Sufficient?*

It would seem that the most obvious way to enhance primary care access for the large number of poor and uninsured individuals in the US is to implement a program of universal health care. Health insurance status is, after all, one of the most important predictors of access to primary care services. While it is undoubtedly important, universal health coverage would likely prove to be insufficient in meeting the needs of this population without further reform efforts.

### *Lessons Learned: Massachusetts, Canada, and the UK*

In 2006, Massachusetts enacted health care reforms that have expanded coverage to nearly all of the state's 6.5 million people. The legislation requires that all the state's citizens obtain health insurance. To ensure that this vision was realized, the legislation established the Commonwealth Care Health Insurance Program, which provides health insurance free-of-cost to citizens at or below 150% of the poverty line (Steinbrook, 2757). It also provides subsidized health coverage, with cost dependent upon an income based sliding scale, to individuals at or below 300% of the federal poverty line (Steinbrook, 2757). As of May 2008, these efforts have expanded coverage to 350,000 previously uninsured citizens (Steinbrook, 2757).

This increase in the number of insured individuals is a commendable accomplishment, but it has not resulted in greater access to primary care services for this population. In the fall of 2009, one-half of Massachusetts internists and 40% of family and general practitioners reported that they were not accepting any new patients (Neergaard). This would indicate that health care coverage alone does not necessarily translate into primary health care.

Countries with longstanding national health systems have also found universal health coverage to be inadequate to meet their citizens' needs for primary health care. Canada established Medicare, the country's public medical insurance program, in 1969 with the passage of the Medical Care Act. This program covers 70% of health care expenses with government funds (Pederson and Donner, 146). The delivery of primary health care under the universal system, however, has not been satisfactory in the past 40 years since its beginning. In 2000, the Canadian government established the Primary Health Care Transition Fund to address problems associated with primary health care (Pederson and Donner, 146). The five objectives of this project were to increase the proportion of the population with access to primary health care services, to enhance the emphasis on health promotion, prevention, and chronic disease management, to increase access to essential services to 24 hours a day, seven days a week, to encourage primary care physicians to communicate with other specialists as part of a multi-disciplinary team, and to facilitate the coordination of primary care with other health care services (Pederson and Donner, 147). While the exact health outcomes of this project have yet to be evaluated, its existence suggests that there is much more to the assurance of quality primary care than guaranteed health coverage.

Access to quality primary health services is also difficult to obtain under the National Health Service (NHS) in the United Kingdom. The National Health Service Act of 1946

established universal coverage for all British citizens. Although they receive health services for free, patients obtaining care under the NHS are limited in their choice of primary care physician. Most often, in fact, patients are assigned general practitioners based on their place of residency. While I was studying at the University of St. Andrews in Scotland, I was given a map of the town divided into different sections based upon which general practitioner was responsible for the health care of that part of the town. Ultimately, then, this system provides very little incentive for primary care physicians to improve the quality of the services rendered to their patients. Because they are paid by the government on a fee-for-service basis and they receive patients solely based on their residency, general practitioners are not necessarily held responsible for the provision of high quality primary care, and, as such, their patients do not always receive it.

Another characteristic of general practitioners under the NHS is their role as “gatekeepers” of other health services. Access to all specialists’ services requires a referral from one’s regular doctor. Gate-keeping arrangements such as this undermine patients’ trust that their primary care providers are acting on their behalf, particularly when referrals to specialty services are discouraged or denied (Shi and Stevens, 141). Many British citizens that I spoke with while abroad expressed discontent for the quality of care received under the system and related stories of acquaintances who purchased private insurance to gain greater control over their health care. This indicates that, despite the availability of primary care in the UK under the NHS, its delivery may undermine the very relationship that differentiates primary care from other forms of medical care.

Given the experiences of Massachusetts, Canada, and the United Kingdom, it is evident that universal health care is not sufficient to meet the poor and uninsured’s need for high quality primary care. Both Massachusetts and Canada still have issues with ensuring the availability of

primary health care providers to individuals, while the United Kingdom suffers from structural problems that make it difficult or impossible for patients to establish trusting relationships with their general practitioner. Universal health insurance programs also do little to discourage the use of the emergency room as a regular source of care, beyond making primary care a feasible alternative.

Efforts to improve the quality of health care received by the poor and uninsured must account for these problems. Universal health care is certainly a pre-requisite for the receipt of high quality care, but it must be supplemented by other programs to strengthen the services provided.

#### *Supplementary Programs*

Countless improvements can be made to the quality of the primary health care setting, but, without promoting utilization of these services, patients will not benefit from these

enhancements. Therefore, it is absolutely crucial that programs be implemented that educate individuals on the proper use of the emergency room and inform them of the health benefits to be had by obtaining and maintaining a relationship with a primary care provider. A pilot program of this type was tried at San Francisco General Hospital. Thirty-eight percent of the patients waiting in the ER were willing to trade being seen at the emergency department for a clinic appointment within three days (Grumbach, Keane, and Bindman, 374). The inclusion of such a brief educational and referral program into emergency department triage would not be a difficult adjustment to implement. Upon determining that a patient's problem is non-urgent, a triage nurse could relate the health costs of ER care as well as the health benefits of primary care. He or she could also, at this time, provide the patient with the contact information of primary care

providers in the area that are accepting new patients. While it may require additional resources initially to deal with overcrowded ERs, its utility and cost would likely decrease with time, as individuals became more aware of the benefits of alternatives to ER care.

Another policy that may reduce ER misuse is the creation of greater co-pays for ER care in comparison to those of primary care. One study in Germany found that the introduction of co-payments has led to a reduction in unnecessary physician's visits (Grabka, Schreyogg, and Busse, 480). Discouraging ER usage must also be coupled with strategies to increase the utility of primary care services.

Given the success of CHCs in enhancing health outcomes for low-income patients, their expansion may seem to be an obvious way to increase access to high quality primary care.

CHCs, however, experience considerable trouble in recruiting clinical staff, particularly in rural areas. Nearly 50% of direct clinical providers were non-physician clinicians in rural CHCs, and this figure was approximately 40% in urban centers (Rosenblatt et al., 1044). Increasing the number of CHCs will, therefore, do little to augment access to primary care without first addressing the shortage of primary care physicians.

A 2008 study predicted that the shortage of primary care providers for adults would reach 35,000-40,000 in the United States by 2025 (Sherman, Moscou, and Dang-Vu, 945). The implementation of universal health care is estimated to increase these shortages by 25% (Sherman, Moscou, and Dang-Vu, 945). It's a matter of supply and demand. Expanding health insurance coverage to all American citizens requires a concomitant expansion of the primary health care workforce. Current research on medical students suggests that the supply is not readily available. In 2008, 17% of graduating medical students were poised to enter primary care

residencies (Sherman, Moscou, and Dang-Vu, 945). Five percent were going into internal medicine, six percent into family medicine, and six percent into pediatrics (Sherman, Moscou, and Dang-Vu, 945). What this figure does not take into account is the proportion of these individuals who chose to go into primary care versus the proportion of individuals who were “forced” into primary care by low scores on their medical boards.

In short, the prestige that medical students—and the medical profession as a whole—associate with primary care is reflected by their hesitancy to enter the field and their belief that primary care is a field for individuals who can enter other specialties. Medical students should, instead, understand the value of primary care in the lives of their future patients and feel compelled to join the field. This requires the creation of a more comprehensive system of incentives than is currently in existence, as well as the destruction of the “only if there are no other options” mentality directed towards primary care residencies.

Currently, the only nationwide program committed to increasing the number of primary care physicians is the National Health Service Corporation (NHSC). In exchange for two to four years of service in a Health Professional Shortage Area, the NHSC will subsidize the costs of medical education (NHSC). This money is provided in the form of scholarships to individuals who join while still enrolled in medical school or in the form of loan repayment for individuals who joined after graduation. Approximately 3800 primary care clinicians are currently working in underserved regions through their affiliation with NHSC (NHSC). While 80% of NHSC physicians will continue to work beyond their initial commitment, only 50% make a career out of caring for poor and uninsured individuals (NHSC). Some medical schools have started similar programs, but enrollment in them has remained small.

While programs such as the NHSC are to be applauded for their contributions to the primary care field, they cannot possibly solve the entirety of the primary care problem. Additionally, prior attempts to incentivize primary care by providing bonuses to physicians through Medicare's Incentive Program (MIP) have had only marginal success. The payments are small, and few providers bother to claim them (Chan et al., 114). Addressing the shortage of primary care providers at its source is likely to be much more successful than either of these prior attempts.

The lack of prestige surrounding the primary care physician, as opposed to the neurosurgeon or cardiologist, is hardly fitting of the critical role they play in healthcare. Wider recognition of the role that these individuals play in preventive care, health maintenance, and management of chronic diseases would increase popular appreciation—and usage—of primary care services, potentially encouraging more medical students to enter the field. Addressing the lack of primary care physicians in this way, rather than through short-term loan repayment programs, will ensure that medical students become—and remain—primary care physicians for the right reasons. Incentive programs, however, will likely continue to be important for some time in order to allow these changes in perception to gain widespread acceptance.

The final barrier to the receipt of primary care services is the lack of cultural and socio-economic competence had by many medical professionals, including primary care physicians.<sup>4</sup> Medical practitioners, as a whole, are often perceived to be unknowing or uncaring about the social, cultural, or economic contexts in which their patients experience disease. This belief is

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<sup>4</sup> This lack of contextual knowledge is often compounded by the deficiencies in communication that exist between patients and practitioners, and among physicians. Addressing this comprehension, however, is likely to have a significant impact on the quality of communication between patients and doctors.

not ill-founded, and it is an issue that must be addressed if poor and uninsured individuals are to receive the best quality of care possible.

Currently, most medical schools offer some mandatory course on the cultural context of medicine. Although often given a descriptive name like “Social Issues in Medicine” or “The Doctor-Patient Relationship,” these courses are widely given monikers like “Touchy-Feely Tuesdays” by medical students, suggesting the seriousness with which they approach its teachings. Medical schools must, therefore, reinvent their curricula in such a way that courses on the cultural, social, and economic factors of health are not secondary to the biological nature of disease. It is not enough to know that black diabetics are two times more likely to require amputation and three times more likely to suffer kidney failure and blindness. Mrs. Jackson did not burdened with these afflictions solely because of her ethnicity; she also faced financial burdens that prevented her from travelling to regular doctors’ appointments and seeking the specialty care she needed. It is, therefore, crucial that medical students be educated on the context that permits these health disparities to exist. In re-structuring their education in this way, medical schools will be creating doctors who not only comprehend the nature of health disparities between the affluent and the poor but also have the understanding needed to work towards their elimination.

While the initial costs of many of these programs may be large, the long-term health savings will certainly outweigh the losses. Results from a 1995 study found that annual publicly and privately financed medical care costs would be cut substantially by increasing access to primary care (White-Means and Thornton, 141). An earlier study of an ER education program, like the one described above, also found financial costs to health systems to be reduced by 50% (Small and Seime, 45).

## **The Future of Health Care for America's Poor and Uninsured**

On Sunday March 28, 2010, the US House of Representatives voted to pass landmark legislation on America's health care system. The \$940 billion plan intends to make health care more accessible to thirty-two of the forty-eight million US citizens without health insurance (Health Care in America). Health insurance coverage will be expanded to include non-dependent children up to the age of 26, and health insurance exchanges will be set up to increase the affordability of coverage for small businesses, the self-employed, and unemployed (Health Care in America). Insurance companies will also be prevented from denying coverage to individuals because of pre-existing conditions. To distribute health care costs fairly across a diverse population, insurance will be mandated.

This health care overhaul is designed to enhance poor and uninsured individuals' access to high quality care, including primary care. This paper has shown that insurance alone cannot guarantee high quality care to patients, and the new health care legislation is taking further action to ensure that its promises of care are met. The law includes provisions for bonus payments to primary care physicians practicing in certain areas (Neergard). Primary care doctors serving in HSPAs will receive a ten percent bonus from Medicare. Additional measures encourage the restructuring of the primary care setting itself. Lawmakers envision a "medical home" in which primary care doctors, nurses, physicians' assistants, and disease educators work together to provide comprehensive medical care to their patients (Neergard).

While the passage of this legislation will undoubtedly increase the demand for primary care, it remains to be seen how its other mandates will fare in terms of increasing the supply of high quality primary care providers. The success or failure of these programs can begin to be

assessed after 2014, when much of the currently uninsured population will gain coverage (Health Care in America). At this time, it will become important to evaluate the receipt of high quality primary care services by low-income populations in comparison to the usage of emergency departments by the same populations to determine if the legislation has met an important health care goal.

**Conclusion:**

Poor and uninsured individuals in the US are compelled and accustomed to rely far too greatly upon the curative services of the emergency department to address non-urgent needs. The health outcomes associated with this behavior reflect a lack of preventive medicine and long-term disease management. Primary care services are a much more desirable alternative to this care. In addition to providing this population with information on prevention, health maintenance, and continuous care for chronic diseases, primary care offers poor and uninsured patients the opportunity to develop a long-term, trusting relationship with a health-care provider. The importance of this relationship's existence in promoting good health outcomes cannot be over-stressed, and it is the key factor differentiating primary care from other medical fields.

Thus far, the poor and uninsured have lacked access to primary care services, and their health has suffered as a result. With the implementation of nationwide health coverage, the financial barrier to access will be removed. The experiences of other similar programs, however, have shown that this provision is not sufficient to ensure the receipt of high quality primary care. Additional considerations must include deterring inappropriate emergency department usage, expanding the primary care workforce, and redesigning medical education to account for the cultural, social, and economic context in which biological disease processes take place. The

adoption of policies of this type will guarantee that the poor and uninsured no longer seek low quality care in the ER but receive high quality care from a knowledgeable, sympathetic primary care provider. In time, health outcomes will grow to reflect this switch, and the occurrence of medical tragedies, like the one suffered by Mrs. Jackson, will no longer reflect an individual's socio-economic status.

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