Access to Quality Health Care, Disease Prevention, and Health Promotion

GOAL

Improve access to comprehensive, high-quality health care services and effective prevention interventions.

OVERVIEW

If you live in a European country, Canada, Japan, or most any other developed nation, chances are you live in a country that provides its citizens basic access to public education as well as to health care and prevention interventions, the two major components of a comprehensive health system. The United States is fairly unique among developed countries in that we share this principle for elementary and secondary education, but we do not share this same principle when applied to our health system.

TEN INTERVENTIONS WITH SOME OF THE LARGEST POTENTIAL IMPACT ON HEALTH OUTCOMES:

- **Family planning**
- **Maternal health and safe motherhood interventions**
- **School health interventions**
- **Integrated management of childhood illnesses**
- **HIV/AIDS prevention**
- **Treatment of sexually transmitted diseases**
- **Immunization of children and adults**
- **Tobacco control**
- **Early screening and treatment of non-communicable diseases and injuries**
- **Directly observed treatment of tuberculosis**

All of these ten interventions involve population-based interventions requiring a public health system as well as individual-based interventions requiring a health care delivery system.

(World Development Report – Investing in Health. Washington, DC, The World Bank, 1993.)

Indeed, among the three major measurements to gauge a health system – cost, quality, and access – the United States ranks poorly compared to other developed countries for its health system's accessibility. *The World Health Report 2000* (World Health Organization, 2000), a study comparing health systems in nearly 200 countries, shows the US is by far the most expensive country for health costs, yet ranks poorly in terms of access to its health system. In part as a result of this poor access, the US ranks only moderately when it comes to the quality of health outcomes (see insert on next page).

Access to a system of high quality health care and prevention is complex, marked by issues of definition and measurement. First, *defining* access means taking into account our entire understanding of how health is created. Therefore, it is difficult to concisely define what access is. However, we can describe it. People who experience good access to health care 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. For example, they have adequate health insurance and an adequate number of health care providers and facilities nearby; transportation is available to them; they are informed about how to enter and maneuver through the health care system, and do so without discrimination or barriers due to their age, disability status, gender, race, ethnicity, sexual orientation, income or education level, occupation, or other life situation; and health care is conducted with sensitivity toward their culture and in a language they understand.

People who experience good access to a comprehensive, high quality health system also experience few financial, structural, and personal barriers to prevention and health promotion interventions. As a result, they are fully informed about choices that impact their health and are active participants in maintaining or improving their health. They live in a healthy community – one that has an identity and vision for the future, knows how to solve and prevent problems, and provides an environment that supports healthy choices such as walkable neighborhoods, healthy food choices, smoke-free environments, and protection from exposure to unnecessary toxic chemicals.

Second, there are issues of *measuring* access. Access to health care and prevention is not currently fully measured by many of our data systems. For instance, one common measurement of access to health care is the percent of a population who have health insurance. This statistic does not fully measure access to health care, yet we lack many other good measurements. So, for example, there is no ongoing Statewide system that tracks the percentage of people who lack dental insurance, who are underinsured, or lack access to health care because of transportation, cultural, language, informational, or structural barriers.

HOW DOES THE US RANK RELATIVE TO OTHER COUNTRIES?

COST:

#1 **The US ranks first in the world for dollars spent per capita for health, spending almost $3,800 per person per year.**

The second leading country only spends $2,600.

The average of the nearly 200 countries studied is $412 per capita per year.

The average of the top 10 countries for disability-adjusted life expectancy is $1,700 per capita per year.

#1 **The US also ranks first for total expenditure on health as a percent of gross domestic product.**

ACCESS:

#55 **The US ranks 55th for fairness of financial contribution to health systems. This ranking reflects how equitably people in a country contribute to health costs; with the US ranking poorly, in part, since a large proportion of households are at risk of impoverishment because of high levels of health expenditures.**

QUALITY:

#24 **Health attainment in the US, mostly measured as disability-adjusted life expectancy, ranks only 24th.**

#32 **The US ranks 32nd for equality of child survival because so many children in the US, particularly those living in poverty or who are minorities, do not have the same chances of survival as other children.**

As an example, national and State statistics show that close to 100% of people over the age of 64 have health insurance, typically Medicare, which would seem to indicate our seniors have excellent access to health care. Yet, we know that Medicare Insurance does not provide outpatient drug coverage as part of its standard plan. Because this is also the population most likely to need outpatient prescription drugs and to live with limited

incomes, this lack of pharmaceutical coverage is a major health care access issue for them. Yet, the statistics we depend on to measure access do not reflect this.

Improving access to and participation in health care and public health improves everyone's chances of living longer healthier lives, especially since we are all vulnerable to facing barriers to our health system. This makes access the one priority area that transcends and cuts across all others.

TEN ESSENTIAL PUBLIC HEALTH SERVICES:

There are ten essential public health services considered to be necessary for a population to have access to prevention. A comprehensive public health system needs to:

- **Monitor health status to identify community health problems**
- **Diagnose and investigate health problems and health hazards in the community**
- **Inform, educate, and empower people about health issues**
- **Mobilize community partnerships to identify and solve health problems**
- **Develop policies and plans that support individual and community health efforts**
- **Enforce laws and regulations that protect health and ensure safety**
- **Link people to needed personal health services and assure the provision of health care when otherwise unavailable**
- **Assure a competent public health and personal health care workforce**
- **Evaluate effectiveness, accessibility, and quality of personal and population-based health services**
- **Research for new insights and innovative solutions**

Source: Institute of Medicine Report, 1988.

PRIMARY

SECONDARY

TERTIARY

Strategies

Building Community Capacity: Develop initiatives to improve the abilities of people and organizations in every community to come together to plan and address health and other related issues such as the social determinants of health. An example is developing local attention to health, and where there is capacity, a local comprehensive community health initiative such as a Healthy Communities Coalition.

Building State and Local Public Health Capacity: Develop initiatives that improve the abilities of the State and communities to plan and address public health by assuring that the Ten Essential Public Health Services (see insert) are available for a regional geographical area and population.

Workforce Development: Assuring that populations have a trained public health and health care workforce is critical to improving access to health and prevention.

Access to Community Preventive Interventions: Fluoridation of drinking water, dental sealants in schools, community health screenings, and comprehensive school health education are some examples.

Access to Health and Dental Insurance: Initiatives that improve access to health and dental insurance are some examples.

Reducing Barriers to High Quality Care: Reducing barriers to health care such as financial barriers (having no health insurance or being underinsured), structural barriers (having no health care facilities or professionals nearby), and personal barriers (informational, prejudices experienced by sexual minorities, cultural differences, language differences, or environmental challenges for people with disabilities) are all strategies to assure improved access to care.

Improving Quality of Health Systems: Access to a *poor* quality system does not necessarily improve health status. Therefore, it is important to evaluate and improve the quality of our health systems through such strategies as tracking immunization levels and childhood lead screening rates.

Health Disparities

(Populations at risk for experiencing barriers to accessing health care and prevention, based on national data in *Healthy People 2010*)

- **Young Adults** (less likely to have a usual source of care; more likely to lack health insurance)
- **Elders** (less likely to have access to providers who can address their special needs; about 98% have Medicare Insurance, but this does not cover most outpatient services such as prescription drugs; more susceptible to medical errors and adverse medical events)
- **People with Disabilities** (face facilities that are not easily accessible; face lack of understanding from health care providers; more likely to face difficulties in obtaining ongoing appropriate health care; less likely to have effective prevention efforts focused on them)
- **Men** (less likely to seek health care, including prevention services; more likely to be uninsured)
- **Women** (longer lifespan with more multiple chronic diseases; more likely to be caregivers)
- **Uninsured and Underinsured Persons** (less likely to have a usual source of care)
- **Ethnic and Racial Minorities** (less likely to have access to culturally and linguistically appropriate prevention and clinical services; less likely to have a usual source of care; more likely to lack health insurance and untrained health care providers; more likely to have untreated dental caries; less likely to have research on health issues faced by them)
- **People Living in Rural Areas** (more likely to lack transportation; more likely to have health services located many miles from their home or work; less likely to access higher education, social services, livable wage jobs, adequate housing, and other community support)
- **Sexual Orientation Minorities** (less likely to have services that are sensitive to their needs)
- **People with Low Socioeconomic Status** (high rates of uninsurance – double the rate for those below the poverty level; less likely to have a usual source of care; more likely to have dental disease such as untreated caries; less likely to have effective prevention efforts focused on them)

"Health is the product of multiple levels of influence. These include genetic and biophysiological processes, individual behaviors, and the context within which people live – the sociocultural environment. A multilevel approach to community health requires us to take into consideration, and act upon, the way that the sociocultural environment affects health."

http://www.thecommunityguide.org

Objectives

Objective numbers are *Healthy People 2010* objective numbers.

- **7–10 (Developmental) Increase the number of communities in Maine that have a community health promotion program that addresses multiple *Healthy Maine 2010* Focus Areas.**

  Maine will identify criteria and surveillance systems to assess, at minimum, the number of service center communities with a community health promotion program.

  Community health promotion programs include all of the following: involved community participation with representatives from at least three of the following community sectors: government, education, business, faith organizations, health care, media, voluntary agencies, and the public; community assessment, guided by a community assessment and planning model, to determine community health problems, resources, perceptions, and priorities for action; targeted and measurable objectives to address any of the following: health outcomes, risk factors, public awareness, services, protection; comprehensive, multifaceted, culturally relevant interventions that have multiple targets for change; and monitoring and evaluation processes to determine whether the objectives are reached.

  Towns that meet Maine's definition of a service center community all have the potential to develop a community health promotion program, such as a Healthy Communities Coalition, and to link some of their goals to regional and State health plan goals. The State Planning Office has identified 95 service center communities throughout Maine that are area hubs which people live in or travel to for work, recreation, shopping, or obtaining services. In addition, all Maine communities can improve their

MAINE HEALTHY COMMUNITIES INITIATIVES

Name of Initiative	General Location
Micmacs On The Move	Aroostook Band of Micmacs
Southern Kennebec Healthy Communities	Augusta
Partnerships for Healthy Communities	Bangor
Healthy Communities Lake Region	Bridgton
Town of Bucksport Health Advisory Committee	Bucksport
Healthy Island Project	Deer Isle/Stonington
Union River Healthy Community Coalition	Ellsworth
Fairfield PATCH	Fairfield
Healthy Community Coalition	Farmington
St. John Valley PATCH	Fort Kent
Schoodic Healthy Communities Coalition	Gouldsboro
North Country Healthy Communities	Greenville
Vital Pathways	Houlton
Prevention Coalition	Indian Island/Penobscot Nation
Healthy Acadia	Mt. Desert Island
Healthy Community Coalition	Parsonsfield Area
Voices in Action: Healthy Communities of Sebasticook Valley	Pittsfield
Greater Portland Partners for Health	Portland
River Valley Healthy Communities Coalition	Rumford
Waterville PATCH	Waterville
Healthy Futures	Winthrop
Community Wellness Coalition	York

(These are community health planning initiatives known to the Bureau of Health. For more information, contact the Community Health Program in the Bureau of Health.)

capacity to bring people and organizations together to look at local health issues. Maine communities can also link with their Healthy Maine Partnerships (funded by the Fund for a Healthy Maine, Maine's share of the National Tobacco Settlement), which cover chronic disease prevention, in whose service areas nearly all Maine communities are covered.

- **(Developmental) 23–12 Increase the number of geographic areas in Maine that have a health improvement plan linked to *Healthy Maine 2010* goals and objectives.**

  Maine is one of the few states without a statewide system of local public health departments. Therefore, one of Maine's challenges is to build the capacity to assure that the 10 essential public health services are achieved for all geographic regions and all of Maine's populations. Maine Turning Point Project, a multi-year initiative funded by Robert Wood Johnson and housed at the Maine Center for Public Health, is looking at how best to address this challenge and working with the Bureau of Health and other public health partners to strengthen public health infrastructure.

HEALTHY MAINE PARTNERSHIPS:

Partnership For A Healthy Community, Presque Isle
Healthy Horizons, Waterville
ACCESS Health, Brunswick
Oxford Hills Coalition, Norway
PROJECT NOW: Northern Oxford Wellness, Rumford
St. John Valley Partnership, Madawaska
St. Croix Valley Healthy Communities, Calais
Choose To Be Healthy, York
S.P.R.I.N.T for Life, Lincoln
Power of Prevention Community Health Partnership Coalition, Van Buren
Healthy Androscoggin, Lewiston
Getting Healthy, Gardiner
Partners for Healthier Communities, Sanford
Downeast Healthy Tomorrows, Lubec
Katahdin Area Partnership, Millinocket
Healthy Acadia, Bar Harbor
TLC for Life Coalition, Newcastle
Healthy Community Coalition, Wilton
Healthy Peninsula Project, Blue Hill
Coastal Hancock Healthy Communities, Ellsworth
Knox County Coalition Against Tobacco (KCCAT), Camden
Coastal Healthy Communities Coalition, Biddeford
Healthy Living, Pittsfield
Communities Promoting Health, Portland
BodySmart, Bridgton
Somerset Heart Health, Skowhegan
Piscataquis Public Health Council, Dover-Foxcroft
Bangor Region Partners for Health, Bangor
Healthy Living Project, Belfast
STOP, Houlton
Campaign for a Healthy Portland, Portland
(All 31 are funded by tobacco settlement dollars.)

MAINE CENTER FOR PUBLIC HEALTH

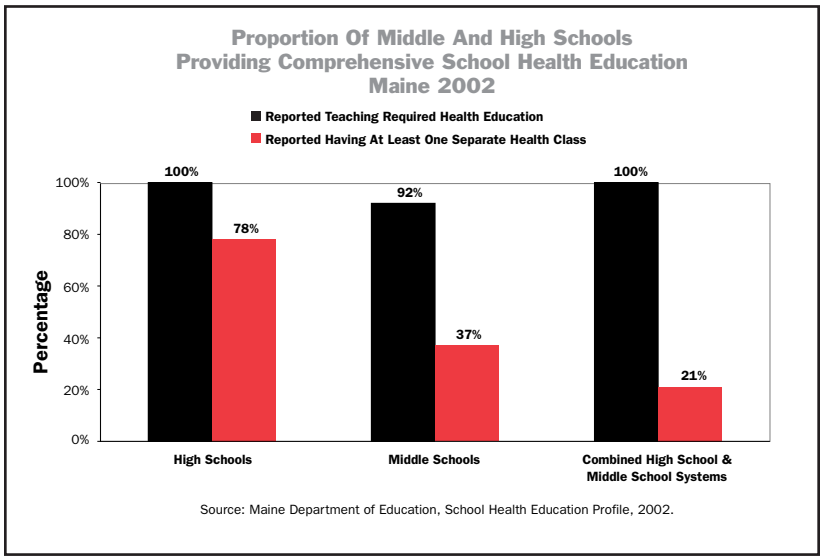
As a result of a recommendation from the Health Care Reform Commission, the Maine State Legislature established the Maine Center for Public Health in 1996 as a private nonprofit organization "to improve the health of Maine citizens through an organized program of policy analysis, education/training, technical assistance, and research." Founded in 1998 as a public-private collaborative, the Center works in partnership with State agencies, Statewide organizations, and community-based organizations.

It is important that all Maine residents have access to the benefits of a well-functioning public health system. Many became acutely aware of the critical importance of building the capacity to respond to public health challenges at the local and state levels during the national anthrax attacks in the fall of 2001, following the September 11 attacks. Maine experienced over 500 possible anthrax incidents that required processing and testing of suspicious substances. All substances tested were negative for anthrax and no one in Maine was diagnosed with the infection. However, the ability to respond to these attacks was limited. For instance, the capacity for local and Statewide health communication and information dissemination, especially to and from health care providers and emergency response agencies, was overcapacity for weeks. Fortunately, some Federal funds are assisting in helping Maine build local and State public health capacity to address challenges posed by public health emergencies.

For related information, see Infectious Disease Chapter objective: "Increase the number of geographic areas in Maine that provide comprehensive epidemiology services to support essential public health services."

- **7–2 (Developmental) Increase the proportion of middle, junior high, and senior high schools that provide comprehensive health education.**

The School Health Education Profile was administered in the spring of 2002 to middle and high school principals with an 86% response rate. Data are reported separately for stand-alone high schools, stand-alone middle schools, and combined high school/middle schools. This survey was a step in developing mechanisms to measure this objective.



Source: Maine Department of Education, School Health Education Profile, 2002.

Comprehensive School Health Education (CSHE) includes curriculum, instruction, and assessment that is sequential from kindergarten through high school and that meets the health education standards outlined in the Maine Learning Results. CSHE addresses the physical, mental, emotional, and social aspects of health and provides knowledge and skills that promote and enhance lifelong healthy behaviors. CSHE is also most effective when delivered in the context of a coordinated school health program.

- **21–14 (Developmental) Increase the geographic areas in Maine that have comprehensive oral health initiatives that include such components as school-linked oral health programs, community water fluoridation, and nonprofit dental centers.**

Current information indicates our Healthy Maine baseline is about 25% of the State that have such initiatives.

Oral health is part of our total health, and untreated oral disease has many serious negative economic and social consequences, as well as adverse impacts on physical health. However, there is no ongoing Statewide surveillance system to monitor oral health status. For instance, oral health conditions, other than oral cancer, are not reportable and there is no system such as our hospital discharge data system to track the incidence or prevalence of dental diseases.

Although there is no mechanism to monitor oral health status, we can measure some of the infrastructure necessary to improve oral health. For instance, we can count and track the number of community interventions that increase access to dental care, fluoridation, sealants in children, and other population-based interventions that are critical to improving oral health status.

The disease burden of dental caries is especially noteworthy because it is largely preventable through community-based initiatives that optimize the use of fluoride and dental sealants, which in combination are often referred to as an "immunization" against tooth decay for children.

What is the current state of some of these population-based interventions in Maine? Currently, there are only 13 nonprofit dental centers throughout the State, but with new State and private funding, three additional ones are expected to open by the end of 2002. There are also some nonprofit clinical facilities sponsored by the Maine Department of Behavioral and Developmental Services as well as the Indian Health Service.

In terms of dental sealant initiatives, about 40% of elementary schools have a State-funded oral health program that provide services (including sealants) to almost 50,000 children. In terms of fluoridation, an important intervention that prevents caries, about 75% of Maine people on public water supplies currently receive fluoridated water. But since over half

(56%) of Maine people use private wells for their drinking water, this means that up to 67% of Maine's total population do not have fluoridated water in their homes (some well water has fluoride naturally).

Community-based, nonprofit dental centers and school-linked programs focus on local needs to improve oral health and prevent dental disease. Community-based prevention initiatives, such as water flouridation and school-linked oral health programs providing sealants and other preventive services, are critical strategies in improving our oral health.

- **(Developmental) Increase the number of dental providers (private practices or health centers or dental clinics) located in designated Dental Health Professional Shortage Areas where Medicaid-eligible (MaineCare) individuals are able to receive dental care.**

The Bureau of Health is working on ways to measure and track this objective. See accompanying table on Maine's Dental Care Analysis Areas.

MaineCare (Maine's Medicaid Program) covers preventive and routine dental services for children under 21, but only a few dental services are covered for adults, and only under certain urgent care guidelines.

The ability of MaineCare to improve access to dental care is constrained by a number of factors, including: a shortage of practicing dentists; the limited number of dentists accepting MaineCare patients; patient-missed appointments that cannot be reimbursed by MaineCare; and paperwork required by MaineCare that is viewed as cumbersome by some providers.

To improve this situation, recent changes in Maine's regulations facilitate the ability of dental hygienists to work in public health settings; i.e., to provide preventive services that otherwise would not be available. MaineCare has also worked to reduce the burden of paperwork and to

MAINE DENTAL CARE ANALYSIS AREAS (DCAA)

DCAA NAME	TOTAL NUMBER OF DENTISTS	POPULATION PER FTE DENTIST	FTE DENTISTS PER 100,000 PEOPLE	SHORTAGE AREA DESIGNATION STATUS
York	9	2,228	44.9	
Biddeford	25	3,299	30.3	
Sanford	12	4,188	23.9	X (LI)
Portland	142	2,313	43.3	X (LI) (city of Portland)
Gorham	10	3,581	27.9	
Parsonsfield	1	6,475	15.4	X
Bridgton	5	3,350	29.8	X (LI)
Brunswick	19	2,770	36.1	
Bath	9	2,732	36.6	
Damariscotta	7	3,277	30.5	X (LI)
Rockland	17	2,470	40.5	X (LI) (Pen Bay Islands)
Belfast	7	3,219	31.1	X (LI)
Lewiston	34	3,274	30.5	X (LI)
Norway	5	3,745	26.7	X (LI)
Fryeburg	2	2,439	41.0	X (LI)
Jay	2	7,810	12.8	X
Farmington	7	2,730	36.6	X (LI)
Bethel	1	4,850	20.6	X (LI)
Rumford	7	2,887	34.6	X (LI)
Kingfield/Rangeley	1	5,381	18.6	X
Gardiner	7	4,618	21.7	X (LI)
Augusta	19	2,288	43.7	X (LI)
Waterville	25	4,598	21.7	X (LI)
Pittsfield	4	3,642	27.5	X (LI)
Skowhegan	9	6,706	14.9	X (LI)
Bingham	0	0	0.0	X
Jackman	0	0	0.0	X
Millinocket/Lincoln	8	3,182	31.4	X (LI)
Grnvil/D-F/Milo	7	4,963	20.2	X (LI)
Corinth/Bangor	34	2,943	34.0	X (LI)
Howland/Old Town	1	22,577	4.4	X (LI)
Bucksport	1	8,002	12.5	X (LI)
Blue Hill	4	3,169	31.6	X (LI)
Ellsworth	8	3,616	27.7	X (LI)
Bar Harbor	4	3,853	26.0	
Goulds/Mlbrdg	3	3,381	29.6	X (LI)
Jonespt/Machias	2	7,246	13.7	X (LI)
Lubec/Eastpt	1	6,193	16.3	X
Calais	4	4,539	22.5	X (LI)
Vanceb/Danfrth	0	0	0.0	X
Island Falls	1	3,895	25.7	
Houlton	7	1,674	59.7	
Mars/Ash/FtFrf	3	9,200	10.9	X (LI)
VBuren/FtKent	2	7,933	12.6	X
Allagash	0	0	0.0	X
Berwick	5	4,993	20.0	
STATE TOTAL	**481**	**3,320**	**30.1**	

Augusta Mental Health Institute	Designated Facility
Bangor Mental Health Institute	Designated Facility
Penobscot Indian Reservation-Old Town	Designated Population
Houlton Band of Maliseets	Designated Population

FTE = Federally-weighted full-time equivalent
X = Dental care professional shortage area
(LI) = Shortage area is designated in part because of low income
Population data are from 1998.

In Maine:

There are close to 600 practicing dentists, over 700 practicing dental hygienists, and at least 1,000 practicing dental assistants. The ratio of dentists in Maine is lower than the national average (about 44/100,000 compared to 48/100,000 nationally). There has been a 3% decrease in dentists per capita in Maine over the past 10 years, compared to a decrease of 12% nationwide.

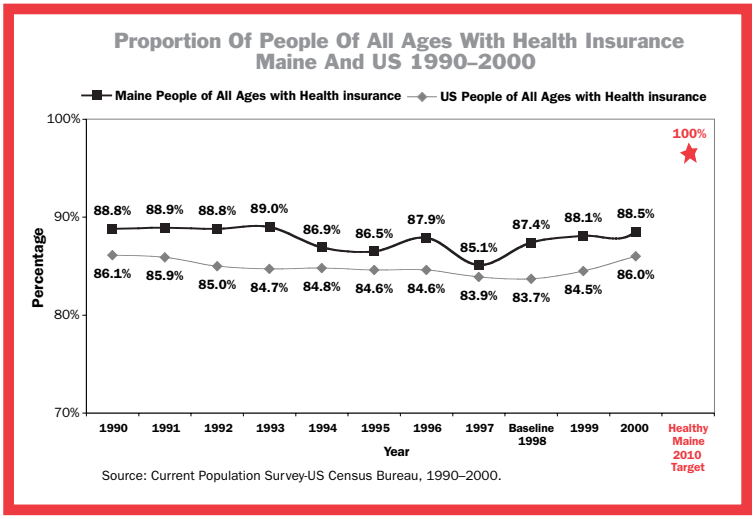
assist with those who miss appointments. Medicaid reimbursement rates were increased in 1998, resulting in a 100% increase in the total amount of dollars reimbursed for dental care. Although dental reimbursements by MaineCare are now about average for the US, many dentists report they do not cover the direct costs of providing care. In 1999, the Maine Legislature created the Maine Dental Education Loan Program, offering financial support for dentists or dental students in exchange for service in underserved areas of the State.

Maine, like 80% of all states, is still challenged by a lack of dentists who accept patients with Medicaid (MaineCare) Insurance. This appears to be an ongoing challenge, since in some areas of our State there is such a lack of dentists that it is difficult to find one who has openings for any new patients, regardless of insurance status.

- **1–1 Increase the proportion of persons with health insurance.**

1–1a Increase the proportion of people of all ages with health insurance.

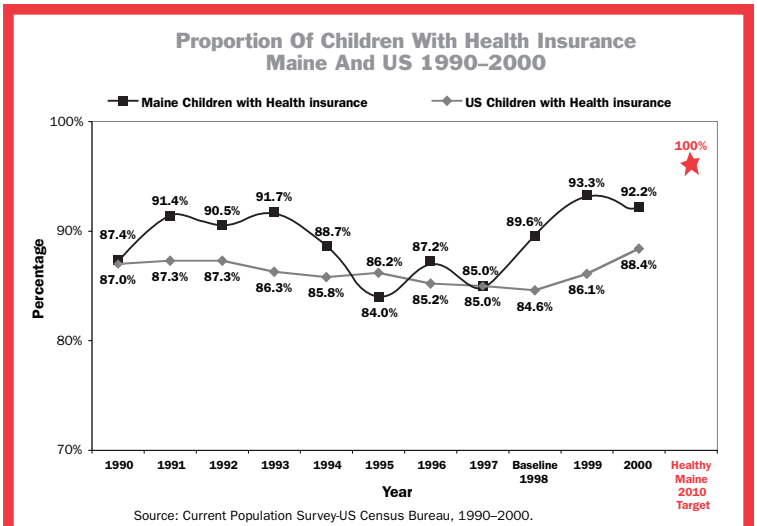
Healthy Maine 2010 Baseline: 87.4%
Healthy Maine 2010 Target: 100%



Source: Current Population Survey-US Census Bureau, 1990–2000.

1–1b Increase the proportion of children with health insurance.

Healthy Maine 2010 Baseline: 89.6%
Healthy Maine 2010 Target: 100%



Source: Current Population Survey-US Census Bureau, 1990–2000.

WHAT ARE MEDICARE, MEDICAID, and MAINECARE?

Medicare: The Federal health insurance program for people age 65 and older and certain people with disabilities or end-stage renal disease. Unlike Medicaid, Medicare is administered by the Federal government. Part A of Medicare covers hospital inpatient services, home health services, limited skilled nursing facility services, and hospice care. Part B covers physician services, hospital outpatient care, laboratory services, durable medical equipment, and other ambulatory care.

Medicare does not cover most nursing home care or other long-term care services, or most outpatient prescription drugs. Medicare covers only about half the health care expenditures of older Americans. About 5% of the nation's nursing home bills are covered by Medicare, compared to about 50% by Medicaid.

Medicaid: Primarily a health insurance program for low-income parents (mostly mothers) and children; a long-term care program for elders; and a funding source for services to people with disabilities.

In Maine, children and women make up about 70% of Medicaid enrollees, and account for about 30% of the expenditures. Likewise, elders and the disabled account for 30% of enrollees and 70% of the expenditures (see pie charts on the following page).

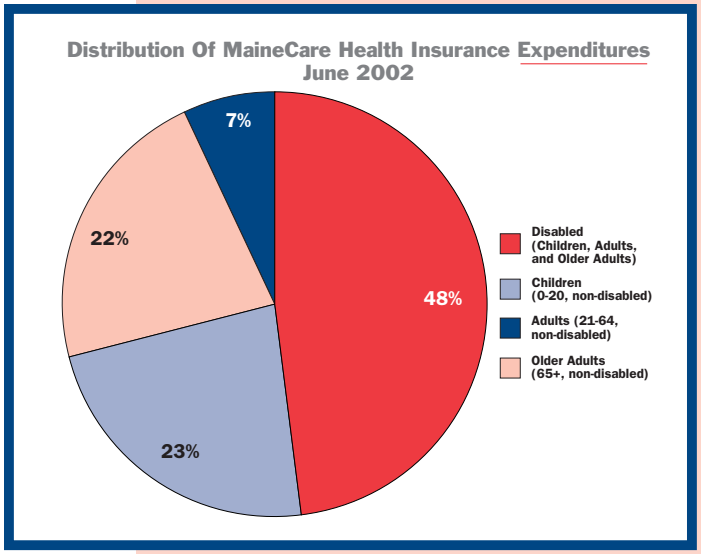
Medicaid covers about 40% of all births (pregnant mothers and newborns) in Maine and the US. Medicaid accounts for about half of all nursing home expenditures nationally, and covers about two-thirds of all nursing home residents who are elders. Medicaid pays for about one-third of the nation's medical bill for the disabled population. Disability for Medicaid eligibility is based on Federal Supplemental Security Income (SSI) program's criteria. Over half of the people eligible for Medicaid because of a disability have a mental disorder disability.

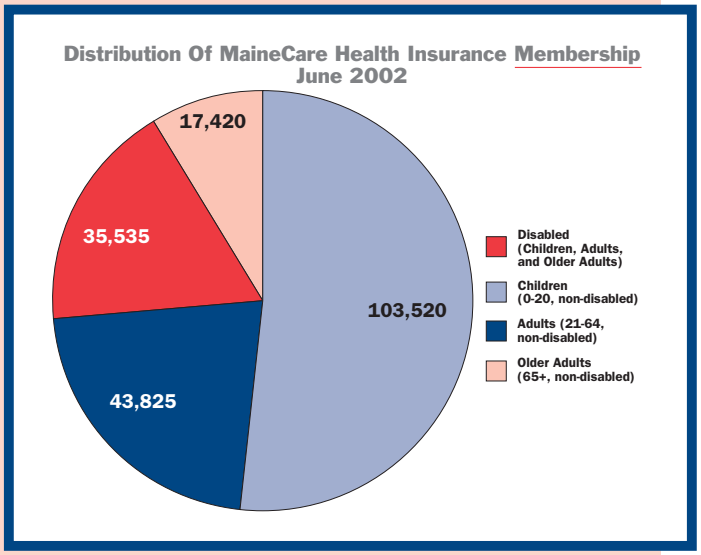
Upper Income Limit Federal Poverty Level (FPL)*	MaineCare Product	Population Eligible
300%	Healthy Maine Prescriptions	People without prescription drug coverage
250%	Many MaineCare Benefits including prescription drugs, most inpatient and outpatient care	People infected with HIV
250%	Full MaineCare Benefits (health insurance and pharmaceutical coverage)	Adults working with a disabling condition (according to Social Security Social Security Administration Administration criteria)
250%	Full MaineCare Benefits	Women ages 40–64 with breast or cervical cancer without health insurance
200%	Full MaineCare Benefits	Pregnant women and children age 0–18
185%	Low Cost Drugs Program, also known as Drugs for the Elderly. Part of Healthy Maine Prescriptions	People over age 64 or with certain disabilities
150%	Full MaineCare Benefits	Parents of children under age 18 and young adults ages 19–20
100%	Full MaineCare Benefits	Childless adults ages 21–64
100%	Full MaineCare Benefits	Over age 64 or disabled and not a wage earner

*Note: Eligibility is sometimes available to people earning more than these income limits because of allowable deductions.

Created as Title XIX of the Social Security Act of 1965, Medicaid is a joint Federal and State program administered by the states and funded by both. In Maine, about two-thirds of services reimbursed by Medicaid are paid by the Federal government, and one-third by State taxpayers. As of July 2002, Medicaid in Maine is known as MaineCare.

MaineCare: As of July 2002, MaineCare is the new name for Maine's Department of Human Services' health insurance coverage programs. MaineCare is the new name for a variety of different products and programs, including: Medicaid, Cub Care, Maine PrimeCare, HealthWorks, MaineNet,





Medical Eye Care, and EPSDT (Early Periodic Screening, Diagnosis, and Treatment Services). Healthy Maine Prescriptions is also a MaineCare product.

Since the State expanded health insurance coverage in 1998, more than 50,000 people who previously did not have health insurance are now covered by MaineCare. 30,000 of these are children. As a result, Maine now has one of the highest rates of insured children in the country.

Healthy Maine Prescriptions: As of July 2002, 114,000 Maine people are enrolled in Healthy Maine Prescriptions, a State program that offers its participants prescription drug discounts, usually about a 25% discount, generally based on the price pharmaceutical manufacturers are reimbursed by the State's Medicaid program. Drugs for the Elderly and Disabled (low-cost drugs program) is a program component with approximately 36,000 enrollees that offers steeper discounts for qualified people.

Federal Poverty Levels (as of February, 2002) by Monthly Income

Family Size	100% FPL	150% FPL	200% FPL	300% FPL
1	$739	$1,108	$1,477	$2,215
2	$995	$1,493	$1,990	$2,985
3	$1,252	$1,878	$2,504	$3,755
4	$1,509	$2,263	$3,017	$4,525

MAINE'S HEALTH CARE SKILLED WORKER SHORTAGE

Maine, like the rest of the nation, is experiencing a shortage of skilled health care workers. According to a September 2001 Maine State Chamber of Commerce and Maine Technical College System survey, respondents from hospitals, long-term care facilities, and home health care services will need 1,584 additional registered and licensed practical nurses by the end of 2002, yet Maine schools will graduate only 531. Additionally, over 400 other health care workers will be needed in eight other skilled worker professions, yet only 108 graduates are projected. According to a March 2001 Maine Hospital Association survey, 60% of responding hospitals indicated they believe radiology technicians and laboratory technicians to be among the greatest recruitment needs. Pharmacists and pharmacy technicians are also in severe shortage. According to a September 2001 Maine Hospital Association survey, over two-thirds of responding hospitals (68%) felt the workforce shortage has affected access to health care.

Not having health insurance is a major public health issue throughout the US. An estimated 43 million Americans, as well as approximately 128,000 adults and 19,000 children in Maine lack health insurance. A recent Institute of Medicine Report ("Care Without Coverage: Too Little, Too Late", 2002) estimates there were more than 18,000 excess deaths among uninsured Americans in 2000, compared with people with health insurance. As a proportion of the US population, this would be an estimated 72 excess deaths in Maine. In this study, people experiencing even a short interruption in coverage had a decline in their health.

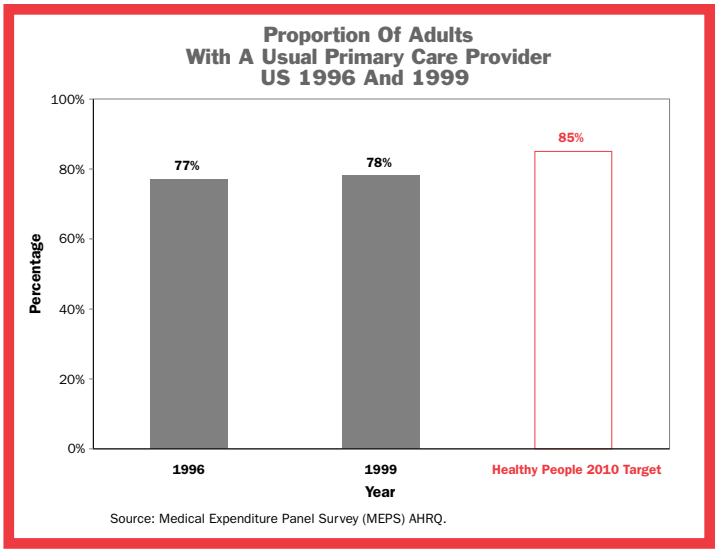
Maine adults who do not have health insurance are more likely to have a lower household income, less formal education, and be younger than Maine adults with health insurance. One-quarter of Maine adults without health insurance have a household income of less than $25,000 (while only 3.6% of Maine adults with a household income of greater than $50,000 lack health insurance). One-quarter of Maine adults without health insurance did not complete their high school education (while over 4% of Maine adults with a four-year college degree lack health insurance). One-fifth of Maine adults without health insurance are 18–34 years old (Me BRFSS).

What about uninsured children in Maine? An estimated 85% of uninsured children in Maine live in households with working parents who are likely to be seasonally employed, employed on a part-time basis, or self-employed. The strongest predictor of uninsurance among Maine children is the self-employment status of the head of the household. The second strongest predictor of uninsurance is the parents' employment in firms with 2 to 25 employees. Seven percent of uninsured Maine children do not have a regular source of health care, whereas all the publicly insured children reported a regular source of care. More than half of uninsured Maine children had not received dental care in the previous 12 months (Maine DHS/Muskie study "Health Insurance Among Maine's Children", 2000). Fortunately, Maine's proportion of children who have health insurance is one of the best in the country, mainly as a result of MaineCare (Medicaid and Cub Care) expansions in 1998.

One major limitation of this objective is that there is no agreement in defining a standard for minimum health insurance benefits. Without this standard, we can only measure the proportion of the population that is insured or not insured, but not those who are underinsured or who have full benefits. Currently, many with health insurance are felt to be underinsured; i.e., they have health insurance but because it is minimal coverage they may face significant financial barriers to accessing appropriate care.

"Ultimate responsibility for the performance of a country's health system lies with government. The careful and responsible management of the well-being of the population – stewardship – is the very essence of good government. The health of people is always a national priority: government responsibility for it is continuous and permanent … Dollar for dollar spent on health, many countries are falling short of their performance potential. The result is a large number of preventable deaths and lives stunted by disability. The impact of this failure is born disproportionately by the poor."

World Health Report 2000, page viii



Source: Medical Expenditure Panel Survey (MEPS) AHRQ.

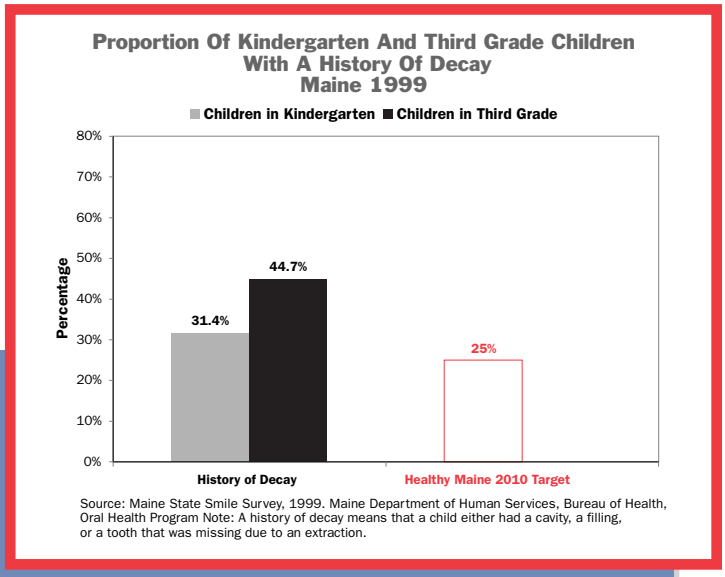
- **1–5 (Developmental) Increase the proportion of persons with a usual primary care provider.**

  Healthy People 2010 Baseline: 77%
  Healthy People 2010 Target: 85%

  The Bureau of Health hopes to develop a mechanism for tracking this objective in Maine.

  Having a usual source of primary care helps people to have their health issues identified early and helps direct them to appropriate care. Primary care providers are often physicians (MD or DO) who are family physicians, pediatricians, or internists; nurse practitioners (NP); or physician assistants (PA). Evidence suggests that having a primary care provider gives greater continuity of care as well as less costly medical care.

  Barriers such as lack of health insurance and provider shortages commonly prevent people from having a primary care provider. Placements of primary care providers through such programs as the National Health Service Corps, the foreign-trained physician program (J1 Waiver Program), and the State's agreements with medical schools (such as with the University of Vermont, University of New England, and Dartmouth) have helped increase the number of primary health care providers in areas of Maine that have historically demonstrated severe shortages such as Aroostook, Waldo, and Washington Counties.



Source: Maine State Smile Survey, 1999. Maine Department of Human Services, Bureau of Health, Oral Health Program Note: A history of decay means that a child either had a cavity, a filling, or a tooth that was missing due to an extraction.

- **21–1b Reduce the proportion of children with dental caries experience in their primary teeth.**

  Healthy Maine 2010 Baseline: 31.4%, 44.7%
  Healthy Maine 2010 Target: 25%

  Of the kindergartners screened in the Smile Survey, 31.4% had a history of dental caries. Of the third graders, 44.7% had a history of dental caries.

  Dental caries is the most common disease of childhood. School-aged children from

In Maine, of the 58,000 people employed in the health sector (10.4% of the total workforce), there are approximately:

2,850 active patient care physicians (2,500 MDs and 350 DOs) – a ratio of about 223 per 100,000 population (223/100,000), which is lower than the national ratio of 266/100,000;

1,230 active primary care physicians – a ratio of 96/100,000 population, compared to 100/100,000 nationally;

370 physician assistants – a ratio of 29/100,000 population, more than twice the national average of 14/100,000; and

670 nurse practitioners – a ratio of 52/100,000 population, much higher than the national average of 28/100,000.

Source: Maine DHS and Maine Department of Financial and Professional Regulation, 1999.

lower-income Maine households have poorer oral health status than do children from higher-income households. Poor oral health in young people as well as in adults may result not only in eventual tooth loss but also in impaired general health, compromised nutrition, days lost from school and work, and a compromised ability to obtain or advance in education and employment.

Dental disease often decreases our ability to maintain proper nutrition and to communicate effectively. Untreated dental disease can have many serious negative consequences, and a negative effect on our chances and achievements in school, social life, and employment. For example, people with dental caries or missing teeth sometimes report being unable to find a job or to get a better job because of their appearance.

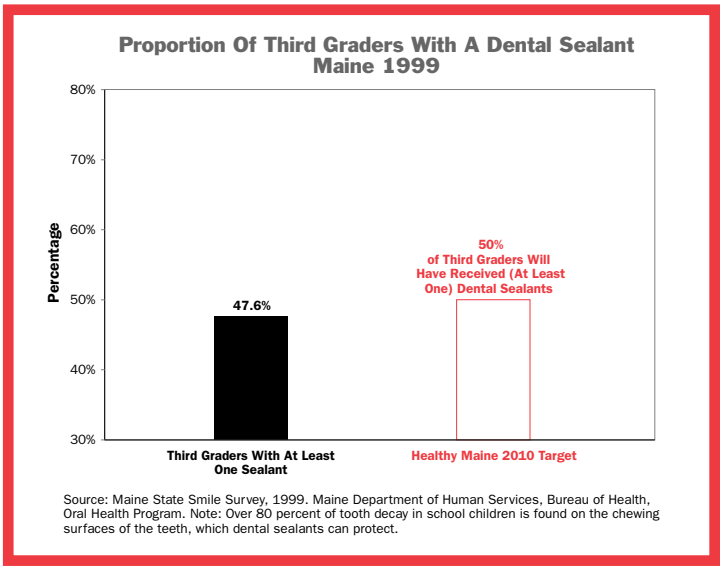
Determinants of poor oral health include poor nutrition, poor hygiene, behaviors such as tobacco addiction or excessive alcohol consumption, or lack of community interventions such as water fluoridation or sealants, and lack of regular access to professional dental care.

- **21–8 Increase the proportion of children who have received dental sealants on their molar teeth.**

  Healthy Maine 2010 Baseline: 47.6%
  Healthy Maine 2010 Target: 50%

  The 1999 Smile Survey revealed that 47.6% of third graders had at least one sealant on a permanent tooth. It was also shown that 56.8% of third graders were in need of dental sealants including additional ones in those with sealants. Since school-based dental sealant programs still account for a smaller number of the sealants being placed, it can be assumed that most of the sealants observed were placed in the dental office.

  Sealants are a plastic material that is applied to the chewing surfaces of the molar teeth to protect against decay. Sealants are most effective when applied soon after the molars erupt. For first molars, this is age 6–8 and age 12–14 for second molars.



Source: Maine State Smile Survey, 1999. Maine Department of Human Services, Bureau of Health, Oral Health Program. Note: Over 80 percent of tooth decay in school children is found on the chewing surfaces of the teeth, which dental sealants can protect.

- **(Developmental) Improve access to end-of-life care.**

  With quality accessible hospice care, many people may be able to spend their final days in comfort and in a setting of their choice. For some, this might mean spending this time pain-free and in the comfort of their homes. However, many people coping with a terminal illness face significant barriers to desired end-of-life care. Financial barriers, health care provider knowledge, and lack of available hospice personnel are just some of these barriers.

  Significant strides were achieved by legislation passed in 2001 that helped reduce financial barriers by requiring health insurance policies in Maine to reimburse for hospice care for those who are terminally ill, and increasing the reimbursement providers receive from MaineCare Insurance (at that time, Medicaid). This legislation also established the Maine Center for End-of-Life Care to centralize education and research regarding quality end-of-life care. (See profile on Joe Mayo.) An objective related to improving access to end-of-life care will be developed with the Maine Center for End-of-Life Care, which is housed in the Maine Hospice Council, since there are no related *Healthy People 2010* objectives.

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