8 Access to and Use of Health Care

Access to care is an important issue in health policy. Lack of access may result from economic barriers (no insurance, poverty), supply and distributional barrier (services not appropriate or not nearby), sociocultural barriers (problems of understanding between providers and clients of different backgrounds).[1] As discussed in the previous chapters, there are gender differentials in socioeconomic status and the needs for health care. Therefore, it can be argued that women's ability to access health care and their use of health care differ from men's. Lack of access leads people to use fewer health services and may lead to poorer health outcomes.[1]

This chapter will provide baseline information comparing women to men, on access to health care and patterns of health care utilization. This chapter presents information on health insurance, use of health care services, HMO enrollment among the Medicaid population, and long-term care. Women's visible and invisible roles in providing health care are discussed at the end of the chapter.

- Utahns without health insurance were more likely to be males, 18 to 22 years of age, without a high school degree, and with a total household income of under $20,000 a year in 1991.

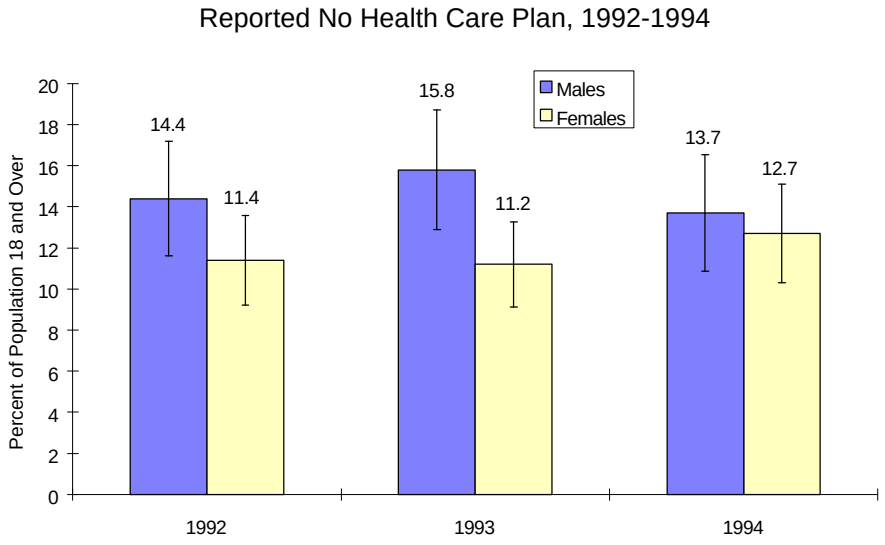
- Women made up 58 percent of Utah enrollees in Medicaid HMOs in June, 1996.

- Utah has a higher hysterectomy rate than all other 12 states in the quality indicators project sponsored by American Health Care Providers Research.

- In FY96, female Medicaid recipients in Utah used about $51 million for long-term care and male recipients nearly $23 million.

- For every female physician in Utah in 1993, there were 6.9 male physicians. The corresponding sex ratio for the U.S. was 4.3.

Insurance Coverage



Source: Behavioral Risk Factor Surveillance System

Lack of health insurance is a considerable barrier to accessing health care, especially preventive care and early detection activities. For women, this often means going without Pap smears, mammograms, prenatal care, and family planning. For uninsured children, dental care and immunizations are harder to obtain. Persons with limited access to health care are more likely to be hospitalized for conditions such as asthma and diabetes that could have been treated earlier in an ambulatory care setting. Women without health insurance are at risk for having problems (such as breast or cervical cancer) that go undiagnosed until they are symptomatic and more difficult to treat successfully.

The 1991 Utah Health Status Survey found that 9.5 percent of Utahns were without health insurance.* Public health insurance, such as Medicaid or Medicare, was used by about 18.5 percent of the state's population. Utahns without health insurance were more likely to be males, 18 to 22 years of age, without a high school degree, and with a total household income of under $20,000 a year. The survey also found that households with children, especially in the lower income categories, were least likely to have health insurance. Over 35 percent of households with four or more children and an income less than $10,000 had no health insurance. The most frequently cited reason for lacking health insurance was "Can't afford it." The 1996 Utah Health Status Survey will be completed soon and will provide current information on this important problem.

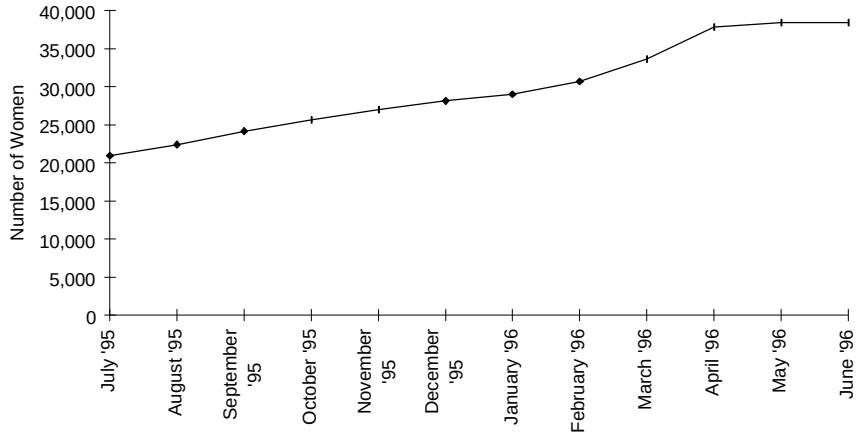
The above figure shows the percentage of adult Utahns, 18 years old and over, reporting having no health insurance coverage during 1992 to 1994, based on the Behavioral Risk Factor Surveillance System (BRFSS). In 1994, the percentage of women without insurance coverage increased and that for men declined from the previous years. The results from BRFSS were somewhat different from that of the 1991 Utah Health Status Survey due to different sampling methodologies and questionnaire designs. BRFSS results provide trend data for this issue, but do not include people under age 18.

* This percentage underestimates those without insurance covrage because poorer households without telephones were not surveyed. Adjusted for households without telephones, the percent was estimated to be 10.8%.

Medicaid Population and Managed Care

The Utah Legislature directed the Utah Department of Health, Division of Health Care Financing (DHCF), to enroll Medicaid recipients living in the four Wasatch Front counties (Weber, Davis, Salt Lake, and Utah) in health maintenance organizations (HMO). DHCF intends to use savings generated to expand Medicaid coverage to more low income individuals. As of July 1, 1996, nearly all individuals mandated to enroll in an HMO were receiving medical care through HMOs. Medicaid has established criteria allowing some recipients whose medical needs cannot be met through an HMO to be exempt from mandatory enrollment.

Number of Medicaid Women Enrolled in HMOs Under Medicaid Coverage by Month, July 1995-June 1996



Source: Division of Health Care Financing, Utah Department of Health

Medicaid HMOs Enrollees: Utah, June 1996

Male:	31,325	42%
Female:	43,258	58%

Source: Division of Health Care Financing, Utah Department of Health

Persons enrolled in HMOs in most cases have a wider scope of benefits, especially in the area of preventive care, than other Medicaid recipients. However, there has been some opposition to mandatory enrollment in HMOs because of concerns that some low income individuals will be unable to navigate a managed care system and will not get needed services.

Medicaid purchases mental health care for 95 percent of Medicaid recipients through pre-paid health plans. Those contracts have increased the number of Medicaid individuals who receive mental health services because a great deal of education was provided to inform recipients about this benefit, and mental health services were reorganized to provide easier access.

Use of Health Care

Utah women, 18 and over, are more likely to report their health as fair to poor (see page 11), make a physician visit (see figure below), have a usual place for medical care (see table at right), undergo surgery, and be hospitalized (see table on next page) than men.

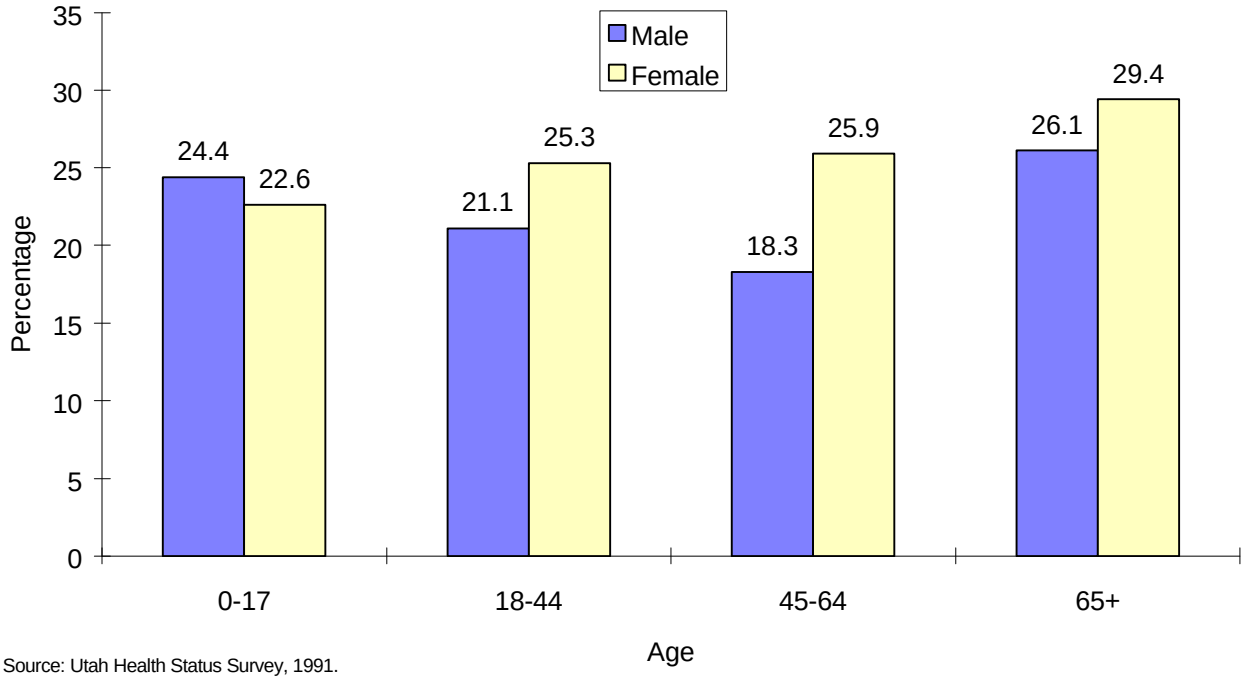
Women use the health care system more frequently than men, but some researchers argue that women receive less diagnostic or therapeutic procedures than men under comparable conditions.[2] In Utah, the overall hospital charges to female inpatients are higher than that to male inpatients (see table on next page). However, after excluding newborns and maternal-related conditions, the total charges and average charges to men are higher than those to women. The descriptive statistics reported here cannot explain the underlying reasons for these differences.

Proportion of Utahns reporting they have a usual place for medical care: Utah, 1993

Men:	76.0%
Women:	83.1%

Source: Utah Behavioral Risk Factor Surveillance System, 1993

Percentage of Utah Men and Women Utilizing Out-Patient Health Care During the Past Twelve Months by Age, 1991



Source: Utah Health Status Survey, 1991.

Number of Hospitalizations and Total Charges by Gender
Utah, 1994

	All	Excluding Newborns and Maternal Conditions	
Discharges		*Number of Discharges*	*Crude Rate per 10,000*
Male	77,515	58,685	618
Female	118,380	61,587	637
Total Charges			*Average Charge*
Male	$544,983,000	$505,297,000	$9,713
Female	$628,574,000	$494,432,000	$8,276

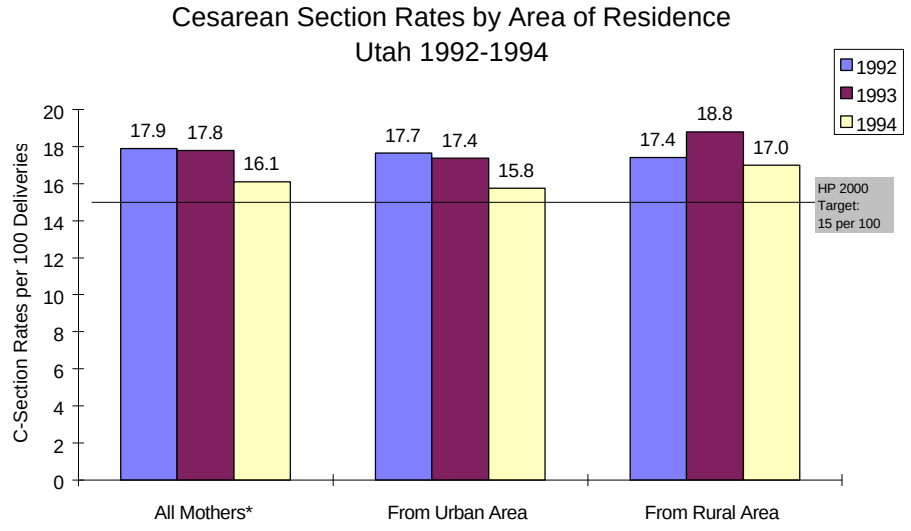
Note: Only Utah residents were included. Maternal-related hospitalizations were defined as Major Diagnostic Category 14. Newborns were discharges with a principle diagnosis of ICD-9 codes V30-V39.

Source: Utah Hospital Discharge Database, Office of Health Data Analysis, Utah Department of Health

Cesarean Section

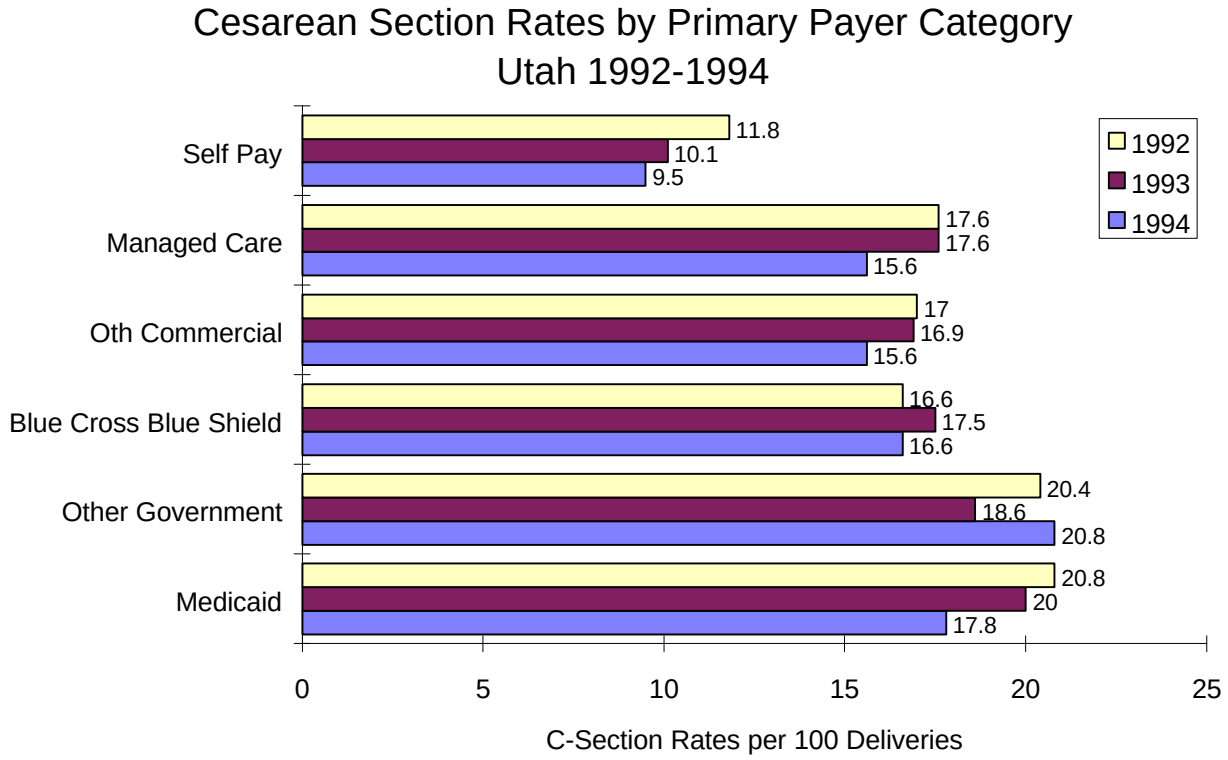
Over the past 25 years, cesarean section rates in the U.S. increased nearly five-fold from 5 percent of deliveries in 1968 to 24 percent in 1992.[3] Cesarean section is the most common procedure for hospitalized women both in the U.S and in Utah.

About 16 percent of deliveries in Utah are cesarean births. Cesarean rates in Utah have declined from 17.9 in 1992 to 16.1 in 1994 (see figure below). Although Utah's cesarean rate is lower than the national rate, the current rate is still higher than the Healthy People 2000 target (15% of all deliveries). Also, there are variations in rates among geographic areas and payer types. Women from rural areas had significantly higher cesarean rates than those from urban areas in both 1993 and 1994. There was a decline in cesarean rates among urban inpatients from 1992 to 1994; however, a similar decline was not observed for rural inpatients.



* Included those from other states
Source: Utah Hospital Discharge Database. Office of Health Data Analysis

Cesarean rates were significantly different across different types of payers (see figure below). Mothers with Medicaid and other types of public health insurance had the highest age-adjusted cesarean rates in 1992 (20.7 and 20.4 per 100 deliveries, respectively). In 1994, age-adjusted cesarean rate for Medicaid patients declined to 17.8 per 100 deliveries, which was still higher than the rates of other insurance carriers, except for other government payers. Self-paid hospital deliveries were significantly less likely to result in a cesarean section than all other deliveries over the three years. Besides Blue Cross/Blue Shield's fee-for service and non-Medicaid government insurance, a decline in cesarean rates has been observed among all other payer categories. Further research is necessary to examine the reasons for the variation in cesarean rates among payers.



Note: All rates were adjusted to the age composition of delivery mothers (age 10 to 54) in 1992 hospital discharge data.
Source: Utah Hospital Discharge Database, Office of Health Data Analysis

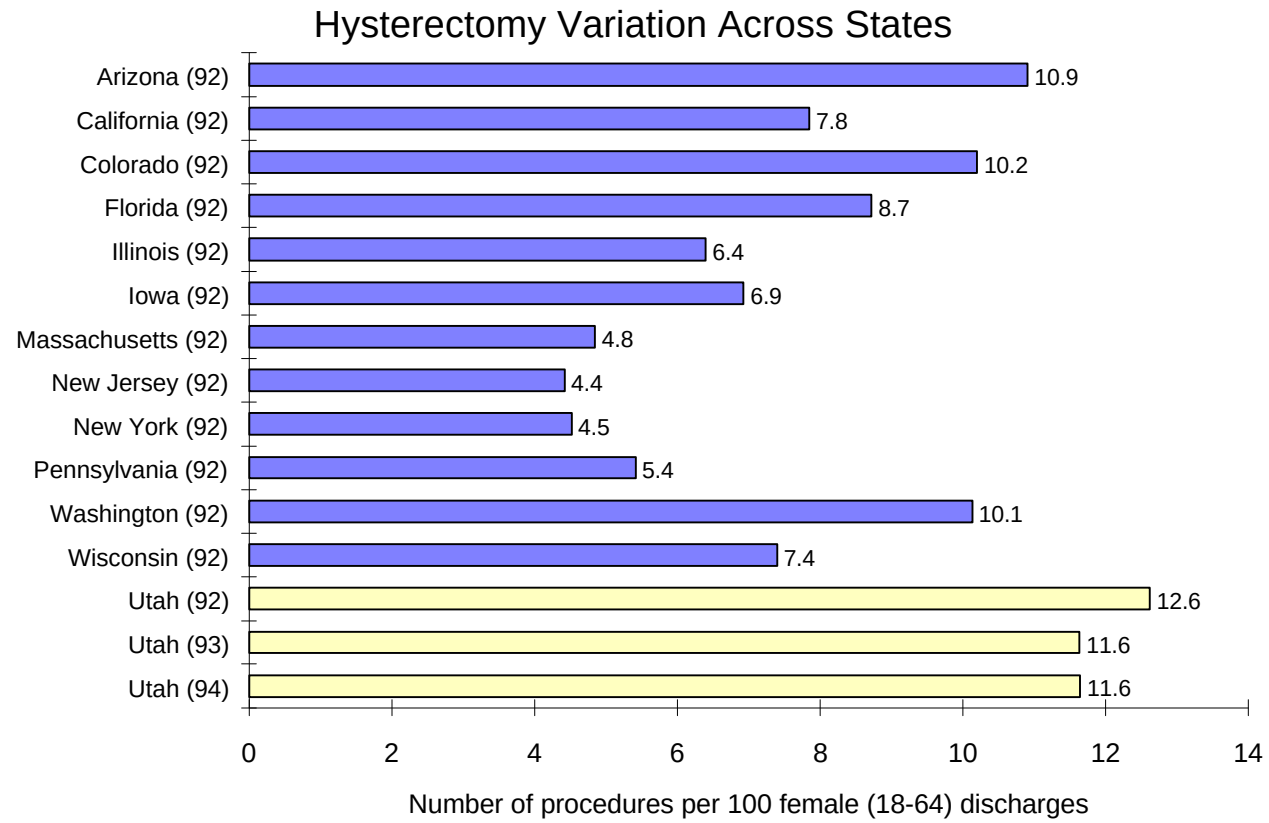
Hysterectomy

Hysterectomy (surgical removal of the uterus) is the second most frequently performed major operation in the United States, with about 590,000 procedures done each year. Annual costs exceed $5 billion. By age 60, more than one-third of women in the United States have had a hysterectomy.[4]

It is widely recognized that the rate of hysterectomy in the U. S. is too high and that some hysterectomies are performed for inappropriate reasons. In a follow-up study of women who had undergone hysterectomy, the surgery had provided significant relief of pelvic pain and an improved quality of life one year after surgery for some women. However, some women reported new problems, including hot flashes, weight gain, depression, anxiety, and lack of interest in sex.[5]

Although variation in hysterectomy rates does not by itself indicate inappropriate use, examining that variation may identify areas where hysterectomy rates can be reduced.[6]

The figure below shows that Utah has a higher hysterectomy rate than all other 12 HCUP-3 project[6] participating states. The denominator for the hysterectomy rate excluded elderly, deliveries, and anyone with a diagnosis of genital cancer or pelvic trauma. These exclusions remove from the study population women for whom hysterectomy is more likely to be appropriate treatment, leaving a group of women for whom high hysterectomy rates may be more suspect. The relatively high hysterectomy rate for Utah suggests the need for further research.



Source: AHCPR HCUP-3 Quality Indicators Project. Utah Hospital Discharge Database, Office of Health Data Analysis

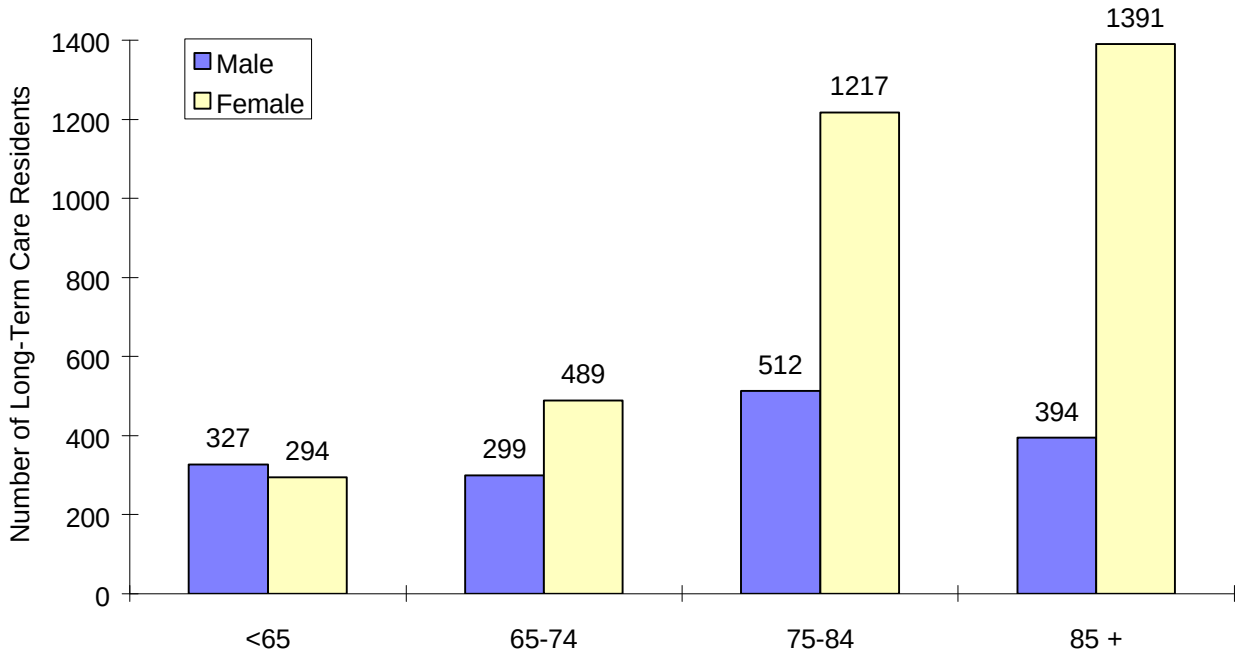
Long-term Care

By the year 2000, Utahns over 65 will number 190,000 and represent 8.8 of the population. The number of people potentially requiring long-term care is projected to continue increasing.[7]

Users of long-term care services include individuals of all ages who suffer from chronic illnesses and functional limitations. However, older people, especially women, are the primary users of long-term care services. Women live longer than men and are more likely to survive their spouses. In the United States, 45 percent of women who reach age 65 use nursing home care at least once before death, but only 28 percent of men use such facilities.[8]

In 1994, 12 percent of Utah nursing home residents were under age 65. The number of male residents in this age group was slightly higher than that of females. About 70 percent of all long-term care residents were women and 36 percent of the residents were aged 85 or older.

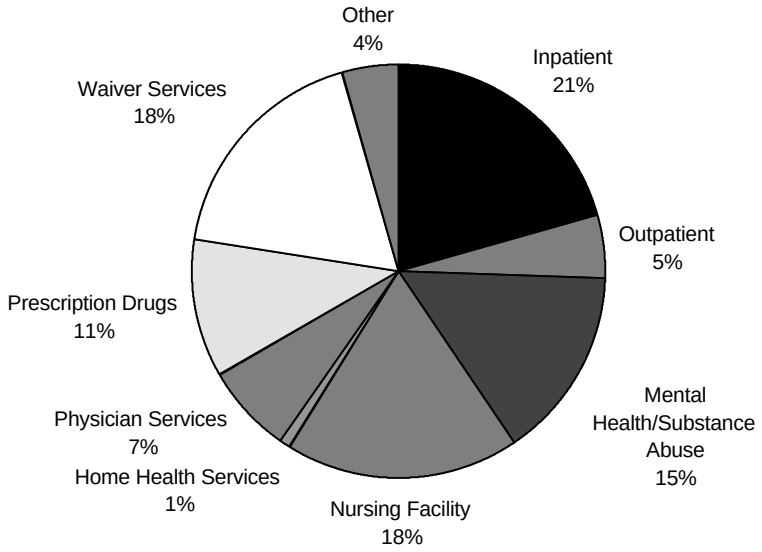
Number of Long-Term Care Residents by Sex and Age
Utah, 1994



Source: Utah Nursing Home Facility Annual Survey
Office of Health Data Analysis, Utah Department of Health

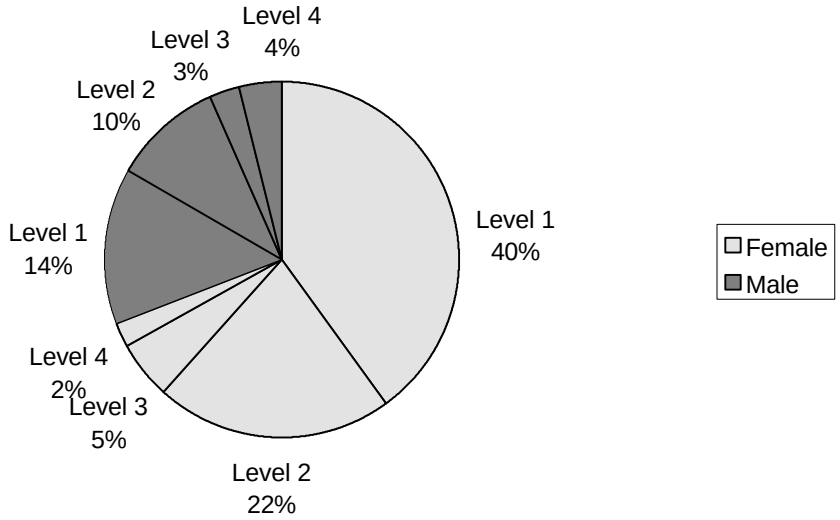
In 1991, $59.9 billion--close to 8 percent of all national health expenditures--was spent on nursing home care.[8] Medicare only pays for a total of 100 days of long-term care. Medicaid covers about 60 percent of the costs of long-term care utilization. Long-term care costs represented 18 percent (about $73,400,000) of Utah's Medicaid expenditures in FY96. During the same period, female Medicaid recipients used about $51 million for long-term care, and male recipients nearly $23 million.

Medicaid Expenditures by Type of Service Utah, FY96*



* fiscal year covers the period from July 1, 1995 to June 30, 1996
These expenditures only included the payment for services; expenditures on HMO premiums were not included.
Source: Division of Health Care Financing, Utah Department of Health

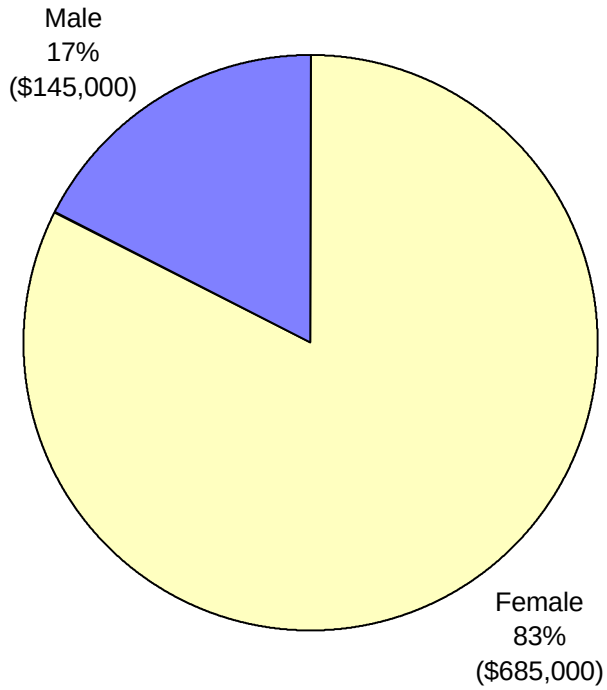
Medicaid Expenditures on Nursing Home Care by Gender and Level* of Care, Utah, FY96**



* level of care describes the intensity of care provided to the patient. Level of care is based on the severity of the illness, intensity of service needed, anticipated outcome, and setting for the service. Levels of care are ranked in order of intensity from the least intense (level 1) to the most intense, (level 4).
** fiscal year covers the period from July 1, 1995 to June 30, 1996
Note: Expenditures are in thousands.
Source: Division of Health Care Financing, Utah Department of Health

Home- and community-based health services have rapidly grown since the last decade.[9] Nationally, women were more likely than men to be under the care of a home health agency. Among persons 65 to 74 years of age, the rate of home health care utilization was 36 percent higher for women than for men, and this differential increased to 65 percent among those 85 years of age and over.[10] Medicaid paid a total of $829,000 on home health services under the Federal aging waiver for low income Utahns over age 65 in FY 1996. Of those expenditures, female clients received 83 percent of the funding.

Medicaid Expenditure for Home Health Services Under Federal Aging Waiver by Gender, FY 1996



Source: Utah Department of Health, Division of Health Care Financing

Women's Visible and Invisible Roles in Health Care

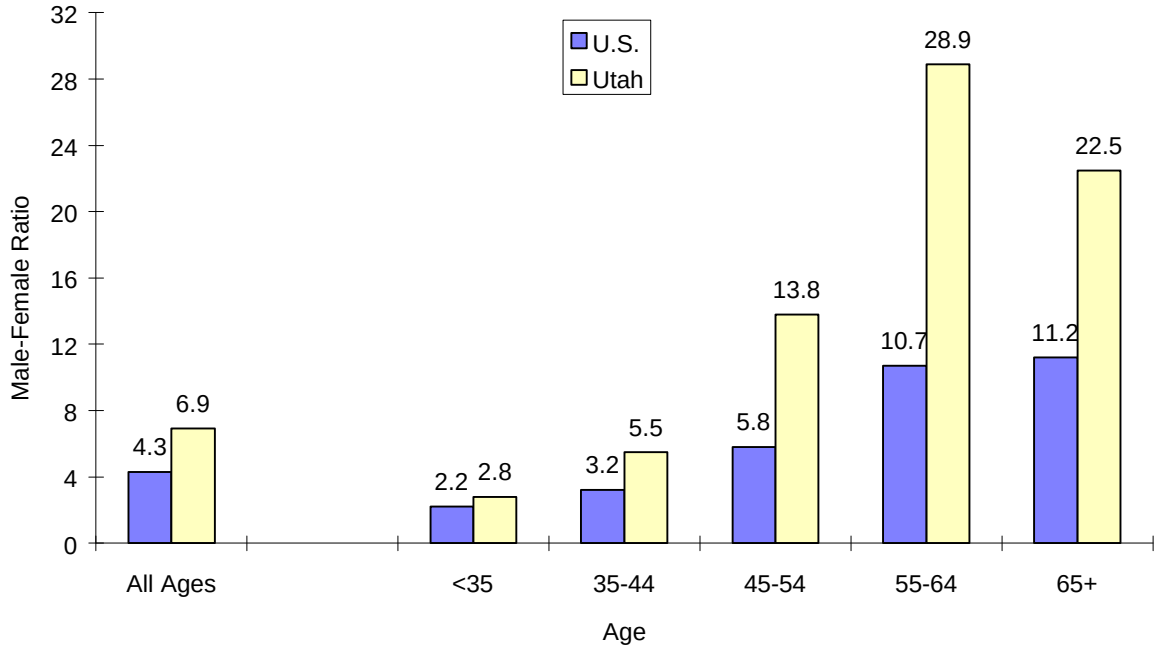
Women's contribution to health care services has not been well documented. Limited information on female health professionals presented below indicates some of women's visible roles in health care service. There is almost no local data available on women's roles in health care within families, although we know that role has always been substantial.

Health Care Professionals

For every female physician in Utah in 1993, there were 6.9 male physicians. The corresponding sex ratio for the U.S. was 4.3. The gap in the gender composition is smaller among younger physicians, and larger among physicians over age 55.

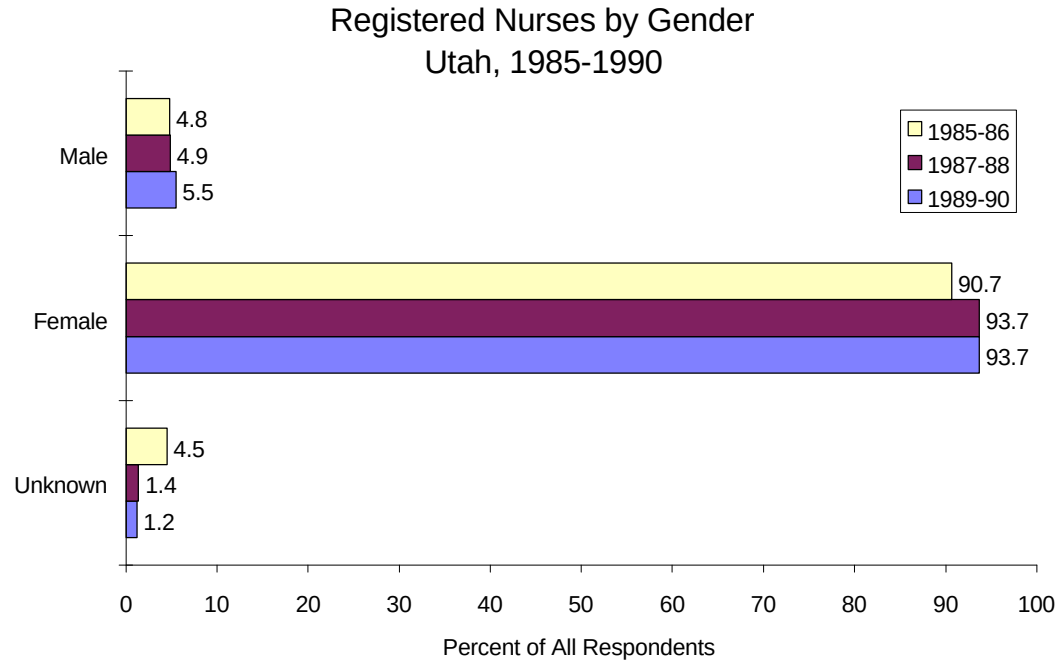
Women doctors made up 14.5 percent of all Utah doctors in 1993.[11] Of those women doctors, 57 percent practiced in office-based settings, 30 percent in hospitals, and 13 percent were involved in other professional activities.

Male-Female Ratio Among Physicians
U.S. and Utah, 1993



Source: American Medical Association: Physician Characteristics and Distribution in the U.S. 1994.

In contrast to the gender profile of physicians, nursing in Utah is mainly a female occupation. Women made up 90 to 94 percent of registered nurses from 1985 through 1990. According to the Utah Division of Occupational and Professional Licensing, Utah had over 6,000 licensed physicians or surgeons, and over 14,000 registered nurses in 1995. More recent information on the gender distributions of physicians and nurses are not available at this time.



Source: Utah Licensed Resgistered Nurses Report, 1990. Utah Department of Health

Women as Caregivers

Women are more likely to be caregivers for health of family members, especially nurturing younger children and caring for chronically ill elderly, than men. However, women's role in caregiving at home is usually invisible. According to a Canadian study, over 85 percent of care given to elderly Canadians is provided by family members, especially women at midlife.[12] It is also unknown how the caregiving role affects the health of women themselves.

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