Access, Primary Care, and the Medical Home

Rights of Passage

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Health Services Research, by now a mature field, has never developed precise terminology for most of the characteristics of health systems and services. Like Alice, its practitioners use terms to mean what they want them to mean, no more, no less.

So it is with access. Everyone knows that, above all, people need “access” to health services to benefit from whatever health services have to offer. But what does “access” mean? Access, according to proper usage, is a noun meaning “a means of approaching or nearing a passage.” People have access. “Accessible” is an adjective, meaning easily approached or entered; services can be said to be accessible if they have characteristics that make it possible for people to get to them. That is, places have varying degrees of accessibility, but people have varying degrees of access. So far, so good. What about “realized access,” which is usually assumed to be synonymous with “utilization?” As characteristics other than access influence use, it confuses things to equate access with utilization.

The paper by Jennifer DeVoe et al entitled, “A Usual Source of Care: Supplement or Substitute for Health Insurance Among Low-Income Children,” deals with “access,” but not only access. It builds on previous evidence in showing the importance of both health insurance (a measure of financial “access”) and a source of primary care (which may vary in its accessibility) as policy strategies. Their paper attempts to tease out the relative advantages of each. The data indicate that, compared with children having both insurance and a regular source of care, insured children without a usual source of care had higher rates of unmet medical needs, no doctor visits in 12 months, and problems obtaining specialty care. On the other hand, having no health insurance but having a regular source of care predicted a higher likelihood of being unable to get timely urgent care, needed counseling, prescriptions, and having more problems obtaining dental treatment.

Not all of the variables used to assess the impact of insurance and usual source of care are “access” variables. “Problem getting specialty care” would be expected to have more to do with having a usual source of care (and even MORE to do with the characteristics of that usual source) because of the need for referral in many health systems and specialty facilities. Similarly, “problem getting counseling” has more to do with the nature of the usual source of care than with “access.” “Meeting needs” is certainly a characteristic of the quality of care received, undoubtedly at least as much as it is an “access” phenomenon. Dental services would not be expected to be related to usual source of care, as most “usual sources” do not provide it; it would be expected to be related to ability to pay (insurance).

Understanding the dynamics of these processes requires thinking about pathways. It has been almost 50 years since Avedis Donabedian suggested that it would be helpful to characterize phenomena in health services as structure, process, or outcome, and to examine the impact of structure on process and both on outcomes. It has been 35 years since the New England Journal of Medicine published a special article on the specific components of structure, process, and outcome, which showed how greater understanding...
of the impact of health services on health could be achieved by exploring pathways from one to the other.\(^5\) Despite the elapsing decades and opportunity to move from mere description to exploration of mechanisms, health services research has not yet established the principle that understanding of mechanisms is imperative to devise strategies for needed changes.

In the study reported by DeVoe et al, the true “access” variable is the health insurance variable, because the passage to reaching services requires a means to pay for it.\(^1\) The usual source of care variable, however, has more to do with the quality of care provided: needed referrals, needed counseling, referral to dental care, and arranging for medications in the absence of a means to pay for them. Sorting out these 2 different pathways provides understanding of the dynamics of receipt of care which, after all, is more important in meeting needs than is access. Although both insurance and usual source of care are necessary, it is important to recognize that they provide different types of benefits; insurance facilitates having a usual source of care, but it is the usual source that can facilitate providing the services that are most needed, even when full insurance is lacking. Clear thinking about likely pathways of effect will greatly facilitate the design of research that is most useful in directing health system change.

Another lesson that health services research could have learned from at least 15 years of descriptive studies is the importance of considering the nature of the usual source of care. Few data sets concerning use of services distinguish receipt of primary care from receipt of specialty care, despite knowledge that a usual source of care that provides good primary care achieves better outcomes at lower costs than a usual source of care that is an outpatient specialist or a hospital clinic.\(^6,7\) It should be no longer acceptable to collect data on usual source of care without specifying the nature of that source - a critical contextual characteristic.\(^8\)

The experience of health system debates in the political arena suggests that health services research has not adequately done the job it needs to do to guide policy makers. Most of the political debate on health care reform focuses on the relatively unimportant procedural issue of whether insurance should be ‘mandatory.’ Other industrialized countries have solved the problem of universality a long time ago, thus releasing their energy to deal with challenges to health services organization and delivery. It is high time that US health services researchers broaden their efforts to address current issues of who should provide what and to what level of performance. Thirty years of Dartmouth studies showing great overuse of specialty services have not resulted in questioning the increasing specialty orientation of the health services system or devoting attention to the quality of specialty care. Where have health services researchers been in thinking about the relative importance (to health) of primary care and specialty care? Primary care is far more comprehensive in other comparable countries than it is in the United States, and many of these countries are considering further ways to devolve much of care from the specialty care to the primary care sector, all the while improving rather than reducing the quality of care.

Even the proposed ‘patient-focused medical home’ fails to consider what primary care should be in terms of WHAT it should provide, focusing instead on HOW it should be provided, particularly by the structural elements of teams and electronic health records. It is time to think about precision of HEALTH goals, and on concepts and mechanisms of effect of the various health system characteristics that provide options for reform - insurance being only one of several key considerations. Pathways research is even more important now than ever before.

REFERENCES