



# Access to Mental and Physical Health Care

The Science of Resilience

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## Definition

The concept of “access to health care” or “health care access” is a multidimensional and complex concept widely used in the medical literature, despite some variation in its operational definition (Cabieses & Bird, 2014; Norris & Aiken, 2006). Commonly, access to mental and physical health care is defined as the degree to which people are able to obtain quality care from the healthcare system that fulfils their medical needs in a timely manner (Escarce & Kapur, 2006). Accordingly, access to health care involves the timely use of personal health services to achieve the best possible physical and mental health outcomes (Evans et al., 2011). People who have adequate access to health care are able to navigate the healthcare system to gain access to the health care services they need, when they need them, to maintain a positive physical and mental health. Access to physical health care involves the use of preventive health services, including screening for disease prevention (for example, screening for cancer, blood glucose, and high blood pressure), as well as the use of personal health services, including hospitals, medical clinics, and doctor’s offices when people are ill or injured (Meshefedjian et al., 2016). The concept, ‘access to mental and physical health care,’ refers to the degree to which people of all age groups (including infants, children, youth, adults, and older adults) benefit from receiving quality and timely health care services (Fulkerson, Haff, & Chino, 2013; Horton & Johnson, 2010; Meshefedjian et al., 2016). Given the vast differences in health care legislation among countries around the world, consistent empirical evidence has documented wide differences in the access to health care that residents of different countries across the globe experience (Cabieses & Bird, 2014). Access to health care is closely connected to the type of health care system available in a country, the general level of development of the country, its demography and geography, and wider issues such as population beliefs and values about health.

### Barriers to Accessing Health Care

Access to comprehensive, quality mental and physical health care services is widely considered a basic human right (Association of Women’s Health, Obstetric and Neonatal Nurses [AWHONN], 2017; Hansen, Krasnik, & Høg, 2007). Therefore, many organizations and medical associations support policy initiatives that guarantee access to such health care services for all people. However, the literature on access to health care has consistently shown that several institutional, cultural, and economic barriers make it challenging for certain groups of people to access the care they need. These barriers are briefly described below.

#### *Citizenship and Immigration Status*

According to the World Health Organisation (WHO), national health care plans often discriminate against undocumented immigrants – which are immigrants residing in a country without documents to prove legal residence in that country, including refugee claimants or

asylum seekers – by making only emergency care available to them (World Health Organization, 2003). Studies have shown that undocumented immigrants in the United States of America (USA) have less access to health care services including preventive care than do USA-born persons (Tung, 2011). In Canada, refugee claimants are less likely than native-born Canadians to seek health care services, including preventative care, long-term health management and specialist care (Newbold, Cho, & McKeary, 2013). Undocumented immigrants face a number of barriers in accessing health care (AWHONN, 2017). For example, undocumented immigrants do not qualify for adult or child health insurance programs as they are not able to purchase health insurance and they do not qualify for any of the subsidies created under the law (AWHONN, 2017; Newbold et al., 2013). Additionally, often undocumented immigrants are too afraid to be reported to the immigration authority to ask for medical attention when they need it or to access preventive care (Hansen et al., 2007). More generally, both undocumented and documented newcomers face significant barriers to using health care services that include language, cost, transportation, cultural practices, and knowledge (Newbold et al., 2013).

### *Race & Ethnicity*

Regardless of their immigration and citizenship status, racial and ethnic minority groups face significant barriers to accessing quality and timely health care services in industrialized nations (Battle, 2002; Evans et al., 2011; Fiscella, Franks, Doescher, & Saver, 2002). Minority race and ethnicity status have been linked to a lower likelihood of having a regular source of care, fewer physician visits, and lower total health-care expenditures (Fiscella et al., 2002). For example, research has shown that African American and Hispanic American adults and children residing in the United States receive less preventive care and less appropriate health care services than non-African Americans and non-Hispanic Americans, respectively (Evans et al., 2011; Fiscella et al., 2002). Similar trends have been documented for newcomers and Indigenous people in Canada (Newbold et al., 2013; Webster, 2018). The disparities in access to health care that racial and ethnic minority groups experience in industrialized nations can be attributed to many intertwined factors, including cultural beliefs and traditions, language barriers, low income, lack of health insurance, lack of information on the health care system, and lack of adequate transportation (Dong, Ringen, & Fujimoto, 2014; Evans et al., 2011; Fiscella et al., 2002; Fulkerson et al., 2013; Lee & Choi, 2009; Newbold et al., 2013; Rodriguez-Alcalá, Qin, & Jeanetta, 2019; Webster, 2018). Often, ethnic minority groups live in economically depressed and underserved neighbourhoods, they may lack the financial means to afford health insurance, and they may also be unable to navigate the mainstream health system. Not enough health care providers understand the cultures and languages of immigrant populations (National Association of Community Health Centers, 2014). Therefore, without interpretation or translation services, language differences between health care providers and the racial or ethnic minority patients they serve can compromise care.

### *Employment Status & Income*

Being unemployed and belonging to a low-income household are two strong predictors of poor access to healthcare in industrialized nations (Ames, 2007, 2008; Fulkerson et al., 2013; Harrington, Rosenberg, & Wilson, 2014; Raiz, 2006). It is well documented that families living in poverty are more likely to lack health insurance and consequently, experience a lower likelihood of having a usual source of care, compared to families in better economic standings (Collins, Rasmussen, Beutel, & Doty, 2015). Affordable insurance is still out of reach for many low-income families, and even for those who can afford insurance, high deductibles and out-of-pocket costs may prevent them from seeking the care that they need. The consequences of the health disparities experienced by low-income families include deteriorating health and wellbeing for vulnerable socio-demographic groups (Fulkerson et al., 2013). Research has consistently indicated that belonging to a low-income family is one of the strongest predictors of poor access to health care for both adults and children, with low-income families having significantly less opportunities for consistent access to care than those in the middle- or high-income categories. For example, in a recent study investigating health disparities among children entering kindergarten in Nevada (USA), the authors found that children in low-income families were less likely than those in middle- or high-income families to have had access to a routine check-up (i.e. not for an illness) in the past 12 months, a routine check-up once per year since birth, a primary care provider (e.g. regular doctor, nurse practitioner, or physician's assistant), and a dental visit in the past 12 months (Fulkerson et al., 2013). Similar results were found in studies that investigated health disparities among adults living in low-income households in the USA and Canada (Harrington et al., 2014; Kirby, 2008; Meshefedjian et al., 2016).

### *Disabilities*

People with disabilities face multiple challenges in accessing proper health care services when they need them (AWHONN, 2017; Smith, 2008). Scheer and colleagues (2003) identified three broad categories of barriers to health care access that persons with disabilities experience: environmental, structural, and process. Environmental barriers include issues of accessibility and lack of adequate services. Structural barriers refer to a lack of insurance coverage for all necessary services, including limited health plan benefit programs that do not provide coverage for services such as physical therapy and occupational therapy, high-quality functional medical equipment adapted to each person's individual needs, and mental health services. Process barriers involve the delivery of service, including lack of provider knowledge and lack of suitability of service. A considerable proportion of people with disabilities report serious problems accessing prescription drugs (32%), dental care (29%), medical equipment (21%), mental health services (17%), and home care (16%) due to cost (Kennedy & Erb, 2002).

The most common barrier that persons with physical disabilities experience in accessing health care services involves insufficient space for wheelchairs and lack of accessible medical

screening equipment essential for early diagnosis of serious diseases, such as breast and cervical cancer (Sanchez et al., 2000; Schopp, Sanford, Hagglund, Gay, & Coatney, 2001). Persons with sensory impairments often experience communication barriers resulting from a lack of alternative modalities to accommodate their needs, such as American Sign Language (ASL) interpreters for the Deaf (Steinberg, Wiggins, Barmada, & Sullivan, 2002; Witte & Kuzel, 2000). For people with learning or cognitive disabilities, obstacles to effective care may occur when long wait times are required, or providers do not allow enough time to explain medical concepts in an accessible manner (Smith, 2008). Personal and cultural barriers to health care access that have been documented in the literature include provider's negative attitudes, misperceptions, and lack of knowledge of persons with disabilities (Sanchez et al., 2000). Negative provider attitudes sometimes result in withholding of treatment or provision of inferior treatment.

### *Sexual Orientation & Gender Minority Status*

Two Spirit, Lesbian, Gay, Bisexual, Pansexual, Trans, Gender Independent, Queer and Questioning (2SLGBTQ+) persons often encounter barriers that affect their access to needed health services and can result in poorer health outcomes (AWHONN, 2017). For example, more than half of 2SLGBTQ+ people have experienced negative interactions with health care providers, including disrespectful treatment, lack of awareness on the part of the clinician about the specific health needs of the 2SLGBTQ+ person, attribution of the person's sexual orientation or gender identity as the cause of an illness, and denial of care (Tolbert, Orgera, Singer, & Damico, 2019). Inequality in the workplace and health insurance sector, and rejection by families and communities are also thought to contribute to the disparities in health outcomes for 2SLGBTQ+ persons.

Disparities in health care access for 2SLGBTQ+ persons are profound, with barriers to health equity for these persons existing at both the social and individual levels (Hudson & Romanelli, 2020). Social-level factors include poverty, stigma, oppression, and social exclusion (Fredriksen-Goldsen et al., 2014). Individual factors that are prominent barriers to engaging in health care among 2SLGBTQ+ communities include mental health problems such as depression, post-traumatic stress disorder (PTSD) symptoms and addictions, and homelessness (Quinn, Reed, Dickson-Gomez, & Kelly, 2018; Romanelli & Hudson, 2017). Other individual-level factors include endocrinological processes (e.g., stress), and biological factors (e.g., allostatic loads), as well as a high likelihood of victimization, abuse and discrimination based on sexual orientation and gender identity. As a result, 2SLGBTQ+ persons experience higher rates of being uninsured, delaying or avoiding health care, and delaying or not getting needed prescription medication compared to their heterosexual and cisgender counterparts (Krehely, 2009).

### *Neighbourhood of Residence*

Empirical evidence has shown that neighborhood-level characteristics have an impact on health care access above and beyond the characteristics of individuals in industrialized

nations (Bell, Wilson, Bissonnette, & Shah, 2013). Numerous studies have shown a strong relationship between neighborhood of residence and a number of health-related indicators, including access to health care. Taken together, these studies identified disparities in access to health care among different neighbourhoods and demonstrated that differential access to health care significantly impact health care utilization and health outcomes (Bell et al., 2013; Pearce, Witten, & Bartie, 2006; Schuurman, Berube, & Crooks, 2010). Specifically, the empirical evidence provided by these studies demonstrated that persons residing in more socioeconomic disadvantaged neighbourhoods and experiencing residential instability are significantly more likely to not access preventive care, not have a usual source of care, and have unmet health care needs (Kirby & Kaneda, 2005, 2006; Prentice, 2006). The availability of, and access to, primary health care is one critical neighborhood characteristic that has the ability to directly impact health. Research has demonstrated that increased distance to health care services results in reduced utilization of the health care system and increased area-based inequities in health status (Bell et al., 2013; Hiscock, Pearce, Blakely, & Witten, 2008). For example, people who live in rural and underserved areas may need to drive long distances to access health care facilities and health care providers (AWHONN, 2017), and therefore, even with reliable transportation, accessing health care facilities may be challenging (Newkirk & Damico, 2014).

### *Homelessness Status*

As mentioned above, unstable housing and, more specifically, experiencing homelessness is a significant predictor of poor access to health care for persons in industrialized nations (Bell et al., 2013; Knittel et al., 2019). People experiencing homelessness are entitled to basic social benefits and social participation services, as well as health insurance and access to health care services (Hensel, 2017). However, the absence of a stable residence makes accessing such services difficult, for example if state offices refuse to accept a claimed address. Studies and data collections of various institutions, associations, and research groups confirm that access to health care for this group of people is notably difficult and, as a result, their mental and physical health status is poor (English, 2006; Hensel, 2017). In fact, plenty of research has shown that homeless persons are at a significant higher risk of experiencing physical health problems and mental health problems, including addictions, compared to persons with stable housing (Bell et al., 2013; English, 2006; Hensel, 2017; Knittel et al., 2019). Persons who live on the street, sleep in hostels, or are at acute risk of imminent homelessness often do not have health insurance and therefore, they are not able to access regular health care services and tend to access medical services only in emergencies, despite having multiple medical problems (Hensel, 2017).

### *Health Care Provider Shortages*

A significant barrier to mental and physical health care is the lack of primary care providers in industrialized nations such as the USA and Canada (AWHONN, 2017). For example, projected estimates of the USA population indicate that there will be a shortage of 20,400

primary care physicians by 2020 (Health Resources and Services Administration, 2013). Training new health care providers, including general practitioners and nurses, is an important component of maintaining an adequate supply of providers.

## Relationship to Resilience

The barriers to accessing mental and physical health care outlined above represent key social determinants of health that heighten the risk of experiencing mental and physical health issues, including depression, anxiety, substance use, and chronic physical health conditions such as diabetes, hypertension and cancer, relative to persons who do not experience such barriers (Battle, 2002; Krehely, 2009; Romanelli & Hudson, 2017). Clearly, in industrialized nations, access to health care is an important factor for the wellbeing of both children and adults as those who have better access to care also have improved mental and physical health status, as well as a better quality of life (Hanson et al., 2003; Shi, Green, & Kazakova, 2004). For patients, negative experiences in the health care system, including instances of insensitivity or disrespect, may give rise to distrust of health providers, failure to seek needed care, and reliance upon self-treatment (Steinberg et al., 2002). Therefore, being able to access quality and timely health care services is a factor that significantly promotes resilience in both children and adults by promoting positive health and wellbeing. Numerous studies have documented that children who have access to quality and timely preventive care and personal health care services, including vaccinations, routine check-ups, and proper treatments and medications, are more likely to perform well in school (English, 2006; Fletcher, 2004; Fulkerson et al., 2013). The better academic performance of these children are due to the fact that, because they are generally healthier than children who have poor access to health care services, they lose less days of school, are better able to pay attention in class, and are also better able to fulfil their responsibilities as students. Similar evidence is also available for adults (Bell et al., 2013; Harrington et al., 2014; Meshefedjian et al., 2016), Adults who have better access to quality and timely preventive care and personal health care services are more likely to: (a) adhere to a healthier lifestyle involving adequate diet and exercise, (b) avoid risky and health-threatening behaviours such as smoking and using illegal drugs, (c) properly fulfil their responsibility at work and in their family system as they are better able to pursue a meaningful career and care for aging parents and young children, and (d) meaningfully engage in close and supporting relationships with family members and with people outside the family system, as well as in community and leisure activities. All these factors promote resilience in both children and adults living in industrialized nations.

## Improving Access to Health Care

The literature suggests that programs and policies promoting health care access in industrialized nations must be sensitive to the specific needs of at-risk groups, including undocumented immigrants, ethnic minorities, low-income families, persons with disabilities,



2SLGBTQ+ persons, persons living in economically disadvantaged and underserved neighbourhoods or in rural areas, persons with unstable residence, and regionally and linguistically isolated residents (Fulkerson et al., 2013). For this reason, institutions, associations, and clubs in many cities should provide easily accessible health care services, such as street outpatient clinics and mobile medical and psychiatric services for at-risk populations (Hensel, 2017).

In a recent qualitative investigation, Hudson and Romanelli (2020), drawing from a health equity framework, interviewed 38 LGBTQ-identifying people of color in New York City. The authors used framework analysis to examine participants' perspectives on the role of community in enhancing health and wellbeing. Community strengths identified by participants included (a) safety, acceptance, and support; (b) interconnectedness and resource sharing; and (c) advocacy, collective action, and community potential.

## Interventions

The literature presents some intervention programs that have successfully been implemented in the USA designed to improve underserved children's access to health care (Ames, 2008). Following are a few examples of model programs.

- A family-centred model for providing health care services to children from low-income, culturally and linguistically diverse families (Evans & Garwick, 2002). This model was developed through a collaboration among parents, health care providers, and cultural specialists.
- Though the results have been mixed, some urban school districts have attempted to improve adolescents' access to mental health services through school-based interventions (Britto, Klosterman, Bonney, Altum, & Hornung, 2001; Weist, Nabors, Myers, & Armbruster, 2000). Some of these programs involve a collaboration with schools to identify uninsured children from low-income families and link them to medical and dental services, while others attempt to identify medical and developmental problems in very young, low-income children and connect them to health and social services (Cuellar et al., 2003).
- Lindsey and Chadwick (1993) describe a health passport system implemented in San Diego, CA, using a centralized computerized database, including information on physical and emotional/behavioural health to maintain and distribute health and education records for children in out-of-home care. This project uses public health nurses to review the health information and consult with foster parents, social workers, and health providers.
- A health passport program for foster children was developed in North Carolina from a collaborative effort between a county's social services and public health departments (National Academy for State Health Policy, n.d.). In the program, a public health nurse

acts as liaison between health agencies and families ensuring continuity of care and avoiding gaps in the health care services children receive. The nurse provides case management to ensure that children received health assessments and follow-up services, works with social workers, trains foster parents, and gives a health passport packet to foster families or other caregivers who are caring for children in protective custody.

## Assessment

Access to health care services can be assessed using measures of service use satisfaction. Several service use satisfaction and service impact measures exist for use with diverse populations, including children, youth, adults, and families, as well as persons with mental health problems or disabilities, among others.

### Single-item Service Use Satisfaction Measures

In some cases, service use satisfaction and impact of service use can be assessed using a measure including only one or two items specifically developed for the purpose of each individual investigation. This can be done either by using an individual measure of service use satisfaction and impact of service used, including only one or a few items (Tom Xu, 2002; Vogan, Lake, Tint, Weiss, & Lunskey, 2017), or by including items assessing these constructs in a more extensive survey (Urbanoski, Rush, Wild, Bassani, & Castel, 2007). In these cases, participants are asked to rate their satisfaction with each service they used in the previous 1-12 months on a Likert scale from very dissatisfied to very satisfied. Respondents may also be asked to rate the impact of the services they have used on a Likert scale from very dissatisfied to very satisfied. Respondents' answers can then be analyzed for each service accessed to assess their satisfaction with each specific service or across all services accessed to understand their satisfaction with services overall. Examples of items include the followings: "It was easy for me to get the services I thought I needed;" "The services I received were helpful to me;" and "Overall, I am satisfied with the services I received over the past six months" (Carlson & Gabriel, 2001).

### The Youth Service Survey (YSS) & Youth Service Survey for Families (YSS-F)

The Youth Service Survey (YSS) is a self-report questionnaire that allows adolescents aged 15-17 to rate the behavioral health services they received in the previous 6 months, while the Youth Service Survey for Families (YSS-F) is a proxy-report measure that assesses caregivers' perceptions of behavioral health services their children aged 17 and under received in the previous 6 months (Jones, 2014). Both surveys consist of 26 closed-ended items in which respondents are asked to express on a 5-point rating scale from strongly agree to strongly disagree the extent to which they are satisfied with the services they or their children received. The 26 items are organized into seven domains that are used to measure different aspects of

satisfaction with public behavioral health services. The seven domains include access, participation, outcomes, satisfaction, cultural sensitivity, social connectedness, and functioning. Adapted versions of these scales have been used in a variety of settings (c.f., Ungar, Liebenberga, Duddingb, Armstrongc, & van de Vijverd, 2013). Liebenberg and colleagues (2016) examined the psychometric properties of a 13-item version of the YSS, using data from 593 at-risk adolescents (12–17 years). The study results supported the use of the reduced version of the YSS as a valid and reliable measure of service quality.

### **The Client Satisfaction Questionnaire Scales (CSQ Scales)**

The Client Satisfaction Questionnaire Scales (CSQ Scales) is a portfolio of measurement instruments designed to assess consumer satisfaction with health and human services, including governmental and public benefit programs and services. The CSQ Scales include five versions of the Client Satisfaction Questionnaire (CSQ), three versions of the CSQ for special populations (big print version, children and youth version and parent rated child services versions) and four versions of the Service Satisfaction Scale (SSS) (Attkisson, 2020a, 2020b, 2020c; Greenfield & Attkisson, 2004). The instruments are brief, based on academic scale development methodology, and written to be applicable across the wide array of health and human services (Vasan & Solomon, 2015).

## Other Notes

### **Topics noted for further investigation:**

- Access to health care in developing countries, and comparison between access to health care in industrialized nations vs developing countries.
- Strategies that institutions can implement to improve universal/global access to health care, including the development of laws and policies.
- Effects of specific state- and community-level initiatives and policies in improving access to health care of underserved and marginalized populations, including, for example, low-income families, ethnic minority families, and people with addictions.

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