

Chapter 9: Healthcare Access

Introduction

According to Healthy Maine 2010, a statewide health promotion and disease prevention agenda, “people who have good access to healthcare are able to obtain needed, appropriate, and high quality (evidence-based) health services in a timely manner without financial, structural, or personal barriers that limit their access.”¹ For women, good access to healthcare services can mean many things throughout their lives, from adequate access to prenatal care in their childbearing years, to prescription drug access in older age. Because access is a broad concept, measurement can take many forms. This section will discuss some of the major indicators of healthcare access in Maine, such as health insurance coverage, health service utilization rates, and practitioner-to-population ratios.

Healthcare Access in Maine

Women who use the health care system frequently have higher out of pocket medical costs, and have lower average incomes compared to men, particularly during their reproductive years.² Because they are poorer (on average) and use more care, women must spend a greater share of their income on health care. And because they are more likely to be single parents, women also shoulder the health care costs for their children, increasing the likelihood that they will experience medical bill or debt problems.² Research has shown that underinsured women with medical bill or debt problems are more likely to have lower incomes and to be single with children compared to males who have medical bill or debt problems.²

While cost is a major barrier to access for many women, geographic distance and lack of providers also restricts women’s access to health care in Maine. Despite its large geographic area with sparsely populated regions, Maine ranks 7th best nationally for its low percentage of people living in a medically under-served region (5.7% compared to U.S. percentage of 12.1%). “Medically underserved areas” are defined in terms of either the distance to health care services or the number of primary health care providers. Unfortunately, gender specific data are not available by geographic region.³

The standard ratio used by the U.S. Department of Health and Human Services for determining Health Professional Shortage Areas (HPSA) is a population-to-practitioner ratio of 1000 people to 1 provider. Maine currently has 44 Mental Health HPSA designated sites, 74 Dental Health HPSA designated sites, and 77 Primary Care HPSA designated sites.⁴

Women with low incomes and their families may have difficulty finding care even in areas with an adequate number of provider because many practices limit the number of Medicaid patients they accept due to low reimbursement rates.³

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Health Care Utilization

The 2010 National Healthcare Quality and Disparity Report found that in all years between 2002 and 2007, females were less likely than males to be able to secure timely medical care, dental care or access to prescription medicines.⁵ Many women do not receive the recommended level of preventative care, and one out of seven women aged 18-64 has no usual source of health care.⁶ Only 79.9% of women nationally have an identified primary care provider, however this is higher than the number of men with primary care providers (72.6%).⁵ Compared to other women, minority and uninsured women are even less likely to have a regular health care provider whom they see on a regular basis.⁷

Among Maine women in 2009, 7.8% reported that they did not have at least one person who they considered their personal doctor (Table 9.1). Younger women were more likely than older women to report not having a personal doctor. One in five women (20%) between the ages of 18-24 years reported that they did not have a personal doctor compared to 3.2% of women over age 65. Women with a college degree were more likely than women with a high school education or less to have a personal doctor. Women at lower income levels were less likely to have a personal doctor compared to women at higher income levels, but the differences were not statistically different.⁸

Table 9.1. Healthcare access among females by age, sex, education, and income, Maine, 2009.

Demographic Groups	% without a personal doctor		% who couldn't see a doctor because of cost	
	%	(95% CI)	%	(95% CI)
Overall	7.8	(6.6, 9.0)	10.8	(9.4, 12.2)
Age				
18-24	20.0	(11.8, 28.2)	16.8	(9.0, 24.6)
25-34	11.6	(7.7, 15.5)	15.2	(10.7, 19.7)
35-44	7.2	(5.0, 9.4)	12.4	(9.9, 14.9)
45-54	6.3	(4.7, 7.9)	14.2	(11.8, 16.6)
55-64	5.2	(3.8, 6.6)	8.7	(6.9, 10.5)
65+	3.2	(2.2, 4.2)	1.9	(1.1, 2.7)
Education				
Less than HS	10.4	(4.5, 16.3)	8.3	(4.2, 12.4)
HS or GED	9.1	(6.7, 11.5)	12.8	(10.3, 15.3)
Post HS	7.6	(5.1, 10.1)	10.7	(8.5, 12.9)
College Grad	6.5	(4.9, 6.1)	9.4	(7.2, 11.6)
Income				
< \$15,000	10.9	(6.0, 15.8)	12.7	(9.4, 16.0)
\$15,000-24,999	9.1	(6.0, 12.2)	17.2	(13.3, 21.1)
\$25,000-34,999	8.1	(5.2, 11.0)	15.3	(11.0, 19.6)
\$35,000-49,999	7.1	(5.1, 10.1)	10.6	(8.1, 13.1)
\$50,000-74,999	5.4	(2.7, 8.1)	10.1	(7.0, 13.2)
\$75,000 +	5.3	(2.9, 7.7)	4.2	(2.2, 6.2)

Source: BRFSS⁸

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Access to care for many women may be limited due to cost. In Maine, one in ten (10.8%) women reported that in the past year they needed to see a doctor, but could not because of cost (Table 9.1). This was especially true for younger women and low income women. There was not a statistically significant relationship between education and limited health care access due to cost.⁸

Many women who require care from medical specialists were not able to gain access to these providers. Nationally in 2008, 30% of women with Medicaid surveyed by the Kaiser Family Foundation stated that they were not able to see a specialist. Similarly, 43% of women without any insurance reported being unable to obtain specialist care.⁷

Health Insurance Status

Women's health insurance status is directly linked to their health and well-being; research shows that insurance coverage is strongly associated with the ability to get needed medical care, dental care, mental health services, and prescription medication.⁹ Women without health insurance are less likely to seek out preventative health care than women with health insurance.⁶

Nationally 20% of women in the U.S. report not having health insurance. In Maine, 12% of women do not have health insurance, which earns the state a rank of 11th best in the nation in terms of insuring women. The lowest rate of uninsured women is 5.2% in Massachusetts.³ Each year between 2002 and 2007, U.S. females were less likely to be insured compared to males, but the number of women aged 18-64 without health insurance increased during this same time period.^{5, 6} Employer-sponsored insurance is the leading form of coverage for women in the U.S. and in Maine, covering 59% of Maine women either through their own job or as a dependent.¹⁰

In 2008 and 2009 Maine women aged 19-64 had a higher percentage of enrollment in MaineCare insurance (Maine's Medicaid Program; 19%) compared to Maine men (14%) and to women nationally (11%; Table 9.2).¹⁰ When younger females are included, the percentage (aged 0-64) enrolled in MaineCare jumps to 24% compared to 20% of Maine males and 18% of females nationally.¹⁰

Table 9.2. Type of health care coverage of adults aged 19-64 by sex, Maine and U.S., 2008-2009.

	Females		Males	
	Maine	U.S.	Maine	U.S.
Employer	59%	60%	60%	58%
Individual	6%	6%	4%	6%
Medicaid	19%	11%	14%	8%
Other Public	4%	3%	5%	3%
Uninsured	12%	20%	17%	25%

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2009 and 2010 Current Population Survey (CPS: Annual Social and Economic Supplements).¹⁰

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Nationally, the share of non-elderly women covered by private health insurance fell eleven percentage points to 67% over the last 25 years, while the proportion covered by Medicaid increased 5 percentage points to 11% over the same time period.⁶

Even those women who have some health insurance may be “underinsured,” meaning that despite having coverage they incur out-of-pocket costs that are high when compared to their income. This is partially due to the current economy in which there was little or no growth in household incomes while health care costs rose rapidly during the same time period.²

Many uninsured women are remaining without coverage for longer periods of time. In 2008, more than a quarter (27%) of uninsured women in the U.S. had been without coverage for at least four years, compared to 20% of uninsured women in 2004 when the economy was stronger.⁷

Lower-income women and women of color are at greater risk for being uninsured, as are women who are single, young, and in fair or poor health.⁷

References

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Conclusion

This report examined women's health in Maine and the factors that contribute to women's health and well-being. The findings of this report indicate that although substantial gains have been made in ensuring women in Maine are healthy, disparities still exist and women continue to face challenges that carry health risks. In Maine, women have made great strides in educational attainment, but they still earn less than men and are more likely to live in poverty. Among Maine women, those with lower income and education are often at greater risk for poor health outcomes and are less likely to access health care.

Women's reproductive health is significant not only for women's health, but for the health of future generations. Women's health prior to and during pregnancy can impact their lifelong health outcomes, as well as their children's growth and development. In Maine it is critical that we ensure access to contraception and comprehensive reproductive services to reduce the increasing rates of sexually transmitted diseases, reduce unintended pregnancies, and ensure healthy maternal and infant outcomes. Substance use during pregnancy, including tobacco, alcohol and opioids, continues to be a concern as rates have not decreased over time.

Injuries are the leading cause of death among women of reproductive age in Maine. It is critical to improve motor vehicle safety to reduce unintentional injury death. More attention is needed to address injury-related falls among women, which can result in disabling conditions and death. Suicide and mental health are also significant concerns for women. Mental illness can have disabling consequences, limiting a woman's ability to work and take care of her health. Yet, services to address mental illness and suicide are limited in many parts of the state. The causes of mental illness among women may stem from women's status in society, burdens of work and caregiving, or violence they may experience at home. In Maine, the pervasiveness of sexual and physical violence among women during adulthood and childhood must continue to be a focus of prevention and intervention efforts, and Maine must ensure that resources are available to respond appropriately.

Maine communities, state and local governments, and the health care system must work together to promote healthy behaviors such as proper nutrition and physical activity, and strive to reduce harmful behaviors, such the use of tobacco, alcohol and other substances. Women's nutritional status and weight influence reproductive health outcomes as well as the development of chronic diseases. Dietary habits have repercussions for future generations, as women are often the primary providers of children's meals. The high prevalence of obesity among women of reproductive age in Maine is concerning for women's long-term health, pregnancy outcomes, and the health of their infants and children.

Women across the country are living longer and the population as a whole is aging. This is especially true for Maine, which has one of the oldest populations in the U.S. As our population continues to age, women's health issues will be at the forefront of our health care system. Diseases such as heart disease, cancer, stroke and diabetes are increasing in Maine as the

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population ages. Educating women about prevention and recognition of symptoms will be a critical task for our health care providers. Our society needs to prepare now to prevent and manage the illnesses that women will face as they age. We also need to recognize the role that women play in caring for the older generation and how caregiving impacts physical and mental health. As the population ages, women will be relied on more and more to provide care to aging parents, possibly at the expense of their own needs.

Women often need to use the health care system more than men and face higher health care costs, but they are more likely to be poor, unemployed, work part-time or in other positions that do not offer benefits such as health insurance. Removing financial barriers to services, such as reproductive health, maternal health care, and screenings for cancer, diabetes, hypertension and heart disease, can help to ensure that women are receiving adequate and appropriate levels of care. Given the proportion people living in rural areas in Maine, access to needed services can be especially difficult for elderly women who are no longer able to drive. Services are also critical in isolated and rural areas to help women who may be in a violent relationship.

Recommendations

- **Maintain a coordinated effort to address women’s health in Maine.** Maine has a public/private partnership, the Maine Women’s Health Campaign (MWHC), devoted to improving the lives of women in the state. MWHC will play a vital role in coordinating women’s health efforts in the state and can help develop an agenda for action.
- **Maintain strong leadership at the State.** Although Maine does not have an official Office of Women’s Health, there is a Women’s Health Coordinator at the Maine Center for Disease Control and Prevention who is in the position to ensure that a coordinated response to women’s health issues across domains continues.
- **Ensure that health systems are able to address women’s needs.** Access to quality services for women during their reproductive years and as they age can help prevent long-term illness and disability. Services related to women’s mental health, reproductive health, substance abuse, domestic and sexual violence, oral health, and preventative care (i.e., cancer screening), need to be available in all parts of the state and accessible to those who need them most.
- **Encourage the health and safety of girls.** By encouraging educational attainment, providing safe homes, schools and neighborhoods, and teaching healthy behavior, Maine can decrease women’s and girls’ experiences with adverse childhood event, improve their status in society, and decrease their risks for long-term illness, such as obesity and tobacco use. Many chronic conditions, including mental health and substance abuse, have their root in childhood and adolescence.
- **Increase opportunities for women.** By increasing access to training and education and improving quality and access to child care, we can increase the number of opportunities available to women. By changing women’s status in society, we can improve women’s health.
- **Continue to monitor progress.** The last women’s health report was completed almost 10 years ago. It is critical to develop a list of women’s health indicators that will be tracked, analyzed and disseminated on a more frequent basis to monitor women’s health and

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provide data for program planning and implementation. It is also important to acknowledge the gaps in our knowledge and data. There are no prevalence data currently available in Maine on several conditions that disproportionately affect women, such as arthritis, osteoporosis and hysterectomies. In addition, we lack systematically collected information on women's experiences with caregiving, contraceptive methods, the health care setting, illicit substance use, and social isolation.

Although this report focuses on women, it is important to realize that by improving health and health care for women, we will strengthen women, their families, and our communities. As the World Health Organization noted in their 2009 report on women's health, "Improve women's health, improve the world."¹

References

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