

Access to Health

by Natalie Huls

Introduction

The Right to the Highest Attainable Standard of Health International Covenant on Economic, Social, and Cultural Rights:

12. (b) Accessibility. Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality ((1996) General Comment No. 14, 2000).

Access to health is an often-overlooked aspect of the right to health. Without practical access, the right to health becomes an empty promise. International human rights conventions and declarations do not directly mention access to health, but the above comment on the International Covenant on Economic, Social, and Cultural Rights does address the issue.

Yet besides this Comment, most international human rights law tends to overlook access to health because the right to health indirectly addresses how that right is to be fulfilled. The right to health states that everyone should have access to health, but does not address the specific issues of access, guarantees to access, and does not explain what access entails.

Access to health means that all people, regardless of differences in race, sex, language, religion, or social origin should have physical access to health facilities, goods, and services. However, in practice access to health is not universally applied: all of the above are frequent barriers to securing adequate redress of health problems. An examination of the barriers is useful to understand the issue of access and to determine how to improve access. The works below give a variety of perspectives on these obstacles manifest, and make recommendations for improving access.

Age-based Barriers

Auchincloss, Amy H.; Joan F. Van Nostrand; and Donna Ronsaville. 2001. "Access to Health Care for Older Persons in the United States: Personal, Structural, and Neighborhood Characteristics." *Journal of Aging and Health* 13(3): 329-355.

Abstract: Objective: To determine the contributions of personal, structural, and neighborhood characteristics to differential access to health care for older persons in the United States... Results: The likelihood of access problems increased sharply with decreasing gradients of family income and for those lacking private health care insurance. Rural areas and poor areas were at a disadvantage in accessing care, whereas residents of neighborhoods that were homogeneous in ancestral heritage appeared better able to access care. Discussion: Considering the high association between neighborhood and personal characteristics, it is notable that any neighborhood effects remained after combining them with personal effects.

Deutchman, Mark; Robert Brayden; Carol D. Siegel; Brenda Beaty; and Lori Crane. 2000. "Childhood Immunization in Rural Family and General Practices: Current Practices, Perceived Barriers and Strategies for Improvement." *Ambulatory Child Health* 6(3): 181-190.

Abstract: The article presents a study to assess current immunization practices, perceived barriers to childhood immunization, and identify strategies that might improve immunization rates. It concludes that family physicians and general practitioners are well positioned to have a positive impact on childhood immunization rates, as they provide the majority of care to rural children, and that adherence to standards for immunization practice should help improve immunization rates.

Dyer, Janyce G. 2003. "The Black Cloud Over the Sunshine State: Health Disparities in South Florida." *Journal of Cultural Diversity* 10(2): 50-56.

Abstract: Florida, the "Sunshine State", is paradise for international tourists and has been adopted as seasonal or permanent home by many wealthy individuals and celebrities. However, Florida is not paradise for the growing number of residents who suffer from poverty, health problems, and a lack of access to health care and social services. The purpose of this paper is to present data on health care problems and disparities throughout the state, of Florida and in select south Florida counties.

Edmunds, Margaret and Molly Joel Coye (eds.). 1998. America's Children: Health Insurance and Access to Care. Washington: National Academy Press.

Working from a unified set of beliefs about health insurance, the committee examined the relationship between health insurance coverage and children's access to health care. They determined that insurance coverage is the major determinant of whether children have access to health care. Key chapters focus on the importance of access, on particular barriers to access, and on various public and private insurance initiatives.

Gleeson, Catherine R.; Michael B. Robinson; and Richard D. Neal. 2002. "A Review of Teenagers' Perceived Needs and Access to Primary Health Care: Implications for Health Services." *Primary Health Care Research and Development* 3(3): 184-194.

Abstract: The government has stated its commitment to provide equality of access to health care for all and has emphasized the need to take account of users' views. The aim of this review was to search for evidence of adolescents' perceived needs for and access to primary health care services and to evaluate and report on the evidence found. The main finding was that a substantial minority of teenagers has health-related problems which are not met by current services. The main barriers to accessing primary health care were a perceived lack of confidentiality, embarrassment and unsympathetic staff.

Howe, E.G. and C.J. Lettieri. 1999. "Health Care Rationing in the Aged: Ethical and Clinical Perspectives." *Drugs and Aging* 15(1): 37-48.

Abstract: This article provides an ethical analysis of the question of whether aged patients' access to health care should be less than, the same or greater than, the access younger patients enjoy, when economic resources are limited. This topic is being urgently considered in the U.S. because managed care is becoming more common and brings with it new challenges to traditional medical ethics, and because the prevalence of the aged is increasing as is the number of patients with Alzheimer's disease (AD).

Newachek, P. W.; M. Hochstein; K.S. Marchi; and N. Halfon. 2002. "Access to Health Care for Young Children in the United States," in N. Halfon, K. T. McLearn and M. A. Schuster (eds.), Child Rearing in America: Challenges Facing Parents of Young Children. New York: Cambridge University Press.

Abstract: This commentary addresses the question of how we might improve access to care for children and pregnant women. Although a number of factors influence access to health services for women and children, the focus of this commentary is on financial barriers to care.

Randolph, Greg D.; Mark Murray; Jilla A. Swanson; and Peter A. Margolis. 2004. "Behind Schedule: Improving Access to Care for Children One Practice at a Time." *Pediatrics* 113(3): 230-238.

Abstract: Access to health care, the timely use of personal health services to achieve the best possible health outcomes, remains a fundamental problem for children in the United States. To date, research and interventions addressing children's access to care have largely focused on policy-level features of the health care system (such as health insurance and geographic availability of providers) with some, although limited, success. Ultimately, access to health care implies entry into the health care system. Practice scheduling systems are the point of entry to primary care health services for children and thus directly determine access to care in pediatric and family medicine practices. Here we explore the rationale for improving access to care for children from an additional angle: through improving practice scheduling systems. It is our hypothesis that some of the most promising contemporary interventions to improve children's access involve improving primary care scheduling systems. These approaches should complement successful policy-level interventions to improve access to care for children.

Sin, Don D.; Larry W. Svenson; Robert L. Cowie; and S.F. Paul Man. 2003. "Can Universal Access to Health Care Eliminate Health Inequalities Between Children of Poor and Nonpoor Families?" *CHEST* 124(1): 51-57.

Abstract: Study objectives: Children from poor families are much more likely to have emergency visits for asthma than those from nonpoor families, which may be related to financial access barriers to good preventive care for the poor. We sought to determine whether in a health-care system that provides free access to outpatient and hospital services, the disparities in the rates of emergency visits for asthma would be less apparent across the income gradient. ...Conclusions: In a setting of universal access to health care, children of poor and nonpoor families had

similar rates of asthma emergency visits; the very poor children, however, continued to experience an excess risk. These findings suggest that a universal health-care system can reduce, but not fully eliminate, the disparities in emergency utilization of asthma across income categories.

Sochalski, Julie and Antonia M. Villaruel. 1999. "Improving Access to Health." *Journal of the Society of Pediatric Nurses* 4(4): 147-154.

Abstract: Issues and Purpose: The number of uninsured children has been growing at an alarming rate. The most vulnerable children are those in lower-income families who are falling through the cracks between evolving government-sponsored health insurance programs. Recent policy initiatives may not be adequate to extend coverage to more children. Conclusions: Many low-income children actually are eligible for Medicaid but are not enrolled for a variety of reasons. The numbers of these children have risen due to welfare reform. Better outreach efforts are needed to ensure that new child health insurance programs and Medicaid expansions achieve their goals. Implications for Practice: A comprehensive assessment of insurance status and referral to community agencies should be an integral part of patient care for all healthcare providers.

Weathers, Andrea; Cynthia Minkovitz; Patricia O'Campo; and Marie Diener-West. 2003. "Health Services Use by Children of Migratory Agricultural Workers: Exploring the Role of Need for Care." *Pediatrics* 111(5): 956-964.

Abstract: Objective: For migrant children: 1) to assess the determinants of health services use among users and nonusers of health services; 2) to evaluate the association between health status and health services use, while controlling for potential confounders ... Conclusions: Migrant children using health services are distinct from nonusers with regards to sociodemographic factors, enabling resources, and need for care. Health services use is associated with less than very good perceived health, despite resource barriers and sociodemographic disadvantages. More efforts are needed to improve access to health care for migrant children.

White, Patience H. 2002. "Access to Health Care: Health Insurance Considerations for Young Adults with Special Health Care Needs/Disabilities." *Pediatrics* 110(6): 1328-1336.

Abstract: Youth with special health care needs/disabilities want what all youth in America want: independence, health, friends, and jobs. Yet, between 19 and 23 years of age (depending on the state), youth with special health care needs/disabilities often find little availability of health insurance or health providers that were an essential part of why they survived and now are looking to participate in adult society. This article reviews the complex system of health insurance options that young adults with special health care needs/disabilities face as they move from pediatric to adult health insurance systems. Yet because of a maze of different eligibility criteria, many of these options are not available to young adults with special health care needs, and they are left with out health insurance. Similarly, the issues surrounding health provider reimbursement often leave the young adult with special health care needs without health care professionals who can manage their complex health conditions as they transition into adulthood. In conclusion, this article outlines what steps could be taken by associations and the health policy, advocacy, and governmental communities to improve the situation.

Economic Barriers

Ayé, Marcellin; Francois Champagne; and André-Pierre Contandriopoulos. 2002. "Economic Role of Solidarity and Social Capital in Accessing Modern Health Care Services in the Ivory Coast." *Social Science and Medicine* 55(11): 1929-1947.

Abstract: In the Ivory Coast, the imposition of user fees for public services was adopted in 1994. Such fees require each person to have adequate financial resources in order to access modern health care services. Many poor people—despite their poverty—are able to access modern health care services that have become quite expensive. The factor that allows this access lies within the solidarity of parents, friends or members of a social network. The treatment of a sick person is an act, which is tied to the systems of life, which are produced and maintained collectively. It is the entire family or group that participates in the finances which bring about treatment. In this study, we show the role of social capital in the processes of financial solidarity for access to modern health care services that now require payment. Our investigation provides valuable insights on the role of social capital with respect to social strategies and community financing mechanisms for the acquisition of modern health care in Africa.

Despard, Caroline. 1998. "The Poor are Different From You and Me." *CMAJ: Canadian Medical Association Journal* 159(4): 392-395.

The article presents the author's experience providing medical care to the working poor, refugees, and immigrants in Ontario. It details the ways access to appropriate care can be thwarted. Key examples include patients unable to follow prescribed treatment, language and illiteracy challenges, the importance of teaching preventive care, and patients without health insurance cards facing the possibility that care will be denied.

Dubay, Lisa and Genevieve M. Kenney. 2001. "Health Care Access and Use Among Low-Income Children: Who Fares Best?" *Health Affairs* 20(1): 112-122.

"Fact Sheet Examines Effects of Being Uninsured on Access to Health Care." 2004. *American Family Physician* 69(5):1032.

Describes a study that found that being uninsured has a strong impact on not having access to health care.

Luo, Ye; and Ming Wen. 2002. "Can We Afford Better Health? A Study of the Health Differentials in China." *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine* 6(4): 471-501.

Abstract: Using survey data collected in eight provinces of China, this study examines the relationship between income disparities and adult physical health outcomes. It also explores the mechanisms underlying these income differentials in health. Our results show that the association between income and health can be explained largely by income differences in other areas. In the Chinese social context, we find that living conditions, access to health care services and community development are important mediating factors. These findings generally agree with earlier explanations on socioeconomic differentials in health. We also find that the factors that are most important in explaining income differentials in health vary by rural/urban residence. However, the results show that these factors are unable to fully explain income differentials in reported illness and disability. Moreover, we do not find consistent effects of lifestyle and health-related behaviors, such as drinking and smoking, on the link between income and health.

Stiehm, Walter L. 2001. "Poverty Law: Access to Healthcare and Barriers to the Poor." *Quinnipiac Health Law Journal* 4: 279-310.

This article provides a short history of American access to healthcare, followed by a brief overview identifying and describing the uninsured. Also discussed is the adequacy of coverage and the impact of being inadequately insured or uninsured has on the poor, as well as on the healthcare delivery system itself. This discussion includes a basic description of the economic and non-economic barriers faced by the poor in obtaining healthcare services.

Ethnic Barriers

Adamson, Joy; Yoav Ben-Schlomo; Nish Charturvedi; and Jenny Donovan. 2003. "Ethnicity, Socio-economic Position and Gender—Do They Affect Reported Health-Care Seeking Behaviour?" *Social Science and Medicine* 57(5): 895-905.

Abstract: While the pursuit of equity of access to health care is a central objective of many health care systems, there is evidence that patients of ethnic minority descent, in lower socio-economic position (SEP) or of female gender are less likely than Whites, more affluent groups or men, respectively, to access secondary and tertiary medical care. This study examined the influence of ethnicity, socio-economic position and gender on an individual's perception of the need and urgency for seeking health care. The study suggests inequalities in access to health care by ethnicity, socio-economic position and gender are not related to patients in these groups failing to self-refer to primary or accident and emergency care, barriers must therefore occur at the level of health care provision.

Allotey, Pascale. 2003. "Guest Editorial: Is Health a Fundamental Right for Migrants?" *Development* 46(3): 6-10.

Allotey discusses the right of migrants to health care. Access to health care is a particularly difficult issue because many governments view access as a privilege rather than a right, thus denying many migrants access to health care.

Andrulis, Dennis P. 2003. "Reducing Racial and Ethnic Disparities in Disease Management to Improve Health Outcomes." *Disease Management and Health Outcomes* 11(12): 789-801.

Abstract: The heightened awareness of substantial racial and ethnic disparities in health outcomes has major implications for how healthcare providers effectively manage health conditions among diverse populations. This report identifies five dimensions that address the major causes of disparities that can exert significant influence over the success and quality of the patient-physician relationship, treatment plans, and health outcomes. These five dimensions are (i) biological and genetic influences; (ii) differential access to care; (iii) quality of care disparities; (iv) clinical-patient perceptions and realities; and (v) language and communication barriers.

Bruce Newbold, K.; and Jeff Danforth. 2003. "Health Status and Canada's Immigrant Population." *Social Science and Medicine* 57(10): 1981-1996.

Abstract: ...Assuming equality of health status between immigrants and non-immigrants, or between immigrant groups is likely an unrealistic and simplistic assumption, given unseen barriers affecting accessibility, the restructuring of the Canadian health care system, and problems with the provision of health care resources to the immigrant population. Using the National Population Health Survey, this paper focuses upon the health status of the immigrant population relative to that of non-immigrants within Canada, with reference to diagnosed

conditions, self-assessed health, and the Health Utilities Index Mark 3. Findings indicate that, with the exception of the most recent arrivals, immigrants experience worse health status across most dimensions relative to non-immigrants. Multivariate analysis reveals that age, income adequacy, gender, and home ownership are dimensions upon which health status differs between the two groups.

Burris, Scott. 2003. "Foreword: Envisioning Health Disparities." *American Journal of Law and Medicine* 29(2/3): 151-158.

The article examines the relationship between disparities in healthcare and racism. It argues that the best way to tackle health disparities is to consider how law can be a cause of disparities, but also how it can be used to reduce disparities.

Caesar, Lena G.; and David R. Williams. 2002. "Socioculture and the Delivery of Health Care." *ASHA Leader* 7(6): 6-9.

Caesar and Williams discuss the delivery of health care in the multicultural population in the U.S. It describes the effect of racial and ethnic differences on access to health care, and states the result of analysis of race-related differences in health status.

Dancy Jr., Joseph; and Penny A. Ralston. 2002. "Health Promotion and Black Elders: Subgroups of Greatest Need." *Research on Aging* 24(2): 218-243.

Abstract: This article profiles three subgroups of African American elders that are at risk in terms of health. Major barriers to optimum health for older rural Blacks are a lack of confidence in the formal health care system, greater rates of poverty than urban elders, geographic isolation, and lack of access to health care and to social supports; for older Black women, barriers include attitudes that reflect an overestimation of health, health pessimism, a lack of confidence in the health care system, lower economic resources, and major family responsibilities that affect the availability of money for, and time to seek, health care; and for older-aged Blacks, barriers are lack of confidence in the formal health care system, dependence on informal supports for health care and an under utilization of formal supports, and lower socioeconomic levels due to this cohort's education and occupational status. Implications for theory, policy, and practice are discussed.

Finke, Bruce; Theresa Bowannie; and Judith Kitzes. 2004. "Palliative Care in the Pueblo of Zuni." *Journal of Palliative Medicine* 7(1): 135-144.

Abstract: ...There are limited formal palliative care services available to rural and reservation dwelling American Indians and Alaska Natives. This collaboration between a tribally operated home health care agency and a federally operated Indian Health Service hospital, with the support of a palliative care center within an academic medical center, has established a palliative care program in the Pueblo of Zuni. ...Barriers to development included the rural setting with limited professional workforce, competing demands in a small agency, the need for coordination across distinct organizations, and the need to address the dying process in a culturally proficient manner. ...The experience of this collaboration suggests that a tribally based, culturally proficient palliative care program can be developed within an American Indian/Alaska Native community and that it can drive the local health system toward improved end-of-life care.

Freeman, H.P. and R. Payne. 2000. "Racial Injustice in Health Care." *New England Journal of Medicine* 342(14): 1045-1047.

Granados, Gilberto; Jyoti Puwula; Nancy Berman; and Patrick T. Dowling. 2001. "Health Care for Latino Children: Impact of Child and Parental Birthplace on Insurance Status and Access to Health Service." *American Journal of Public Health* 91(11): 1806-1808.

Abstract: This study sought to assess the impact of child and parental birthplace on insurance status and access to health care among Latino children in the United States. The study found that Latino children of immigrant parents are more likely to lack insurance and access to routine health care than are Latino children of US-born parents. Previous studies have shown that despite higher levels of potential eligibility, noncitizen families are less likely to have health insurance. In this study, we attempted to measure the impact of parental and child birthplace on insurance status and access to care among Latino children.

Hagan, Jacqueline; Nestor Rodriguez; Randy Capps; and Nika Kabiri. 2003. "The Effects of Recent Welfare and Immigration Reforms on Immigrants' Access to Health Care." *International Migration Review* 37(2): 444-464.

Abstract: This study investigates the impact of the Personal Responsibility and Work Opportunity Reconciliation Act and the Illegal Immigration Reform and Immigrant Responsibility Act, both passed in 1996, on the use of health-care services in immigrant communities in five Texas counties. The study presents findings of interviews with public agency officials, directors of community-based organizations, and members of 500 households during two research phases, 1997-1998 and 1998-1999. In the household sample, 20 percent of U.S. citizens and 30 percent of legal permanent residents who reported having received Medicaid during the five years before they were interviewed also reported losing the coverage during the past year. Some lost coverage because of welfare reform restrictions on noncitizen eligibility or because of changes in income or household size, but many eligible immigrants also withdrew from Medicaid "voluntarily."

"It's Better if You're White." 1999. *Economist* 350(8108): 28-30.

This article focuses on the economic and racial inequalities of health care in the United States, concluding that both poverty and minority status leads to decreased access to health care. Doctor bias, language barriers, and differences in cultural practices also are found to have adverse effects on access.

Ku, Leighton and Sheetal Matani. 2001. "Left Out: Immigrants' Access to Health Care and Insurance." *Health Affairs* 20(1): 247-257.

Leighton and Matani contemplate the limitation of access to health care and insurance for immigrant adults and children in the United States. Claiming that Latinos are the highest uninsured racial group, the paper assesses health care barriers for immigrants, and evaluates immigrant access to ambulatory medical and emergency room care.

Kung, Winnie W. 2004. "Cultural and Practical Barriers to Seeking Mental Health Treatment for Chinese Americans." *Journal of Community Psychology* 32(1): 27-44.

Abstract: Based on a sample of 1747 from the Chinese American Psychiatric Epidemiological Study, this report examined perceived barriers to mental health treatment. Two factors emerged, namely practical barriers, which included cost of treatment, time, knowledge of access, and language, and cultural barriers consisting of credibility of treatment, recognition of need, and fear of loss of face. Average ratings of all practical barrier items were higher than cultural barrier items, demonstrating the importance of pragmatic considerations for this population. In a novel attempt, this study examined the empirical link between these perceived barriers and actual mental health

service use. The practical barrier factor showed significance in predicting service use for both the whole sample and a subsample of individuals with at least one lifetime mental disorder. Cultural barriers, however, did not attain significance. Practice and research implications of the findings are discussed.

Lado, Marianne Engelmann. 2001. "Unfinished Agenda: The Need for Civil Rights Litigation to Address Race Discrimination and Inequalities in Health Care Delivery." *Texas Journal on Civil Liberties and Civil Rights* 6(1): 1-46.

The article argues that civil rights litigation could play a vital role in battling continuing patterns of discrimination in the provision of health care and the lack of access to care experience by many low-income African Americans. Moreover, the current transformation of health care financing and delivery systems presents unique opportunities for intervention and legal challenge now, before historical practices replicate themselves and become entrenched in the new health care industry.

Majette, Gwendolyn Roberts. 2003. "Access to Health Care: What a Difference Shades of Color Make." *Loyola University Chicago Institute for Health Law Annals of Health Law* 12: 121.

This comparative analysis outlines some of the major issues that affect access to health care for various minority communities, focusing on barriers to access for four distinct racial/ethnic groups: African Americans, Asian Americans, Hispanic Americans, and Native Americans. It is claimed that race, ethnicity, and sex affect whether one receives health care, as well as the quality of health care received. The only difference among the various ethnic groups is how the adverse effects manifest themselves.

Manos, Michele M.; Wendy A. Leyden; Cynthia I. Resendez; Elizabeth G. Klein; Tom L. Wilson; and Heidi M. Bauer. 2001. "A Community-Based Collaboration to Assess and Improve Medical Insurance Status and Access to Health Care of Latino Children." *Public Health Report* 116(6): 575-585.

This study sought to understand and improve access to medical insurance for Latino children living in a California community of predominantly low-income immigrant families. The article also explores options offered in California for medically insuring children not covered through parents' employment; examines a collaborative partnership between the Kaiser Permanente Division of Research and the Canal Community Alliance in conducting the research; and looks at classification of families in terms of eligibility and enrollment.

Noah, Barbara A. 1998. "Racial Disparities in the Delivery of Health Care." *San Diego Law Review* 35: 135.

First by surveying several examples of disparities in access to health, and then by connecting these examples with the existing legal literature concerning the range of possible remedies for discrimination, this article attempts to frame the debate about racial justice in the delivery of health care services. It concludes that such approaches as education and regulatory responses for patterns of disparate care provide the most promising avenues for addressing the problem of racial disparities in health care.

"Overcoming Cultural Barriers." 2003. *H&HN: Hospitals and Health Networks* 77(7): 68.

Focusing on the efforts of the Glendale Adventist Medical Center to provide Armenian-Americans with information and access to the health care system in California, this article highlights the launch of a TV program by Hearts N' Health entitled Healthy Families that educates that population on how to improve their health and access to health.

“Racial and Ethnic Disparities in Immunizations Outlined.” 2003. *Biotech Week*: 138-140.

Abstract: Researchers have published recommendations for clinicians on the racial and ethnic disparities in immunizations in a recent issue of the journal “Family Medicine.” According to the research there continue to be significant racial and ethnic disparities in rates of childhood and adult immunizations in the United States. Causes are multifactorial, including inequities in education, income, and socioeconomic status, structural and systemic barriers in the health care delivery system and beliefs, preferences and practice patterns of the recipients and providers of care.

Reede, Joan Y. 2003. “A Recurring Theme: The Need for Minority Physicians.” *Health Affairs* 22(4): 91-94.

Abstract: There is compelling evidence for the need to increase diversity within the physician workforce to ensure high-quality medical education, access to health care for the underserved, advances in research, and improved business performance. To have enough physicians to meet the future needs of the general public, as well as of minority citizens, we must recruit from diverse populations. The need for physicians, particularly underrepresented minorities, will continue to grow. Addressing shortages requires inventive efforts to counter obstacles created by the anti-affirmative action movement, as well as strategies to encourage institutions to become more engaged in diversity efforts.

Reid, Gary; Nick Crofts; and Lorraine Beyer. 2001. “Drug Treatment Services for Ethnic Communities in Victoria, Australia: An Examination of Cultural and Institutional Barriers.” *Ethnicity and Health* 6 (1): 13-27.

Abstract: Under-representation of ethnic minorities at drug treatment services represents under-utilization rather than a lower need. ...Intense shame and loss of face linked to illicit drug use was common in ethnic communities and as a consequence seeking help for drug treatment was fraught with difficulties. Accessing drug treatment services often occurred following a crisis, but a sense of despair and confusion often prevailed owing to a lack of knowledge of available assistance. Even when treatment services were accessed most key informants and ethnic communities viewed them as culturally insensitive, inflexible and with language barriers that obstructed the flow of effective information. Understanding of the ethnic family ethos was of pivotal importance but frequently ignored by treatment services, contributing to the exclusion of ethnic communities from appropriate assistance. Ethnic communities need to be assisted to participate in drug issue discussions and community development strategies in order for their utilization of drug treatment services to be improved.

Rhodes, Penny; Andrew Nocon; and John Wright. 2003. “Access to Diabetes Services: The Experiences of Bangladeshi People in Bradford, UK.” *Ethnicity and Health* 8(3): 171-189.

Abstract: Recent years have seen a renewed emphasis in UK healthcare policy on access to services, yet there has been little research into possible inequalities in access for people from different ethnic backgrounds. This paper examines access from the point of view of a group of Bangladeshi people with diabetes, whose views were obtained as part of a wider evaluation of diabetes services. ...The wider evaluation provides a context within which to identify similarities with, as well as differences from, other groups in the community, and the findings show that the

experiences of this vulnerable group highlight more general weaknesses in service provision. The paper also shows that conventional analysis of access in terms of barriers to be overcome misses a crucial dimension: the ability to make full use of services. Gaining access does not mean that needs will be met appropriately, and patients vary in the extent to which they are able and enabled to play an active role in obtaining the services they need.

Rosenbaum, Sara; Anne Markus; and Julie Darnell. 2000. "U.S. Civil Rights Policy and Access to Health Care by Minority Americans: Implications for a Changing Health System." *Medical Care Research and Review* 57(3): 236-260.

Abstract: The history of health care discrimination as well as ongoing, extensive evidence of racial disparities argue for continued vigilance in the area of health care and civil rights. Under Title VI of the Civil Rights Act of 1964, individuals have challenged de facto discriminatory policies adopted by health entities receiving federal financial assistance. Title VI health litigation is difficult because of complex issues of proof as well as confounding problems of poverty and lack of health insurance that affect both claims and remedies. An analysis of cases brought under the law suggests that discrimination claims within a particular market fare better than those challenging decisions to relocate or alter the market served. This has important implications for claims involving discrimination by managed care organizations. Because the same potential for discrimination exists in the new health system of managed care, although in altered form, data collection and evaluation are warranted.

Ruiz, Pedro. 2002. "Commentary: Hispanic Access to Health/Mental Health Services." *Psychiatric Quarterly* 73(2): 85-93.

Abstract: Currently, the Hispanic population of the United States is growing very rapidly. Despite the significance of this growth and the fact that it is expected that Hispanics will be soon the largest ethnic minority group in this country, the access to health/mental health care for the Hispanic population is rather limited. Many factors are currently affecting the Hispanics' access to health/mental health care services. Among them, cultural and language barriers, insufficient numbers of Hispanic manpower in the health care professions, low educational and socioeconomic levels, the high number of uninsured Hispanics, and ethnic and racial prejudices and discrimination. In this commentary, I address the factors that interfere with the Hispanics' access to health/mental health care, and advance recommendations geared to alleviate and/or resolve this critical problem.

Satcher, David. 2003. "Overlooked and Underserved: Improving the Health Care of Men of Color." *American Journal of Public Health* 93(5): 707-710.

Men of color are among the most overlooked of the groups experiencing the poorest health outcomes, and face some of the biggest barriers to care. The author argues that we must ensure that all Americans have access to culturally competent, affordable and accessible health care services. Of primary importance is equal health insurance coverage. Also stressed is the importance of recognizing non-financial barriers to care such as issues of racism and sexism within the health system and among health providers.

United Nations. 2001. *Migrants' Right to Health*. Geneva: Joint United Nations Programme on HIV/AIDS.

This paper addresses some issues involved in relation to the rights of migrants' health. Section D specifically discusses the problem of access. In many developing countries, health facilities are poorly equipped, drugs are not always available, and STD/HIV prevention and care is poor. Furthermore, drug costs are high and the burden of health care falls heavily on the individual

consumer. Migrants are especially vulnerable to a lack of access due to the additional factors of language barriers, cultural barriers, and racism. If migrants are to achieve full access to their right to health, projects aimed at improving access must address the issues of access to prevention and care at the origin, transit places, and final destination of migrants.

Wallace, Steven P.; and Valentine Villa, M. 2003. "Equitable Health Systems: Cultural and Structural Issues for Latino Elders." *American Journal of Law and Medicine* 29(2/3).

Abstract: This article examines the extent to which the U.S. healthcare system is equitable for older Latinos, using the World Health Organization (WHO) and the related Organization for Economic Cooperation and Development (OECD) criteria on health outcomes, access/responsiveness and financing. We argue that improving health equity requires more than actions aimed at health behavior and culturally-based beliefs targeted at the individual. Improving equity also requires changes in broader social and political processes affecting entire populations and organizations of care, paying special attention to how these changes affect the Latino elderly.

Watson, Sidney D. 2000. "Race, Ethnicity, and Quality of Care: Inequities and Incentives." *American Journal of Law and Medicine* 27(2/3).

Abstract: The author presents a systemic approach to reducing race-based treatment disparities that utilizes reporting systems and financial incentives to produce structural change. He also describes research documenting the different care provided to racial and ethnic minorities; the role of slavery and segregation in creating today's health care systems and its race-based prejudices, misconceptions and fears; and racial and ethnic disparities as medical error.

Watson, Sidney D. 2003. "Reforming Civil Rights with Systems Reform: Health Care Disparities, Translation Services, and Safe Harbors." *Washington and Lee Race and Ethnic Ancestry Law Journal* 9:13.

Here Watson explores the adoption of a systems reform approach to reduce racial and ethnic disparities in health care. Systems reform can be either an internal management tool or a regulatory model. This approach shifts the focus from blame-laying, creates a format and justification for data reporting, and supplements agency enforcement with more internal and external accountability. Such an approach offers a way to strengthen civil rights enforcement, particularly with respect to health care.

Gender-based Barriers

Bobinski, Mary Anne; and Phyllis Griffin Epps. 2002. "Women, Poverty, Access to Health Care, and the Perils of Symbolic Reform." *The Journal of Gender, Race and Justice* 5: 233.

Abstract: This article looks at health care through gendered eyes. It reviews the conflicting evidence about gender-related differences in health care treatments and outcomes. This article has provided a gender-sensitive view of three related aspects of the health care system: evidence about gender-related consequences for health status or treatment; access to health care as measured by access to health insurance; and gender-sensitive issues in coverage under private and public health insurance policies.

Box, Tamara L.; Maren Olsen; Eugene Z. Oddone; and Sheri A. Keitz. 2003. "Healthcare Access and Utilization by Patients Infected with Human Immunodeficiency Virus: Does Gender Matter?" *Journal of Women's Health* 12(4): 391–398.

Abstract: Objective: To examine access to and utilization of primary healthcare services with respect to sex differences. Greater family and child-rearing responsibilities are possible barriers to healthcare access and utilization for women with HIV infection... Conclusions: Women had greater familial responsibilities than men, but this was not a barrier to access or utilization of healthcare services. Despite less advanced HIV disease, women received similar care and had similar utilization of health services.

"Gender-based Barriers in Pakistan Affect Female Patients and Their Providers." 2003. *Health Policy* (October 13):65-67.

Focusing on the effect of gender-based health system barriers on female patients and their providers in Pakistan, this study addresses the difficulty of maintaining female health and family planning workers; the lack of sensitivity to women's gender-based cultural constraints, and ways to ensure better functioning of government health services.

Hatton, Diane C.; Dorothy Kleffel; Susan Bennett; and Elizabeth A. Nancy Gaffrey. 2001. "Homeless Women and Children's Access to Health Care: A Paradox." *Journal of Community Health Nursing* 18(1): 25-35.

Abstract: Homeless women and children who reside in shelters experience many health-related problems. The aim of the qualitative study reported here was to (a) explore how shelter staffs manage health problems among their residents and assist them in accessing health services, and (b) identify clinical strategies for community health nurses working with this population. Findings demonstrate a paradox whereby homeless shelter staffs try to gain access to care for their residents through a system that is designed to keep them out. In addition, findings indicate a need for increased community health nursing services in homeless shelters. Strategies for resolving this paradox include providing assessment, policy development, and assurance of health care for homeless women and children.

Hazarika, Gautam. 2000. "Gender Difference in Children's Nutrition and Access to Health Care in Pakistan." *Journal of Development Studies* 37(1): 73-93.

Abstract: This article analyzes gender differences in children's nutrition and access to health care in Pakistan with a view to uncovering parents' motives for the favoring of sons in South Asia. It is found that, among 0 to 5-year-old children, boys are favored in the allocation of health care. However, girls appear as nourished as or better nourished than boys. This is taken to be evidence that intra-household gender discrimination has primary origins not in prenatal preference for boys but in differential returns to parents from investment in boys and girls.

Jackson, Sharon; Delia Camacho; Karen M. Freund; Judyall Bigby; Jacqueline Walcott-McQuigg; Ebony Huges; Ana Nunez; Wanda Dillard; Carl Weiner; Tracy Withz; and Ann Zerr. 2001. "Women's Health Centers and Minority Women: Addressing Barriers to Care." The National Centers of Excellence in Women's Health. *Journal of Women's Health and Gender-Based Medicine* 10(6): 551-560.

Abstract: New models of care delivery have been developed to better coordinate and integrate healthcare for women. In the United States, one of the challenges is to incorporate the needs of racial and ethnic minority

populations into these newer care paradigms. This paper begins with a brief historical review of the experience of racial and ethnic minorities in the American healthcare system to provide a context for discussing barriers and limitations of more traditional models of women's healthcare. Specific approaches used by National Centers of Excellence in Women's Health are presented as examples of strategies that may be implemented by other communities to address these barriers.

Kyomuhendo, Grade Bantebya. 2003. "Low Use of Rural Maternity Service in Uganda: Impact of Women's Status, Traditional Beliefs and Limited Resources." *Reproductive Health Matters* 11(221): 16-27.

Abstract: In Uganda, lack of resources and skilled staff to improve quality and delivery of maternity services, despite good policies and concerted efforts, have not yielded an increase in utilization of those services by women or a reduction in the high ratio of maternal deaths. This paper reports a study conducted from November 2000 to October 2001 in Hoima, a rural district in western Uganda, whose aim was to enhance understanding of why, when faced with complications of pregnancy or delivery, women continue to choose high risk options leading to severe morbidity and even their own deaths. The findings demonstrate that adherence to traditional birthing practices and beliefs that pregnancy is a test of endurance and maternal death a sad but normal event, are important factors. The use of primary health units and the referral hospital, including when complications occur, was considered only as a last resort. Lack of skilled staff at primary health care level, complaints of abuse, neglect and poor treatment in hospital and poorly understood reasons for procedures, plus health workers' views that women were ignorant, also explain the unwillingness of women to deliver in health facilities and seek care for complications. Appropriate interventions are needed to address the barriers between rural mothers and the formal health care system, including community education on all aspects of essential obstetric care and sensitization of service providers to the situation of rural mothers.

Language Barriers

Bischoff, Alexander; Patrick A. Bovier; Rrustemi Isah; Gariazzo Francoise; Eytan Ariel; and Loutan Louis. 2003. "Language Barriers Between Nurses and Asylum Seekers: Their Impact on Symptom Reporting and Referral." *Social Science and Medicine* 57(3): 503-513.

Abstract: The objective of this study was to determine whether language barriers during the screening interview affected the reporting of asylum seekers' health problems and their referral to further health care. Seven hundred and twenty-three standard screening questionnaires, administered by nurses to asylum-seekers at the time of entry into Geneva/Switzerland between June and December 1998, were reviewed, as well as information pertaining to language use during the interview. Adequate language concordance was significantly associated with higher reporting of past experience of traumatic events and of severe psychological symptoms, contrasting with much fewer referrals to psychological care when language concordance was inadequate. These results suggest the importance of addressing language barriers in primary care centers in order to adequately detect and refer traumatized refugees.

Ngo-Metzger, Quyen; Michael P. Massagli; Brian R. Clarridge; Michael Manocchia; Roger B. Davis; Lisa I. Iezzoni; and Russel S. Phillips. 2003. "Linguistic and Cultural Barriers to Care: Perspectives of Chinese and Vietnamese Immigrants." *JGIM: Journal of General Internal Medicine* 18(1): 44-53.

Abstract: The objective of the study was to examine factors contributing to quality of care from the perspective of Chinese- and Vietnamese-American patients with limited English language skills. The authors conclude that cultural and linguistically appropriate health care services may lead to improved health care quality for Asian-American patients who have limited English language skills. Important aspects of quality include providers' respect for traditional health beliefs and practices, access to professional interpreters, and assistance in obtaining social services.

Plantiko, Barbara. 2002. "Not-So-Equal Protection: Securing Individuals of Limited English Proficiency with Meaningful Access to Medical Services." *Golden Gate University Law Review* 32: 239.

The article focuses on how language discrimination manifests in various health care settings and how it deprives individuals with limited or no English proficiency of access to a variety of essential medical services. Included are an overview of existing judicial and legislative actions and a statement of what the current problems are. To this end, the authors suggest that because medical care is a vital service, individuals of limited English proficiency could argue their case under the Equal Protection Clause in search of the same medical treatment enjoyed by English speakers.

Pöchlhacker, Franz. 2000. "Language Barriers in Vienna Hospitals." *Ethnicity and Health* 5(2): 113-120.

Abstract: As part of a wider investigation of cross-cultural communication practices in health care and social service institutions of Vienna, a survey among hospital staff was conducted to establish the need for mediated communication between service providers and non-German-speaking patients. The responses of 508 doctors, nurses and therapists demonstrate a substantial need for interpreting services, which is currently met by family members (most often children) and bilingual hospital employees (most often cleaners). Most of the respondents were well aware of the shortcomings of ad hoc interpreting arrangements and voiced a clear preference and demand for a hospital interpreting service to improve communication with and health care provision to non-German-speaking patients.

Silver, Richard. 2000. "The Right to English Health and Social Services in Quebec: A Legal and Political Analysis." *McGill Law Journal* 45: 681.

Abstract: The right to English health and social services in Quebec raises important issues in the context of Quebec language policy, in that French is the official language of Quebec and intended to be the common language of all Quebecers. The author first gives an overview of language policy in the Quebec and federal contexts. He then traces the evolution of the right to English health and social services, enshrined in legislation in 1986, and its implementation. He next examines the application of the legislation during a period of transformation of the Quebec health and social services system and the degree of respect given the right under a new government. Finally, he analyzes whether the right to English services infringes the Charter of the French language, dealing particularly with the right to work in French and the issue of signs in the health and social services sector. The author concludes that the right to English services has become politicized in recent years and that lack of political will has prevented the government from fully respecting its obligations under health and social services legislation.

Workman, Elizabeth T.; Nancy T. Lombardo; and Jeanne Marie LeBet. 2003. "Overcoming Language Barriers When Providing Health Information: Why We Should Care and What We Can Do." *Journal of Consumer Health on the Internet* 7(2): 23-34.

Abstract: There is need for multilingual health information in different formats. New technologies offer solutions to providing consumer health information despite problematic issues. Libraries can play a key role in making multilingual materials available to their constituent populations and the world.

Location-based Barriers

Adam, Y. M. and H. M. Salihu. 2002. "Barriers to the Use of Antenatal and Obstetric Care Services in Rural Kano, Nigeria." *Journal of Obstetrics and Gynaecology* 22(8): 600-604.

Abstract: The objective of this study was to identify the socio-cultural and economic factors that act as barriers to women's use of antenatal care services and hospital delivery in a rural community in Kano State, Northern Nigeria. The study was based on an interview of 107 pregnant women conducted by a trained midwife in the native language of the area. Findings indicate that the majority of women (88%) (CI = 81.8–94.2%) in the study area did not attend for antenatal care, and 96.3% (CI = 93.0–99.8%) had delivered or plan to deliver at home without a skilled attendant. Major barriers identified were economic, cultural and those related to the women's perception of their condition. The study recommends that poverty reduction and economic empowerment of rural women are prerequisites for any tangible improvement in the utilization of antenatal care and obstetric delivery services.

Andrews, Bruce; Peter Simmons; Ian Long; and Ross Wilson. 2002. "Identifying and Overcoming the Barriers to Aboriginal Access to General Practitioner Services in Rural New South Wales." *Australian Journal of Rural Health* 10(4): 196-202.

Abstract: The Wiradjuri General Practitioners and Aboriginal Health Workers Project aimed to help improve Aboriginal health in central western New South Wales (NSW) by identifying and overcoming the barriers to the Aboriginal population's access to general practitioner services. The central strategy of the project was to convene three rounds of consultative meetings that brought together Aboriginal community members, general practitioners and Aboriginal health workers to express and define local issues and problems, and to propose solutions. The solutions included general practitioner outreach clinics, a focus on pre-winter immunization, bulk-billing of Aboriginal patients, Aboriginal cultural awareness training for all general practice personnel, employing Aboriginal staff in general practice, and closer professional interaction between general practitioners and Aboriginal health workers.

Andrulis, Dennis P. 2000. "Community, Service, and Public Strategies to Improve Health Care Access in the Changing Urban Environment." *American Journal of Public Health* 90(6): 858-863.

Discusses the issue of access to health care in relation to America's cities. Principally, individual and community characteristics such as transportation, levels of education, language, culture, proximity to providers, health literacy and health beliefs can exacerbate urban access problems. Progress through Medicaid and other actions helps reduce inequities in access for certain populations, but not for all populations.

Baxter, Judith; Lucinda L. Bryant; Sharon Scarbro; and Susan M. Shetterly. 2001. "Patterns of Rural Hispanic and Non-Hispanic White Health-Care Use." *Research on Aging* 23(1): 37-61.

Abstract: This cross-sectional study examines utilization of health care resources, including nursing homes, among 1,433 rural Hispanic and non-Hispanic White participants in the San Luis Valley Health and Aging Study. Results show substantially greater non-Hispanic White residence in nursing homes, greater Hispanic use of professional home nursing services, but little ethnic difference in outpatient care or hospitalization. Analyses based on the behavior model of utilization find health care use strongly associated with need factors.

Booyesen, Fikkie le R. 2003. "Urban-Rural Inequalities in Health Care Delivery in South Africa." *Development Southern Africa* 20(5): 659-674.

Abstract: Urban-rural inequalities in access to health care services continue to persist in South Africa, and in almost all cases discriminate against the poor. In certain cases disparities are even worse in urban areas, although levels of service delivery admittedly are consistently worse in rural areas. People in rural areas are generally more dependent on public and other health care services than on private services, compared with people living in urban areas. There is limited evidence of substantial intra-urban disparities, with inequality being worse in smaller urban settlements (i.e. towns) as opposed to larger ones (i.e. small cities and metropolitan areas). The article emphasizes the important role the envisaged future decentralization of selected health services to local government is likely to play in addressing these inequalities and the lack of service delivery at this level.

Glei, Dana A.; Noreen Goldman; and Germán Rodríguez. 2003. "Utilization of Care During Pregnancy in Rural Guatemala: Does Obstetrical Need Matter?" *Social Science and Medicine* 57(12): 2447-2464.

Abstract: This study examines factors associated with the use of biomedical care during pregnancy in Guatemala, focusing on the extent to which complications in an ongoing or previous pregnancy affect a woman's decisions to seek care. The findings, based on multilevel models, suggest that obstetrical need, as well as demographic, social, and cultural factors, are important predictors of pregnancy care. In contrast, measures of availability and access to health services have modest effects. The results also suggest the importance of unobserved variables—such as quality of care—in explaining women's decisions about pregnancy care. These results imply that improving proximity to biomedical services is unlikely to have a dramatic impact on utilization in the absence of additional changes that improve the quality of care or reduce barriers to access. Moreover, current efforts aimed at incorporating midwives into the formal health-care system may need to extend their focus beyond the modification of midwife practices to consider the provision of culturally appropriate, high-quality services by traditional and biomedical providers alike.

Hampshire, Kate. 2002. "Networks of Nomads: Negotiating Access to Health Resources Among Pastoralist Women in Chad." *Social Science and Medicine* 54(7): 1025-1038.

The author assesses the availability of access to health resources among pastoralist women in Chad by examining the importance of social support systems for access to health care, and the implications of the spatial mobility of nomads for health care access.

Hosain, G. M. Monawar and Nilesh Chatterjee. 1998. "Health-care Utilization by Disabled Persons: A Survey in Rural Bangladesh." *Disability and Rehabilitation* 20(9): 337-346.

Abstract: The purpose of the present study was to examine the utilization of health services by disabled person in rural Bangladesh and to identify associated factors to inform the development of appropriate health services. ...The conclusions of this study are that social and cultural barriers prevent certain groups, notably women and demographically dependent age groups, from accessing health care. ...A combination of educational and economic

initiatives such as a disability benefits allowance would strongly promote the health of disabled persons and create a general awareness of disability in Bangladesh...

Jütting, Johannes P. 2004. "Do Community-Based Health Insurance Schemes Improve Poor People's Access to Health Care? Evidence from Rural Senegal." *World Development* 32(2): 273-289.

Abstract: Community-based health insurance is an emerging and promising concept, which addresses health care challenges faced in particular by the rural poor. The aim of this paper is to analyze whether rural Senegal members of a health insurance scheme are actually better-off than nonmembers. The results show that in poor environments, insurance programs can work: Members of les mutuelles de sante (mutual health organizations) have a higher probability of using hospitalization services than nonmembers and pay substantially less when they need care. Furthermore, the analysis revealed that while the schemes achieved to attract poor people, the poorest of the poor remained excluded.

Levine, Phyllis; Denise Lishner; Mary Richardson; and Alice Porter. 2001. "Faces on the Data: Access to Health Care for People with Disabilities Living in Rural Communities," in R. M. Moore (ed.), The Hidden America: Social Problems in Rural America for the Twenty-First Century. Selinsgrove: Susquehanna University Press.

Access to health care is already limited for people in rural communities. For people with disabilities living in rural areas, the difficulties of access are even more pronounced. However, access can improve by building interagency communication and bringing agencies together; encouraging public health agencies to focus more on disability; improving provider education; insisting on fairly priced equipment and services; and creating gathering places and opportunities for people with disabilities and their families to meet, socialize, and network.

Lohlein, Daniela; Johannes Jutting; and Peter Wehrheim. 2003. "Rural Russia in Transition: What Determines Access to Health-Care Services?" *Post-Soviet Affairs* 19(1): 80-95.

Magilvy, Joan K. and JoAnn G. Congdon. 2000. "The Crisis Nature of Health Care Transitions for Rural Older Adults." *Public Health Nursing* 17(5): 336-346.

Abstract: The complex health, socioeconomic, and environmental problems experienced by many American elders often places them at high risk for disease and disability. Although availability of health services is improving in rural areas, barriers such as distance, geography, and poor distribution often limit access to health care.

Magilvy, Joan K.; JoAnn G. Congdon; Ruby J. Martinez; Renel Davis; and Jennifer Averill. 2000. "Caring for our Own: Health Care Experiences of Rural Hispanic Elders." *Journal of Aging Studies* 14 (2): 171-191.

Abstract: Many rural elders find access to health care a serious problem, and for ethnic minority rural populations such as Hispanics, language, cultural, and economic barriers further compound the problem. Based on one large longitudinal and three companion ethnographic studies of rural aging and health care in which a large percentage of the participants were Hispanic, this article describes results of analysis and interpretation of findings across the four studies related to Hispanic families' experiences with health care. Three themes were identified: (1) taking care of our own.' Hispanic families struggling to meet obligations; (2) spirituality as integral to life and health; and (3) acceptance or prejudice: understanding cultural differences. A description of observed patterns of

utilization of specific health care services by older Hispanics and their families is included, and implications for health care delivery and research are addressed.

Rodriguez, Emelyn. 2001. "Rural Health Care: Is There a Doctor in the House?" *California Journal* 32(4): 10-17.

Principally exploring focusing on the health care system of rural areas in California, the author examines why it is so difficult of deliver medical services to those areas.

Rosenthal, Thomas C.; Chester Fox; and Stephen J. Lurie. 2000. "Access to Health Care for the Rural Elderly." *JAMA: Journal of the American Medical Association* 284(16): 2034-2037.

The authors discuss the patterns of practice and the social, policy, and research issues influencing care for the rural elderly. They examine relevant demographics, funding for rural health services, the availability of geriatric clinicians in rural communities, and data on inpatient hospitalization and nursing home placement services.

Overview of Access to Health and Barriers to Access

"Access to Health Care 'Still Unequal'." 2003. *Community Care* (1479): 13.

Report on the speech of John Reid, the British Health Secretary during the 2003 National Health Service (NHS) conference in Edinburgh, England. He acknowledged that access to health services continued to vary according to wealth and class.

Apolone, Giovanni. 2003. "Health Coverage in Italy." *Journal of Ambulatory Care Management* 26(4): 378-383.

Abstract: The article focuses on the operations of the National Health Service in Italy, and discusses universal health care and coverage to Italians and other legal non-Italian residents who have full access to health care. The article also discusses the enhancement of the government's capability to control and monitor the health care system in terms of expenditures and costs.

Axworthy, Lloyd; and Jerry Spiegel. 2002. "Retaining Canada's Health Care System as a Global Public Good." *CMAJ: Canadian Medical Association Journal* 167(4): 365-367.

The article discusses the health care system in Canada, and the outlook for public health services there. The authors specifically examine the principles of universal access to health care and health care equity as the basis for Canada's health care system. They also examine the pressures and opportunities that globalization has presented to health care.

Benatar, S.R.; A.S. Daar; and P.A. Singer. 2003. "Global Health Ethics: The Rationale for Mutual Caring." *International Affairs* 79(1): 107-139.

Abstract: Despite spectacular twentieth century scientific and technological progress, the world is more inequitable than it was fifty years ago. This is evident both in terms of access to health care for individuals, and in relation to the health of whole populations. Disparities in wealth and

health within and between nations are widening inexorably and the rapidly expanding global economy has failed to reduce poverty among those with little if any access to health care. In this context the Universal Declaration of Human Rights remains an unrealized aspiration for the majority of the world's people. Given these realities, no single discipline, or body of knowledge is likely to make much difference. The authors believe that an interdisciplinary approach is required, and that bioethics, an interdisciplinary field, can make a contribution towards improving health globally.

Birbeck, Gretchen L.; and Theodore Munsat. 2002. "Neurologic Services in Sub-Saharan Africa: A Case Study Among Zambian Primary Healthcare Workers." *Journal of Neurological Sciences* 200 (1/2): 75-79.

Abstract: In many parts of the developing world, access to physician consultation and neurologic expertise is limited or nonexistent. We conducted a survey among non-physician, primary healthcare workers (PHCWs) to determine the neurological needs and services in rural Zambia. Over 40% of PHCWs surveyed work in primary care clinics without a physician available for consultation. Their patients must travel a median of 50 km to access a physician and geographic barriers are a frequent problem. In addition to difficulty physically accessing care, PHCWs reported that financial barriers to physician referral are substantial. Traditional beliefs, social stigma, and discriminatory healthcare policies associated with neurologic conditions were also noted to deter and defer care and care seeking.

Bobinski, Mary Anne. 2003. "Health Disparities and the Law: Wrong in Search of a Right." *American Journal of Law and Medicine* 29(363).

The article explores the promise and limits of law in addressing disparities in health. It also explores research on disparities in treatment, outcomes, and health status associated with gender, ethnicity/race and socioeconomics.

Bullas, Sheila. 2003. "Diversity, Equal Access and Information." *Informatics in Primary Care* 11(1): 33-37.

Abstract: The overall aim of diversity is to ensure that every individual, whatever their differences, has fair and equitable access to health care and to employment based on clinical need and merit. This has advantages for staff by allowing them to give of their best and for patients by better identifying and meeting their needs. Evidence shows that individuals from minority groups are often not treated fairly and positive action is required to redress the balance.

Cummins, Penelope. 2002. "Access to Health Care in the Western Cape." *Lancet* 360(9350): 49-51.

This article examines access to health care in the Western Cape of South Africa. Color-coding of people in South Africa continues despite progress in racial tensions after Apartheid. The article also examines why geographical proximity is one of the biggest barriers to all varieties of health care in the Western Cape.

Cunnam, Prisilla; and Brij Maharaj. 2000. "Against the Odds: Health Care in and Informal Settlement in Durban." *Development Southern Africa* 17(5): 667-687.

In Durban, one of the fastest-growing cities in the world, the demands of accelerated urbanization, particularly with regard to health care, are compounded by the legacy of apartheid planning. This has resulted in health service provision being fragmented along racial, administrative financial and spatial lines. This article examines health conditions in Canaan, an informal settlement in Durban. All the diseases found to be prevalent, apart from STDs, are related to poor socio-economic conditions.

Engqvist, Lars. 2002. "How to Safeguard the Right of Common Access in the Health Service." *Scandinavian Journal of Primary Health Care* 20(2): 65-67.

All people should have a right to health care and social services on equal terms and care should be provided according to need. However, the supply of Swedish health care does not always match need, resulting in long waiting lists. The Swedish Riksdag adopted an action plan for the health service that is based on strengthening primary care, boosting the medical component of elder care, and expanding psychiatric care. Sweden also seeks to implement the 0790 rule, which means patients can contact their health care clinic the same day (0 waiting time), see the family doctor within 7 days, and receive treatment within in 90 days.

Feinstein, F. Ronald. 2001. "Access to Health Care: It's Not Rocket Science -- It's Tougher." *Journal of Legal Medicine* 22(2): 235-246.

Focusing on access to health care in the United States, Feinstein discusses the concept of a value equation which equates value in the marketplace with quality and cost, and the variation in care being delivered to the Medicare population depending on where they live. Evidence shows that prompt access to a specialist will result in more superior and efficient care.

George, Ajay; and Greg Rubin. 2003. "Non-Attendance in General Practice: A Systematic Review and its Implications for Access to Primary Health Care." *Family Practice* 20(2): 178-185.

Abstract: ...Non-attendance in general practice has received increasing attention over the past few years. Its relationship with access to health care has been recognized and is of particular relevance in light of the access targets set out in the NHS Plan. Methods. The literature was searched for articles relating to non-attendance. ...The epidemiology of non-attendance has been well described, but there is little work on the reasons for non-attendance. Evidence for effective interventions to improve attendance in primary care is lacking, and this may prove to be an area of research interest in the future. As well as specific interventions to reduce non-attendance, new approaches to health care access are required in order to tackle this issue.

Goddard, Maria; and Peter Smith. 2001. "Equity of Access to Health Care Services: Theory and Evidence from the UK." *Social Science and Medicine* 53(9): 1149-1163.

Hendriks, A. 1998. "The Right to Health in National and International Jurisprudence." *European Journal of Health Law* 5 (4): 389-409.

Abstract: The right to health is a fundamental human right, solidly embedded in international human rights law. As with other human rights, this right creates corresponding obligations for States which they are due to respect, protect and fulfill. The right to health embodies both positive and negative contents rights, ranging from the right to adequate protection of health to the right to equal access to health care. In addition, the right to health obliges States to create conditions favorable to the achievement and maintenance of the highest attainable level of

health. This article describes and analyses national and international case law with respect to these three components of the right to health in an effort to delineate the general contours of this right. It is argued that courts and other (quasi-)judicial bodies more or less explicitly acknowledge that States are required to ensure a minimum level of health protection, (equal access to) essential health care and satisfaction of basic human needs. From the existing body of case law touching on the right to health it remains, however, difficult to conclude how courts define the minimum core content of the right to health, let alone to gain further insights into the normative meaning of this right.

Herp, Michel Van; Veronique Parqué; Edward Rackley; and Nathan Ford. 2003. "Mortality, Violence and Lack of Access to Healthcare in the Democratic Republic of Congo." *Disasters* 27(2): 141-154.

Abstract: The people of the Democratic Republic of Congo for decades have been living in a situation of chronic crisis. Violence, population displacement and the destruction of infrastructure and health services have devastated the health of the population. In 2001, Médecins Sans Frontières conducted a survey in five areas of western and central DRC to assess mortality, access to health-care, vaccination coverage and exposure to violence. High mortality rates were found in front-line zones, mainly due to malnutrition and infectious diseases. In Basankusu approximately 10 per cent of the total population and 25 per cent of the under-five population had perished in the year before the survey. Humanitarian needs remain acute across the country, particularly near the front line. Infectious-disease control and treatment are a priority, as is increasing access to health-care. Humanitarian assistance must be increased considerably, especially in rural areas and zones that have been affected directly by conflict.

Johnson, Merrilyn O. 2001. "Meeting Health Care Needs of a Vulnerable Population: Perceived Barriers." *Journal of Community Health Nursing* 18(1): 35-53.

Abstract: This study utilized the qualitative methodology of focus groups to explore health care needs and perceived barriers to obtaining health care for urban and rural women and children in areas served by nurse practitioner (NP) and certified nurse midwife (CNM) clinics. The clinics operate in a southeastern county with a rural health professional shortage area designation, and an urban ZIP code area with high rates of infant mortality and serious pediatric conditions. The aim of the study was to delineate barriers to health care in order to develop appropriate services at the clinics and to improve access. Four focus groups with a total of 31 women from the communities were convened. Content analysis shows that access to the clinics is hampered by the community women's limited knowledge of CNMs and NPs and their specific roles in providing health care services. The women suggested that clinics counter their low profile by a more vigorous outreach promotion.

Kronenfeld, Jennie Jacobs (ed.). 2002. *Social Inequalities, Health and Health Care Delivery*. Boston: JAI.

Social factors play an important causal role in creating social distributions of health. The papers in this volume address this statement by examining issues of gender, age, race, and poverty as they relate to access to health care. Various sections deal with macro-system issues, patient characteristics, and providers. Some authors take a theoretical approach, while others test theories, but all serve to provide the reader with a multisided view of the barriers to access to health care.

Liu, Gordon G.; Zhongyun Zhao; Renhua Cai; Tetsuji Yamada; and Tadashi Yamada. 2002. "Equity in Health Access to: Assessing the Urban Health Insurance Reform in China." *Social Science and Medicine* 55(10): 1779-1795.

Abstract: This study evaluates changes in access to health care in response to the pilot experiment of urban health insurance reform in China. ...Specifically, this study examines the pre- and post-reform changes in the likelihood of obtaining various health care services across sub-population groups with different socioeconomic status and health conditions, in an attempt to shed light on the impact of reform on both vertical and horizontal equity measures in health care utilization. ...In conclusion, the reform model has demonstrated promising advantages over pre-reform insurance programs in many aspects, especially in the improvement of equity in access to basic care provided at outpatient settings.

Manderson, Lenore; and Pascale Allotey. 2003. "Cultural Politics and Clinical Competence in Australian Health Services." *Anthropology and Medicine* 10(1): 71-86.

Abstract: Medical competence is demonstrated in multiple ways in clinical settings, and includes technical competence, both in terms of diagnosis and management, and cultural competence, as demonstrated in communication between providers and clients. In cross-cultural contexts, such communication is complicated by interpersonal communication and the social and cultural context. To illustrate this, we present four case studies that illustrate the themes from interviews with immigrant women and refugees from Middle Eastern and Sabel African backgrounds, conducted as part of a study of their reproductive health. In our analysis, we highlight the limitations of conventional models of communication. We illustrate the need for health providers to appreciate the possible barriers of education, ethnicity, religion and gender that can impede communication, and the need to be mindful of broader structural, institutional and inter-cultural factors that affect the quality of the clinical encounter.

McKinney, Louise W. 2002. "Barriers to Access to Health Care." *Health Matrix: Journal of Law Medicine* 12(1): 1-7.

This article discusses how to avoid financial barriers and barriers for people with disabilities.

Mesri, Parastoo Anita. 2003. "The Violation of the Human Right to Health as a Factor in the Zapatista Revolution of Chiapas, Mexico." *Tulsa Journal of Comparative and International Law* 10: 473.

This article examines the violation of the right to health in Chiapas, Mexico as a factor in setting the stage for the armed Zapatista uprising. The author examines socio-economic factors in Chiapas, as well as international health law, and Mexican national health law.

Morrith Taub, Leslie-Faith. 2002. "A Policy Analysis of Access to Health Care Inclusive of Cost, Quality, and Scope of Services." *Policy, Politics, and Nursing Practice* 3(2): 167-177.

Abstract: A policy analysis of access to health care was undertaken using a review of current studies and proposals for health care reform in order to uncover the issues of cost, quality, and scope of services that would be required to realize health care coverage for the 38.7 million Americans who remain uncovered. This national issue was explored at the state level, and it was also explored at the individual level by a description of those affected by age, race, ethnicity, health status, and gender. Finally, the author looks at health care reform as one of many other issues affecting the American citizen as choices are made about how to utilize limited resources.

Ncayiyana, Daniel J. 2002. "Africa Can Solve its own Health Problems." *BMJ: British Medical Journal* 324(7339): 688-690.

An editorial opining that Africa has the resources to solve its health problems, but that it has wasted its political emancipation through political adventurism and civil wars. The author ultimately states the need to address inequalities in access to health care, and suggests that participating in the global economic movement will help solve Africa's poverty problem.

Neri, M.T.; and T. Kroll. 2003. "Understanding the Consequences of Access Barriers to Health Care: Experiences of Adults with Disabilities." *Disability and Rehabilitation* 25(2): 85-97.

Abstract: Purpose: The study explores: (1) the scope and nature of the consequences that adults with disabilities perceive as the result of inappropriate access to health care services; (2) the variability of these consequences by demographic attributes such as disability type, gender, and health insurance type, and (3) the inter-relatedness and multidimensionality of these consequences. ...Conclusions: Health insurers and providers need a better understanding of the multiple consequences of access barriers. Based on this knowledge, detrimental and costly effects of inappropriate service delivery could be more effectively prevented. Implications for health care services and policy are discussed.

Pirisi, Angela. 2000. "Low Health Literacy Prevents Equal Access to Care." *Lancet (Elsevier)* 356 (9244): 1828.

Abstract: The article focuses on low health literacy, which prevents many patients from making full use of treatments and clinical information, and may result in them being unable to make the best use of their health-care services. Further discusses the barriers to health literacy related to medical terminology and cultural, language, education and age-related issues; the effects of low literacy; and the responsibility of health care providers to communicate medical information effectively.

Politzer, Robert M.; Jean Yoon; Leiyu Shi; Ronda G. Huges; Jerrilynn Regan; and Marilyn H. Gaston. 2001. "Inequality in America: The Contribution of Health Care Centers in Reducing and Eliminating Disparities in Access to Care." *Medical Care Research and Review* 58(2): 234-249.

Abstract: Reducing and eliminating health status disparities by providing access to appropriate health care is a goal of the nation's health care delivery system. This article reviews the literature that demonstrates a relationship between access to appropriate health care and reductions in health status disparities. The authors present an evaluation of the ability of health centers to provide such access. Access to a regular and usual source of care alone can mitigate health status disparities. The safety net health center network has reduced racial/ethnic, income, and insurance status disparities in access to primary care and important preventive screening procedures. Evidence suggests that health centers are successful in reducing and eliminating health access disparities by establishing themselves as their patients' usual and regular source of care. This relationship portends well for reducing and eliminating health status disparities.

Powell, Martin; and Mark Exworthy. 2003. "Equal Access to Health Care and the British National Health Service." *Policy Studies* 24(1): 51-65.

Abstract: Equal access to health care is a central objective of many health care systems, and is often seen as the founding principle of the British National Health Service. However, this paper argues that it can be seen as a piece of grand or flamboyant rhetoric of symbolic politics, representing a misreading, or at least an

oversimplification, of history. It examines stated equity objectives in the NHS by placing them in the cells of an equity matrix. It is discovered that few NHS policies have aimed to achieve 'equal access to health care' in any meaningful sense. Moreover, this rhetorical emphasis has obscured wider issues, in that little attention has been paid to issues such as which variations are unacceptable, how much variation should be tolerated, and the potential trade-offs between concepts such as equity and efficiency.

Reese, Shelly. 1998. "Access to Health Care." *American Demographics* 20(8): 56.

The main barrier to access to health care in the United States, according to the Agency for Health Care Policy and Research's 1996 Medical Expenditure Panel Survey, was the inability to pay. However, barriers are not consistent across all groups. Hispanic families encountered barriers more frequently than non-Hispanic black and white families. Families in the Western United States also faced more barriers than families in other geographical regions, and rural dwellers faced more difficulties than urban dwellers.

Rice, Dorothy P. 1998. "The Cost of Instant Access to Health Care." *JAMA: Journal of the American Medical Association* 279(13): 1030.

Rice, Nigel; and Peter C. Smith. 2001. "Ethics and Geographical Equity in Health Care." *Journal of Medical Ethics* 27(4): 256-262.

Abstract: Important variations in access to health care and health outcomes are associated with geography, giving rise to profound ethical concerns. This paper discusses the consequences of such concerns for the allocation of health care finance to geographical regions. Specifically, it examines the ethical drivers underlying capitation systems, which have become the principal method of allocating health care finance to regions in most countries. Although most capitation systems are based on empirical models of health care expenditure, there is much debate about which needs factors to include in (or exclude from) such models. This concern with legitimate and illegitimate drivers of health care expenditure reflects the ethical concerns underlying the geographical distribution of health care finance.

Rocha, Cynthia J.; and Liz England Kabalka. 1999. "A Comparison Study of Access to Health Care Under a Medicaid Managed Care Program." *Health and Social Work* 24(3): 169-180.

Abstract: This article investigates the health care and insurance status of a low-income urban area in East Tennessee. The article reviews the background of TennCare, a compulsory Medicaid managed care program initiated in Tennessee in 1994. The study compared TennCare recipients with other insurance groups on key demographic and access variables. Possible explanations for how TennCare recipients rate their care also were examined. Qualitative analysis revealed accounts of long waiting periods, out-of-town specialist care, problems with obtaining pharmaceuticals, and general confusion about the new system. Implications of these findings for social work policy practitioners are discussed, and suggestions for alleviating the burden on patients are offered.

Rogers, Anne; and Julian Flowers. 1999. "Improving Access Needs a Whole Systems Approach." *BMJ: British Medical Journal* 319(7214): 866-888.

This editorial states that improving access to health care in Great Britain requires a whole systems approach and would be central to averting crises in the winter between 1999 and 2000. The authors also explore existing initiatives by the British government and its National Health

Service to improve access; list ways in which access could be improved; and explain the importance of access in health and social care arrangements.

Rosero-Bixby, Luis. 2004. "Spatial Access to Health Care in Costa Rica and its Equity: A GIS-based Study." *Social Science and Medicine* 58(7): 1271-1284.

Abstract: This study assembles a geographic information system (GIS) to relate the 2000 census population (demand) with an inventory of health facilities (supply). It assesses the equity in access to health care by Costa Ricans and the impact on it by the ongoing reform of the health sector. It uses traditional measurements of access based on the distance to the closest facility and proposes a more comprehensive index of accessibility that results from the aggregation of all facilities weighted by their size, proximity, and characteristics of both the population and the facility. The data show substantial improvements in access (and equity) to outpatient care between 1994 and 2000. These improvements are linked to the health sector reform implemented since 1995.

United Nations. 2001. *Improving Access to Care in Developing Countries: Lessons from Practice, Research, Resources and Partnerships*. Paris: French Ministry of Foreign Affairs, World Health Organization, UNAIDS.

This publication reflects the shared experience of 155 international experts in advocating accelerated access to care for HIV/AIDS patients in developing countries. It features papers on lessons learnt and on analyzing key issues in the implementation of the care agenda, as well as a Declaration for a Framework for Action, which was adopted at a meeting of these experts held in Paris in 2001 at the invitation of the French Ministry of Foreign Affairs.

Valios, Natalie. 2003. "Less Equal Than Others?" *Community Care* (1486): 24-27.

Offers a look at the quality of health care services provided to people with learning disabilities in Great Britain. The barriers to care include difficulties related to challenging behavior; the shortness of a typical appointment; wheelchair accessibility; communication problems; and dependence on caregivers accompanying patients. The article also discusses government initiatives to provide equal access to health care.

Van Der Mei, Anne Pieter. 2003. "Cross-Border Access to Health Care Within the European Union: Recent Developments in Law and Policy." *European Journal of Health Law* 10(4): 369-381.

The article provides an overview of European initiatives concerning the rights of patients to gain access to health care across borders. The author describes new cases before the European Court of Justice; the development of a policy on patient mobility that recognizes both the interest of patients and the need to protect the financing and infrastructure of health care and insurance systems; and the importance of policy that promotes collaboration between member states and those entities responsible for running health care systems.

Waters, Hugh R. 2000. "Measuring Equity in Access to Health Care." *Social Science and Medicine* 51(4): 599-613.

Zayas-Cabán, Teresa. 2003. "Modeling Access to Health Care Within a Community." *IMA Journal of Management Mathematics* 16(6): 273-279.

Abstract: Health disparities have been a growing concern in the USA. Differences in access to healthcare play a role in these health disparities. This article presents a model that illustrates access to healthcare in two rural Midwestern communities. The simulation model developed helps determine if people in these communities have equal access to health care and if physician's insurance coverage practices prevent certain people from accessing care. From the simulation, it can be determined which characteristics may lead to the disparities in access to health care. Using the results of such a simulation model, the community may then begin to take action in order to ensure equal access to health care for all people within the community and help reduce health disparities.