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DIMENSIONS OF THE CONCEPT OF
ACCESS TO HEALTH CARE *

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IT is my function to report briefly on some meanings that can be ascribed to "access to health care" and to suggest how such understanding may serve our discussion.

In its simplest sense, access refers to entry or use of the health care system. Some will object to the use of service as part of the concept on the ground that, if one is in the system, there is no problem of access. But actual use is proof of the presence of access. For much of our conference discussion, this expanded definition may suffice.

Access to health care also can be said to be a political idea. And it is a technical idea for research workers who seek to measure progress toward access for certain population groups or erosion of access when programs are reduced.

As a political idea, access to health care has been, if not a slogan,

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certainly a broad political movement to assure care to the public generally and certainly to groups seen as underserved. This movement has received wide popular support in federal and state health legislation during the past 30 years. As a result, we have seen access become much more broadly based, even to the point of its incorporation in certain entitlement programs. As a political idea, access can be defined as all of the public policy, legal, social, and related considerations that surround the entry or use of personal health services by population groups.

Access, as a technical idea, has been the object of study by research workers who measure movement toward or away from a particular level of access to health care. More refined and complex definitions are required here. Several different technical definitions of access are in the literature and there seems to be no consensus. Penchansky and Thomas have proposed a multidimensional meaning of access that can serve our purpose rather well. I have simplified their definition. They see access as a broad or general concept that summarizes a set of specific dimensions or areas that influence the ability and desire of potential patients to use the health care system, i.e., the compatibility between characteristics of providers and health services on the one hand and characteristics and expectations of patients on the other.¹ They identify five independent dimensions or areas in their definition of access to health care. In the circular announcing this health conference, it was proposed that we draw upon three of these dimensions. This is not to imply that the other two are less important, but rather, they do not seem to have been placed at so serious a risk by the actions of Congress in 1981, and there is a practical limit to the number of dimensions I can discuss.

The three dimensions or aspects of access that I propose for our attention are affordability, acceptability, and availability. Each permits description of the compatibility or the fit between prospective patients and the health care system. As noted, each seems at great risk with the new federal legislation and the severity of the budget cuts proposed for 1983 and 1984.

Now, to place these dimensions in the form of questions: Is health care affordable? Is health care acceptable? Is health care available?

Only for one of the three questions is there a second element that should be made explicit. Here I refer to availability and the second element is the notion of overavailability or oversupply. As enlarged and restated, the question reads:

Is health care, in the sense of health facilities and personnel, available

to those who are in need? And — for some groups — is some health care overly available?

In a conference like this, where it is assumed that we shall focus on scarcity and loss of services, why do I introduce the notion that access to services for some are likely to continue to be overly available? And why does it matter? I am trying to say something stronger than the point that overly available services for some have the consequence of too few services for others, as if health resources and personnel were being preempted by one group against the claims of others. Nor do I mean alone that services may be overly available for the rich, which they probably are. I think too of the poor and not necessarily of the demands of the poor. In the first years of Medicaid we saw a very considerable rate of increase in surgery for the poor. And there has been a recent dramatic increase in the annual rate of surgery for those over 75. Possibly all of this surgery is necessary, but the wide development of second surgical opinion programs suggests that this is in question.

When we counterpose “too little available care for some against overly available care for others,” we are moving toward the realm of ethical questions. If as a nation we move to cut back and deny access to service for the more vulnerable groups, as we are now doing, do we feel any responsibility to distribute this burden and to redistribute scarce resources? These are moral questions and they invite moral judgments. These questions address what might seem to be a missing term from the conference title, the notion of equity. The title could have been written “Struggle for the Assurance of Equity of Access to Health Care.” Actually, equity was not cited in the title because of the very high rate of increases in annual health expenditures in the public sector and acknowledgment that some of the things that have to be done are not alone a matter of distributive justice. But let us insert equity here in order to talk about it.

Equity implies that like cases should be treated alike. By extension to health, it can mean such things as that similar cases of illness roughly should be treated alike, and anyone in medical need should not be denied access to necessary care for such reason as inability to pay.

Until the mid-1970s, equity of access to care was a central health policy issue but it has now been displaced to one side by our preoccupation with cost containment. Equity must be brought to the fore again because it may temper both the extent and the forms of cost containment strategies that we are pursuing and may even stimulate us to the use of more imaginative solutions.

Vladeck urges that we distinguish between two kinds of cost containment. One involves simply a reduction in outlays by source of payment, one generally achieved by a cut-back in services. This is the method predominantly invoked in the present federal solution. But this kind of cost containment may only transfer or increase expenditures to other parties and, moreover, this approach is often accompanied by an increase in unit cost. The second and preferable form of cost-containment, one that Vladeck calls "true cost-containment," aims at reducing the (annual) rate of increase used to produce a given volume of service, an approach that must be placed on the doorstep of hospitals, physicians, health professionals, and politicians. This implies the pursuit of greater efficiency and efficacy within the professions, and it also requires political decisions of the most difficult kind since it could lead to even more direct controls over providers.²

Conceivably, through greater effort at what Vladeck calls "true" cost containment, the nation may be able to ameliorate some of the impact of budget cutting on the access of traditionally underserved groups to medical care.

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