

ALTERNATIVE DESIGNS FOR CONDUCTING THE ROBERT WOOD JOHNSON
FOUNDATION SURVEY OF ACCESS TO HEALTH CARE

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A. BACKGROUND

The availability of accurate and timely information concerning Americans' access to health care is essential to health policymakers. The Robert Wood Johnson Foundation (RWJF) has sponsored major surveys on access to health care in 1976, 1982, and 1986. In September 1991, the Project HOPE Center for Health Affairs was awarded a grant from RWJF to design the 1993 survey on access to health care. With the development of a number of large federal health-related data collection efforts, major emphasis for the RWJF survey was to be placed on identifying new areas of policy inquiry as well as on developing alternative methodological approaches.

The themes explored in the three previous RWJF surveys as well as the methodological approaches have varied somewhat. The 1976 Robert Wood Johnson Foundation access survey -- whose interviews were conducted in-person with approximately 8,000 individuals -- oversampled persons with episodes of illness, non-SMSA Southern blacks, and Hispanics living in the Southwest. The 1982 RWJF access survey of approximately 7,000 individuals used telephone interviews and oversampled those with incomes below 150% of the federal poverty level.

In 1986, RWJF also used a telephone survey. The sample size was approximately 10,000, and Americans with chronic and serious illness were oversampled.

During the past 15 years, the federal government has developed several major surveys which provide data about some of the areas of inquiry previously studied through RWJF surveys. The 1977 National Medical Care Expenditure Survey (NMCES), the 1980 National Medical Care Utilization and Expenditure Survey (NMCUES), and the 1987 National Medical Expenditure Survey (NMES) have each collected extensive data on health care utilization and expenditures using national probability samples ranging in size from approximately 6,000 to 14,000 households.

The National Health Interview Survey (NHIS), sponsored annually by the National Center for Health Statistics, routinely collects data about health care status and use and has included supplements which obtain data about health insurance and other financial barriers to care. Other federal surveys such as the Survey of Income and Program Participation (SIPP) and the Current Population Survey (CPS) also collect health insurance coverage information. More

specialized surveys, for example, the National Survey of Family Growth, gather information about access to particular types of health services (i.e., prenatal care). Despite these efforts, many experts believe that critical deficiencies in knowledge remain. The 1993 RWJF Survey of Access to Health Care is being designed to extend, rather than duplicate, these efforts.

The Survey of Access to Health Care grows out of the RWJF's mission to improve the health and health care of the American people. Shortly after becoming a national philanthropy in 1972, the Foundation devoted much of its resources to building the capacity of the nation to provide primary health care services through demonstrations of innovative health programs, training programs for primary care medical providers, and health services research. RWJF funding goals were revised in 1991 to build on its longstanding work in the area of improving access to health care, and to reflect the changing health care system in the U.S. The four new goals are:

- 1) To assure that Americans of all ages have access to basic health care;
- 2) To improve the way services are organized and provided to people with chronic health conditions;
- 3) To promote health and prevent disease by reducing harm caused by substance abuse (including illegal drugs,

alcohol, and tobacco);

- 4) To seek opportunities to help the nation address the problem of escalating medical costs.

To address these goals RWJF will invest approximately \$170 million in program development, training, research, and communications projects in 1993. By identifying and highlighting problems in access to basic health services as well as related problems in the other Foundation goal areas, the 1993 Survey of Access to Health Care will guide the Foundation and other interested in policy and program development to improve health care.

In developing the 1993 survey, we have considered these health policy areas as well as issues related to survey methodology. The methodological goal was to examine cost-effective methods of reducing both noncoverage bias and nonresponse bias so as to ensure that the sample accurately reflected the number of persons who have experienced a variety of access barriers. Rather than drawing a prohibitively large and expensive sample, we explored alternative approaches for targeting the survey to persons who may experience financial and nonfinancial barriers to obtaining care.

B. POLICY ISSUES

In terms of substantive areas in which to focus the

survey, five primary objectives were identified in a series of meetings between the Robert Wood Johnson Foundation and Project HOPE and its consultants:

- o Analysis of the organization of medical care and its effect on access to care;
- o Exploration of health care seeking behavior and barriers to obtaining care;
- o Comparison of persons with and without poor access;
- o Examination of access to care and appropriateness of care for persons with specific chronic conditions;
- o Investigation of the role of community-based programs on access to care.

The survey will continue to collect data on traditional indicators of access, including characteristics of usual source of care, travel time, waiting time, reason for not having a usual source of care, and provider setting. It is also important to continue collecting data about predisposing characteristics such as age, race, sex and measures of health status. Although indicators of realized access include both objective and subjective measures, a decision was made to place high priority on objective measures such as use of physicians' services, hospitals, dental services and prescription drugs. The survey will de-emphasize subjective measures of access such as satisfaction with care and overall views about the U.S. medical system. While such topics remain important, they are duplicative of numerous other recent studies.

Two new priorities for the survey were identified. First, we intend to explore in detail individuals' reasons for seeking or not seeking care. Earlier studies, (for example, Berk and Wilensky, 1985; Wilensky and Berk, 1985; Hayward et al., 1988; Garrison, 1990) have shown that persons without health insurance coverage use fewer health care services than those with some third-party payment. Nevertheless, it is important to recognize that even among persons with comparable coverage there is considerable variation in the amount of services used. Thus, additional attention will be focused on understanding variations within insurance-status categories. Why do some people get care despite lack of coverage while others with coverage use services sparingly?

There will be an increased emphasis on examining the decision-making process that underlies health care seeking behavior. Specifically, we need to better understand the decisions people make to determine when medical care is necessary, where to go for care, and how to interact with the medical care system during the course of an illness. In addition, increased emphasis will be placed on understanding the role of the community-level health care delivery system in providing access for low-income people.

Probable topic areas and

examples of specific research questions to be addressed by the survey include:

(i) The impact of financial barriers on access to care, including why some persons with health insurance do not get care and some get care despite financial barriers.

(ii) The effect of cultural and attitudinal barriers on access, particularly with respect to racial and ethnic minority groups.

(iii) The organization of medical care delivery as it relates to access, including the access implications of differences in the availability of generalist and specialist medical providers across geographic areas and how access to care affected by new forms of health care organizations such as "urgent care" centers and preferred-provider networks?

(iv) The role of community-based programs on promoting access.

C. METHODS ISSUES

Most of the better-known surveys that have examined access to health care have used personal interviews. Such surveys include the Center for Health Administration Studies (CHAS) surveys in 1953, 1958, 1963, 1970, and 1976 (the latter sponsored by the Robert Wood Johnson Foundation). The Current Medicare Beneficiary Survey conducted by HCFA also uses personal interviews, while the 1977 NMCES, the 1980 NMCUES, and the 1987 NMES used personal interviews during the

initial and final interviews while some interim interviews were conducted by phone. The National Health Interview Survey also uses in-person interviewing.

During the 1980s, however, more and more organizations -- including the Robert Wood Johnson Foundation -- elected to conduct surveys by telephone (Massey, 1988).

As of 1990, telephone surveys could reach over 93 percent of U.S. households (U.S. Statistical Abstracts, 1991). And, for obtaining certain types of information, that coverage is adequate. At least two studies suggested that national estimates (of health status and use, respectively) were not affected by the telephone interview mode (Marcus et al., 1986; Corey and Freeman, 1990). Corey and Freeman (1990) demonstrated, however, that estimates of insurance coverage were affected. Due to a lower rate of phone coverage among the uninsured, the 1986 RWJF survey underestimated the percentage of the population who lacked insurance coverage.

The exclusion of nontelephone households from the sampling frame is of understandable concern. It could be argued that the telephone itself is an enabling factor in obtaining care. Nevertheless, the use of only in-person interviews is costly and, therefore, could necessitate a substantially reduced sample. In designing the RWJF access survey, we have tried to find

a mechanism for using the telephone as the primary survey method, while still allowing for a limited number of personal interviews.

D. LINKED METHODOLOGY

The Robert Wood Johnson Foundation and Project HOPE are currently exploring the possibility of linking the RWJF access survey to a larger national probability survey that is conducted in-person. A linked methodology has two primary advantages over either all in-person or telephone interviews with a national probability sample. First, if nontelephone households can be identified in the initial survey, a linked methodology would allow the vast majority of persons to be interviewed by phone for the followback survey, while still allowing nontelephone households and respondents with hearing problems to be targeted for personal interviews. This methodology has been used successfully by the National Center for Health Statistics (NCHS), with the National Survey of Family Growth (NSFG) conducted as a follow-back survey to the National Health Interview Survey, and could be applied to other large surveys as well.

Second, this methodology would allow relatively small subpopulations to be targeted for the followback survey. In 1993, NCHS intends to include an access-to-care screener as part of the NHIS. This supplement, as well as additional questions on family resources, could make the NHIS an ideal survey to use as a sampling frame for a follow-

back survey on access. Use of the NHIS or another large survey as a sampling frame would allow persons to be selected for the RWJF access survey based on their responses to a broad range of questions. With the appropriate array of questions available, persons who indicated facing barriers to care could be oversampled and health care seeking behavior could be further investigated.

Redesigning the RWJF Survey of Access to Health Care as a followback supplement to an existing survey thus offers unique advantages. While the traditional approach to measuring access to care -- a strategy which focuses on estimates of the proportion of the population facing barriers -- can be supported through the implementation of a national probability survey with no more than 10,000 respondents, a more in-depth examination of access barriers requires a substantially larger sample size.

Table 1 presents the number of respondents in different surveys who face specific access barriers and, thus, would be suitable for analysis. For example, an issue which should be of interest to health policymakers is how those who are poor and uninsured do get care when they are ill. While the 1986 RWJF survey with a sample size of 10,000 included only 184 of such individuals, use of a larger survey such as NHIS, NMES, or CPS could yield 1,500 to

6,000 individuals. The use of a large survey as a screener could dramatically increase the analytical power of the RWJF survey and allow more detailed exploration of these issues.

At the present time, researchers at the Robert Wood Johnson Foundation, Project HOPE, and the National Center for Health Statistics are actively exploring the development of a major public/private initiative which would allow the RWJF survey to be conducted through the National Center for Health Statistics. The successful implementation of such a methodology would provide significant benefits to the health services research and health policymaking communities.

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TABLE I
YIELD OF PERSONS WITH REPORTED ACCESS PROBLEMS: NHIS, NMES, RWJF, and CPS

Survey	Sample Size	Number of Poor and Uninsured	Number with No Usual Source Care	Number Unable to Obtain Care	Number in Fair or Poor Health/No Dr. Visits
1989 NHIS	116,929	4,709	N.A.	N.A.	1,293
1987 NMES	38,446	1,525	5,493*	827	1,294*
1986 RWJF	10,130	184	1,551	617	275
1991 CPS	about 150,000	6,404	N.A.	N.A.	N.A.

* From NMES Access Supplement (sample size = 30,038).