

THE “CUT” ON ACCESS

The Medieval Barbers

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Access to medical care has been responsible for a number of changes, and likely future changes, in ambulatory and mental health clinics. Access is important because to prevent or reduce disease one must be able to engage care-providers and receive appropriate treatments. However, bottom-line-oriented health maintenance organizations (HMOs) have used access to improve their ability to affect cost and quality rather than control disease. Access remains the most challenging for the uninsured but is complicated across the board. Access to mental health care is very limited and very challenging. The potential patients themselves, because of the stigmatization and the potential impact on a person's military career, limit their access to mental health care in the military. Staffing changes have been made to improve access in ambulatory and mental health clinics and to reduce the workload of the physicians and psychiatrists. The issues of access are closely intertwined with the factors associated with healthcare costs and quality.

Access has been an issue in healthcare from the onset. Historically, in ambulatory and inpatient hospital settings, poorhouses were used mainly for sheltering and feeding the indigent population, with the main medical focus being quarantine and prevention of the spread of disease to others in the public. Availability depended both on location and local resources. It seems very likely during those early years in American healthcare that there was a hierarchical system based on socioeconomic status and being able to pay for care with regard to quality and access, which still holds true today. In rural areas physicians are not readily available and specialists are even further away. Patients must pay indirectly or directly for access either by paying more money to keep someone on staff or by paying for transportation for the physician or themselves. This limited access

drives up costs for the consumers. With the increases in healthcare costs we have seen the development of managed care programs and capitation.

Reducing access allows a managed care organization the opportunity to deliver higher quality care to those who do obtain access. The embraced concept is that the fewer visits a patient has the less money it costs a system. This was one of the tenets of capitation, which necessitated that a system control access to medical resources or risk losing money on each individual who over-accessed the system. There has been a big push to develop standards of care and quantify outcome as it relates to the number of visits. For example, if some research has shown improvement in some psychiatric disorder symptoms (especially depression) in as few as 12 sessions, then that will set the bar for how many sessions the managed care organizations (MCOs) will cover. This can be problematic in many ways because it is not always what is best for every patient.

MCOs have made limited efforts to streamline access systems and improve one's ability to get in to be seen. The mechanized, pre-recorded, call-in selection system is often more confusing than helpful. Tri-Care is a perfect example of an organization that carefully crafted an 'access system' that is especially difficult for an individual to orient (especially when naïve to the system) and therefore successfully decreases individual access to the system. Those who maneuver the system to gain access are likely more motivated, self-directed and adherent than those who cannot get access. It has shown that people in HMOs tend to be healthier than those not in HMOs because they know they can afford the reduced access and are more health-oriented people to begin with.

Presently in Maryland, access to mental health care may be somewhat inverted. The state made fiscal promises to the mental health community that it could not keep and,

as a result, many agencies were bankrupted in the process. Long term, historical institutions like Chestnut Lodge folded overnight. The chronic and persistent mentally ill and the developmentally disabled are best able to access the system because their eligibility and access to money are well defined. For the less significantly mentally ill, access is more complicated and many are now having to pay some portion of the cost, which is likely another tool to decrease the pool of individuals seeking access. The \$5 or \$10 per visit payment has little impact on the financial situation, but it will discourage someone with very limited resources from coming in often.

In the military mental health clinics access is good for patients interested in psychotherapy. There seems to be enough psychologists, social workers, Family Advocacy providers and technicians to see patients but the psychiatrists are very underrepresented. There is also a clear stigma attached to military persons who access mental health resources. The patients themselves limit their access to available mental health treatment because of their perceived impact on their careers. To try and change this perception and stigmatization the Air Force has changed the name of their Mental Health clinics to Life Skills.

Access has been systematically limited or directed to reduce the perceived 'over use' of the system and these changes have only provided a short-term cost-savings. A policy area that has changed is that of prescription privileges for psychologists in New Mexico. That state has authorized psychologists to give prescriptions to improve access to psychiatric prescriptions in rural areas. If psychologists can expand their duties in this way, it increases the possibility for nurses, nurse practitioners, or physician assistants to provide some of the ambulatory primary prevention and primary care services to

underserved populations or the national population as a whole. This may decrease costs to the consumer, increase access and reduce the strain on the physicians who are overtaxed. The support staff can handle certain medical conditions and issues. Adding more nurses and technicians to the support staff greatly improves access. Many people would not be satisfied if this was the only contact they received for their visit. Although, when patients can relate to being seen by a “team”, they realize they don’t need to rely on the physician for everything. Most patients need reassurance or education on self-care, which the nurse can provide. The better trained the support staff is the more the physician can concentrate on diagnosing and treatment. This should be done as part of a team-effort to care for a population not as a corporate decision to reduce cost or access to expensive care. Creating a system that intelligently affords people appropriate access or even promotes access is more likely to reduce costs in the long run.

In conclusion, access is an important factor in healthcare delivery. It impacts both healthcare costs and quality. If HMOs control access for the sole purpose of cost containment they may lose some of the quality of care in medicine. The control of access should be used to prevent or control diseases. Access to mental health and ambulatory clinics is not only the most challenging for the patients but also presents challenges for the health care providers. Adding more nurses and technicians to improve access and reduce the workload to the physicians is beneficial only if care provided is a team effort and population focused. It is necessary in the future to continue to address the issues of access so that the improvements of health care services may guarantee all people receive basic healthcare anytime and anywhere.