



AN ABSTRACT OF THE THESIS OF

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Title: Seeking Primary Care in Oregon: Utilization of the Emergency Room Services  
in a Salem Hospital

Abstract approved:

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Sunil Khanna

This thesis examines how changes made to the Oregon Health Plan (OHP) in 2003 impacts those now utilizing the emergency room (ER) for primary health care. This thesis also examines how these changes impact staff members working in the ER of Salem Hospital. Through the utilization of qualitative research methods, this study finds that changes made to the OHP have greatly impacted those with reduced health care coverage as well as those without any health care coverage. Guided by the theories of Critical Medical Anthropology (CMA) and structural violence this study finds that patients experience a loss of personal agency, feelings of hopelessness, and diminished social capital. Not understanding the policy of the OHP the ER staff places blame on OHP recipients, seeing them as abusing the system. The conclusion drawn from this study is that the implemented policy changes to the OHP set into motion a cycle that perpetuates the health disparities that result from income disparity.

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Seeking Primary Care in Oregon: Utilization of the Emergency Room Services in a  
Salem Hospital

by

Elizabeth A. Young

A THESIS

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I understand that my thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

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Elizabeth A. Young, Author

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# TABLE OF CONTENTS

	<u>Page</u>
Chapter 1 – Introduction.....	1
Research Site.....	4
The History of the Oregon Health Plan.....	6
Why Patients Visit the Emergency Room.....	10
Health Disparities.....	12
Chapter 2- Theoretical Foundations and Methods Used in the Study.....	17
Theoretical Framework.....	17
Data Collection.....	21
Limitations of Methods Used in the Study.....	23
Participants-Patients.....	24
Participants-Staff.....	25
Data Analysis.....	26
Limitations.....	28
Chapter 3 –Patient Results.....	31

## TABLE OF CONTENTS (Continued)

	<u>Page</u>
Personal Agency.....	31
Community Health.....	34
Feelings of Suffering, Hope, and Hopelessness.....	39
Chapter 4 – Staff Results.....	43
Quantitative Results.....	43
Qualitative Results.....	44
Recommendations from Staff.....	51
Chapter 5 –Recommendations and Conclusion.....	55
Recommendations.....	56
Conclusion.....	59
Bibliography .....	62
Appendix.....	69



## LIST OF FIGURES

<u>Figure</u>	<u>Page</u>
1. Layout of Salem Emergency Department.....	4
2. Summary of Staff Survey Results (table).....	44
3. Cycle of Health Disparities.....	56

# **Seeking Primary Care in Oregon: Utilization of the Emergency Room Services in a Salem Hospital**

## **Chapter 1-Introduction**

The emergency room (ER) of American hospitals is portrayed in night time dramas and reality documentaries as a chaotic place only visited for urgent situations that require immediate care. Nurses run to help the gravely injured, the incapacitated, and those dancing in the state between life and death. Doctors race from patient to patient ordering medicine, examining charts while trying to deduce the condition of the patient, and occasionally commanding that a task must be done “STAT.” The ER is the last place most people want to be but for some it is the only option to receive primary health care.

The recently changed policy of the Oregon Health Plan (OHP), a system created to provide health coverage, drives people to rely on the ER for primary care. With an influx of primary care patients visiting the ER for care the staffs of Oregon’s ERs are overworked and frustrated. Patients visiting the ER because they have nowhere else to turn are victims of these policy changes, feeling helpless and disillusioned. Perhaps Gary<sup>1</sup>, a 37 year old man visiting the ER for primary care sums it up best: “Feeling bad makes everything seem helpless but I’m in a place where OHP has made it clear that I am helpless and I feel hopeless.” Gary’s statement illustrates the lived experience of policy change that is rarely explored.

The state of Oregon implemented a pioneering program, the OHP, in 1994 to help many of its citizens have access to health care (Department of Human Services

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<sup>1</sup> Names have been changed

2006). The OHP, the state's Medicaid program that relies on a prioritized list of health conditions and treatments, (Oberlander 2006) effectively qualified 100,000 individuals in addition to the already eligible 250,000 individuals covered by Medicaid. While successful in aiding the uninsured to obtain health insurance, a high unemployment rate resulting in diminished income tax revenue led the state to issue severe cutbacks to the Oregon Health Plan in 2003 (Lowe 2006).

Utilizing payer mix reports and case mix reports, Lowe and colleagues (2006) conducted a study on the impact changes made to the OHP has on visits to the ER. Lowe et al. (2006) finds that 32% of ER visits were by OHP recipients after policy changes down from 38% prior to policy changes. In addition, 18% of visits to the ER were by uninsured patients prior to policy changes. This number increases to 22% after policy changes were implemented in March of 2003. Lowe et al. (2006) relies primarily on quantitative data that, while important, is unable to account for the personal stories, viewpoints, and opinions of those seeking health care in Oregon. While Lowe's study provides valuable insight into the impact of policy change, it does not examine the human experience. My study fills this gap by striving to understand how policy change impact the lives of those who are uninsured in Oregon, which is vital in understanding the current state of health care. The following study attempts to understand how changes to the OHP impact those relying on the ER for primary care from the perspective of both patients and staff members at one hospital's emergency room.

The purpose of my study is to understand how implemented changes made to the OHP have impacted those who utilize the ER for primary care and the perspective

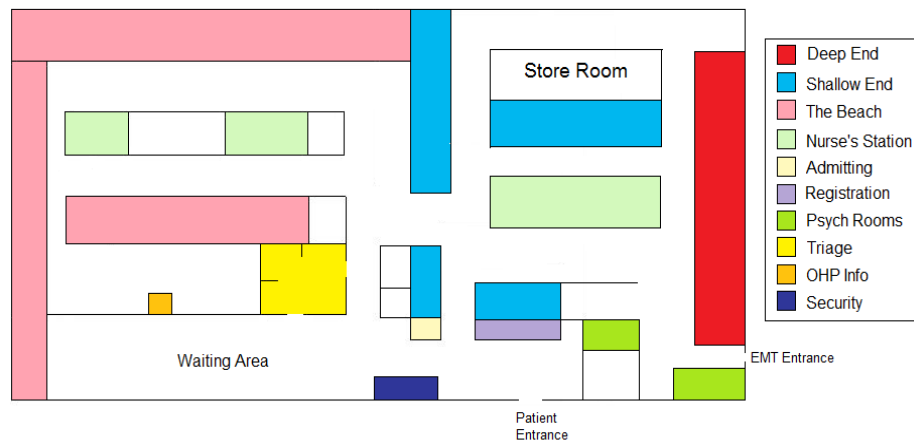
of hospital staff. Primary care administered in the ER is neither a sufficient way of delivering efficient care (Spillane et al. 1997) nor is it cost effective (Oetjen and Rotarius 2002). The ER serves as a valuable safety net for vulnerable populations who have nowhere else to turn for primary care and vulnerable populations seeking treatment in the ER are at higher risk of receiving substandard care (Mechanic and Tanner 2007). This study attempts to explore the lived experience of policy change as it impacts those utilizing the ER for primary care as well as those who are working in the system treating primary care seekers. Guided by the theoretical models of critical medical anthropology (CMA) and structural violence, this study examines the interaction of political economic structures of policy and the resulting outcome of policy implementation from the perspective of patients and hospital staff. My study is important because it relies on the use of mixed anthropological research methods lending an understanding of the impact policy implementation has on the human experience. Interviews with patients and qualitative surveys distributed to the staff allow for the exploration of the impact of policy. In my study the numbers of quantitative data are complimented by the voice of qualitative data, allowing for a better understanding of how policy of the OHP impacts those now coping with policy changes. The creation of policy inherently contains a significant human component (Ervin 2005) that must be accounted for. My utilization of anthropological research methods in this study allows for the impact of policy to be understood in terms of those who are directly impacted. Those who create policy are often removed from the arenas in which the ramifications of policy are felt creating a great need for the story of those impacted to be told. In this thesis I argue that implemented policy changes of

the OHP create a cycle that perpetuates and reinforces the health disparities of the vulnerable population of the poor.

## Research Site

I worked as a “Family Patient Liaison” in the emergency department of Salem Regional Hospital for the completion of my internship requirement. Located near the downtown area of Salem and minutes from the state capitol, the emergency room of Salem Hospital serves more than 65,000 people each year. The layout of the emergency department of Salem Hospital is below:

Figure 1. Layout of Salem Hospital Emergency Department



The entrance of the department is dedicated to the admitting station, the waiting area, and the nursing triage area. The back area of the department is where the doctors and nurses treat patients. This area is divided into three sections based on severity of patient conditions. One staff member described this back area as “the deep end, the shallow end, and the beach.” The deep end correlating with those patients

requiring immediate attention, the shallow end for patients in critical condition, and the beach for the area where non-severe and primary care patients are placed.

As a “Family Patient Liaison” I was responsible for helping the admitting clerk register patients, helping patients feel at ease while waiting to be seen in the triage area of the ER, and helping to keep family members in touch with patients who have been admitted to the hospital. My time as a “Family Patient Liaison” allowed me to connect with the staff members and to observe firsthand how many patients utilize the ER for primary care and begin to understand the impact policy changes have on the lived experience. Being a “Family Patient Liaison” allows for first-hand experience in an ER that continually sees Oregonians seeking primary health care. Interning in an ER with so many patients seeking primary health care brought to light the concern of why so many are forced to turn to an establishment intended to treat those in dire need of emergency care. Many staff members of the hospital assume that uninsured patients visit the ER simply because they can. Serving as a “Family Patient Liaison” allowed me to see that many patients visit the ER because they have nowhere else to turn for health care.

Having worked as a “Family Patient Liaison” and interacting directly with those seeking care in the ER I wanted to understand the perspective of the patients and explore this disconnect between the staff and the reality of the policy of the OHP. Because the discipline of anthropology is “the holistic and comparative study of people, or, more properly, humankind,” (Brown 1998:1) it lends itself to the understanding of issues through the exploration of the human experience and how the human experience is impacted by social structures and the role of power. More

specifically, medical anthropology attempts to “understand the causes of health and illness in societies” (Brown 1998:1) and the ways in which “health is influenced by the environment, our genetic inheritance, and, most importantly, our socioeconomic circumstances,” (Brown 1998:1). The way in which the uninsured in Oregon are impacted as a result of policy change is often represented through the utilization of quantitative data, giving no credence to the lived experience.

## **The History of the Oregon Health Plan**

### ***Creation of the Oregon Health Plan***

Governor Neil Goldschmidt appointed a group of concerned citizens in 1987 as a response to the massive number of uninsured Oregonians. The group became the first step toward the recognition of health care problems. Comprised of lawmakers, politicians, business leaders, consumers, and insurers, this group encompassed individuals from different sectors of society (Oregon Blue Book 2007). Headed by then Senator and emergency room physician, John Kitzhaber, this group set out with a goal “to keep Oregonians healthy through an explicit health policy and equitable means of allocating health care resources within the state,” (Oregon Blue Book 2007:13).

Legislation passed as a result of the efforts of this group between the years of 1989 and 1993 came to be known as the Oregon Health Plan: a creative plan in universal health care. The appointed group of concerned citizens outlined the major goals and purpose of the OHP: all citizens should have universal access to a basic level of care, society is in charge of financing care for the poor, basic levels of care

must be defined through an appropriate process based on a publicly debated criteria, care should reflect a consensus of social values that consider the good of society as a whole, over-treatment must be discouraged, and funding for health care must be balanced with funding for other programs that affect health (Office of Medical Assistance Programs (OMAP) 2004).

Acting as a blueprint for universal access to affordable and basic health care, the OHP called for insurance reform as well as the stewardship of public resources. When first envisioned in the late 1980s, OHP aimed to provide basic health care to those of low-income status as well as those who had been previously denied coverage due to medical reasons. Group insurance plans became available to small employers that included one with low premiums and one that had guaranteed availability of services. Seeking to reduce the shifting of costs, the OHP placed an emphasis on managed care, preventative care, early intervention, and primary care. A pioneering idea, the OHP tackled two of the most important issues faced in health care: the guarantee of health care to all citizens of the United States and the need for containing rising health care costs (Fox and Leichter 1991).

A reduction in Medicaid expenditures resulted in either a decrease in the number of people included in the program, a reduced reimbursement rate for providers, or a cut in the benefit program. Kitzhaber decided to focus on the lesser of the three: the possibility of a prioritized list that eliminated only the least effective treatments (Bodenheimer 1997). Kitzhaber generated the outline of a plan which included key features he felt would be a step toward providing care to more people: an increase of eligibility for Medicaid services to all those below the poverty line, the



creation of a prioritized list that outlined services provided by the Medicaid program, the authority of the legislature to decide which services could be provided for depending on the state budget, the requirement of an employer mandate, and making services available through managed care (Bodenheimer 1997).

The OHP needed to obtain a federal waiver from the government due to its principle of explicitly amending or eradicating services that are determined to be essential by the Medicaid program and the OHP's plan to make other departures from the federal program (Brown 1991). The Clinton Administration approved the OHP waiver in March of 1993 and the fully formed plan began on February 1, 1994 (Bodenheimer 1997). While the state of Oregon was granted the waiver it came with two major conditions: all line changes of the prioritized list had to be approved by the Health Care Financing Administration and the state was prohibited to consider functional limitations in the prioritization process (Leichter 1999).

### ***Expansion***

A 30 cent increase in tobacco resulted in the expansion of the OHP to the 360,000 who were without health coverage because of the defeat of the legislation that required employers to provide insurance to employees (Bodenheimer, 1997). The consequent expansion allowed the inclusion of 25,000 children to the OHP, as well as, the provision of an added 21,000 people with state subsidies to obtain private health insurance (Bodenheimer 1997). As part of this expansion, the state established the Family Health Insurance Assistance Program (FHIAP) in 1997: a state system of graduated subsidies based on an individual's capability to pay which allowed uninsured working Oregonians with family incomes at or below 150 percent of the

federal poverty line to obtain policies for themselves and their families (Leichter 1999). The creation of FHIAP and the federally funded State Children's Health Insurance Program (SCHIP) helped the state of Oregon move closer to its vision of universal health care as an effort to build on public and private partnership (Office for Oregon Health Policy and Research [OHPR], 2005).

### ***Oregon Health Plan 2 (OHP2)***

The state of Oregon applied for a waiver of Section 1115 of the Social Security act and a waiver from Health Insurance Flexibility and Accountability in 2002 so as to modify and expand the OHP. This modification and expansion created the second phase of the OHP known as OHP2 in the wake of the fiscal crisis brought about by unemployment rates and diminished income tax revenues. Looking to expand coverage to those who had an income at or below 185 percent of the federal poverty level, OHP2 divided the Medicaid program into two separate benefit packages: OHP Plus and OHP Standard (Lowe 2006).

OHP2 introduced changes which altered the founding principles of the original legislation. As a result of OHP2, those who subscribed to the Standard benefit package of the OHP were given a reduced number of benefits, including the elimination of outpatient behavioral health and chemical dependency coverage, temporary loss of prescription drug coverage and vision coverage. In addition to cuts in the benefit package, the OHP Standard clients experienced the application of a considerable co-payment as well as more stringent administrative rules, including a lockout of six months if premiums were not paid (The Robert Wood Johnson Foundation (RWJF) 2004). As a direct result of these changes, the OHP Standard

enrollment fell 50%: from 102,000 enrollees to 51,000 (Office for Oregon Health Policy Research (OHPR) 2005). The introduction of the Plus benefit package resembled the original Standard benefit package, serving the disabled, low-income seniors, families that are eligible for Temporary Aid to Needy Families (TANF), as well as pregnant women, and children (RWJF 2004). Implemented changes to the OHP gave primary care physicians (PCP) the option of refusing those patients who could not afford co-payments, forcing patients to turn to the ER for care. The Emergency Medical Treatment and Active Labor Act (EMTLA), put into effect in 1986 (Lowe 2006), protects patients seeking emergency care by prohibiting the turning away of patients by hospitals, inadvertently creating the ERs of Oregon as valuable safety nets for patients.

### **Why Patients Visit the Emergency Room**

Patients visit the ER for many reasons including accessibility (Afialo et al. 2004), the ER's acceptance of any and all patients who seek care (Howard et al. 2005), the patient's belief that his or her condition is in need of urgent medical attention (Howard et al. 2005), barriers to care due to inadequate coverage, and factors relating to culture, education level, language, the patient's psychosocial status, and environment (Richardson and Hwang 2001). In their review of the ER utilization literature, Richardson and Hwang (2001) find that the ER is excessively utilized by uninsured patients, patients without a PCP, patients with Medicaid, and patients who are members of vulnerable populations. Researchers estimate that between 35% and 50% of patient visits to the ER are for non-urgent complaints (Northington et al. 2005). Prior research suggests that utilization of the ER as primary care is not a cost

effective of providing health care (Spillane et al. 1997). This is due to the fact that ERs are designed to provide high-quality health care to those experiencing life threatening situations (Oetjen and Rotarius 2002).

An influx in patients seeking primary care treatment in the ER has major consequences. These consequences include less care time for patients and decreased time to teach, counsel, and inform a patient about resources to better maintain health (Northington et al. 2005). The prevalence of patients utilizing the ER for primary care ultimately leads to a delay in care for those patients presenting with an emergent condition, resulting in higher rates of morbidity and mortality (Young 1995). Howard et al. (2005) report that nurses in the ER are under additional strain due to the influx of patients seeking primary care treatment, effectively impacting the quality of nurse-patient relationships and reducing the amount of time a nurse has to educate a patient on medical conditions and contributing to the misunderstanding of why these patients seek care in the ER.

Asplin and colleagues (2001) recognize that blaming vulnerable populations seeking treatment in the ER for non-urgent complaints happens because staff members do not recognize that these patients have nowhere else to go. The Medicaid Access Study of 1994 reports that fewer than half of the ERs in the study offer appointments or authorization for walk-in visits, and more than 90% of clinics require a cash copayment for after-hour care within 2 days. These data help to explain how ERs serve as safety nets for vulnerable populations (Asplin 2001).

Implemented changes to the OHP in 2003 ultimately forces patients to seek primary care in the ER because the ER cannot turn people away (Lowe 2006). The

ER serving as a safety net for vulnerable populations is problematic because care in the ER is not comprehensive or efficient (Spillane et al. 1997). Furthermore, patients seeking primary care in the ER ultimately impact the ability of ER staff to provide appropriate care to those patients requiring true emergency care (Northington et al. 2005). Patients who turn to the ER for primary care because of implemented changes to the OHP are often misunderstood and criticized for choosing the ER further contributing to the health disparities faced by this group (Asplin et al. 2001). My study is intended to understand how policy changes to the OHP impact those seeking care in the ER and how the hospital staff of Salem hospital perceives those seeking primary care.

## **Health Disparities**

Research shows that the primary causes of health disparities in a population are socioeconomic disparities, which include income, education, and occupation (Adler and Newman 2002). Robert and House (2003) identifies the relationship between health and socioeconomic status (SES) arguing that individuals in the lower strata of the socioeconomic scale are at a disadvantage in terms of environmental, biomedical, psychosocial, and behavioral risk factors for health. The utilization of primary care, as well as the overall health of an individual, is greatly influenced by SES (Fiscella et al. 2000). Those in poverty experience the greatest amount of burden (Adler and Newman 2002).

Individuals with lower SES are more likely to face greater burden because of many reasons: lack of education, lower levels of income, and occupational status

(Adler and Newman 2002). First, education is directly tied to life skills and knowledge that allow for access to resources and information related to the promotion of good health (Adler and Newman 2002), placing those with less education and lower SES at a great disadvantage. Lower levels of income are associated with inadequate housing, poor nutrition, and less education (Adler and Newman 2002) all of which obstruct the obtainment of good health. An individual's occupational status can have a great impact on overall health status. Regular employment is shown to contribute to better health (Adler and Newman 2002). Furthermore, the status of employment greatly impacts an individual's health status. Lower-status job generally held by those in a lower socioeconomic position can expose employees to both psychosocial and physical risks (Adler and Newman 2002).

In addition, those with lower SES are more likely to work and live in worse physical environments, forcing individuals to be exposed to harmful elements in their environment (Adler and Newman 2002). While the physical environment plays a vital role in the health of an individual a more important factor is the social environment. Lack of engagement in social networks and social isolation greatly impact health, both of which contribute to a relative risk of mortality (Adler and Newman 2002). Individuals with lower SES are at a greater risk of health disparities because SES, while greatly tied to physical and mental health, is also attributed to the obtainment of health care.

When an uninsured or underinsured individual seeks treatment in a medical facility, he or she is more likely to receive poorer-quality care and less medical care than those who are insured (Adler and Newman 2002). A major factor in the overall

health of an individual is the amount of stress an individual encounters in daily life (Adler and Newman 2002). While everyone experiences stress it is those individuals with SES who work and live in more stressful environments (Adler and Newman 2002). Factors contributing to stress for those with lower SES include insecure employment, economic strain, low control at work, and stressful life events (Brunner 1997).

Implemented change to the OHP in 2003 effectively established the ER as one of the only places the under and uninsured can turn to for primary health care concerns. The Emergency Medical Treatment and Active Labor Act (EMTALA) effectively designates hospitals as the only place in the health care system with guaranteed care (Medicine 2007). While many assume that being uninsured is the major risk factor for non-urgent visits in the ER, it is interrupted care and lack of primary, preventative care which forces patients to turn to the ER (Medicine 2007). Research shows that uninsured patients without a regular source of primary care are frequent users of the ER for care (O'Brien et al. 1997).

Low SES is often associated with vulnerable groups that are subject to harm because of an “interaction between the resources available to individuals and communities and the life challenges they face,” (Mechanic and Tanner 2007:1220). Vulnerable populations are viewed in two distinct categories: victims and sinners (Mechanic and Tanner 2007). The uninsured, viewed as responsible for their circumstances, are subject to discrimination because the public views them as to blame for their own circumstances, contributing to stigma and less public compassion (Mechanic and Tanner 2007). As a result of this, the uninsured are often regarded as

unworthy of public assistance because they are viewed as responsible for their current condition due to poor life decisions and a lack of self control (Mechanic and Tanner 2007).

The OHP, as a Medicaid program, is intended to assist with ensuring that medical care is affordable for those who are considered low income (Department of Human Services 2007). Individuals who are in the lower strata of the socioeconomic hierarchy have a far greater burden when it comes to sustained health effects (Adler and Newman 2002) and are thus in greater need of sustained primary health care. Research indicates that those who have no health insurance receive less care than those with health insurance (Adler and Newman 2002). In terms of community health, inequalities in health greatly impacts and reduces the quality life for all; it is only through the elimination of health inequities that population health can be achieved (Libbey 2007). In terms of eliminating health inequities, the only way to be effective is by meeting the needs of vulnerable populations (Libbey 2007)

By understanding the lived experiences of those impacted by the policy changes made to the OHP we are able to understand the current status of health care and how health care policy can be better implemented to benefit the population of Oregon. Furthermore, the creation and implementation of policy are done so by people who are disconnected from the reality of those who are greatly impacted by the policy. Ervin (2005) recognizes that decisions of policy, while seemingly innocent to policy makers, can be have unexpected, costly, and negative consequences. The research conducted by anthropologists often leads to discoveries and unexpected linkages created by policy changes. This gives great need for the understanding of



the lived experience, but more importantly, the dissemination of this lived experience to those who make policy. My study is designed to understand the human experience of those impacted by policy changes made to the OHP in the context of why individuals utilize the ER for primary care and how vulnerable populations are at greater risks for health disparities.

After reviewing the literature of why patients seek primary care in the ER and the health disparities experienced by vulnerable populations the gap in the understanding of how policy implementation is actually experienced becomes alarmingly clear. Changes made to the OHP and the impact these changes have on the ERs of Oregon is explored by Lowe and colleagues (2005) but this research only explores the impersonal statistical numbers. My study is especially relevant today in light of the upcoming presidential election and the endless discussions of what candidates will do for those Americans who are underinsured or uninsured. Understanding the lived human experience of policy changes made to the OHP is time consuming and requires face to face interaction with those seeking primary care in the ER. Perhaps the gap in knowledge regarding the lived experience of policy changes to the OHP exists because policy creators do not desire to see the face of the vulnerable population with nowhere to turn but the ER. Through the utilization of qualitative research methods my study helps to fill this gap by bringing to light the stories of those who rely on the ER for primary care and helps to educate policy makers of the grim reality of the current state of health care in Oregon.

## **Chapter 2-Theoretical Foundations and Methods Used in the Study**

The creators of the OHP envisioned a program that would benefit those unable to provide health coverage for themselves. Implemented changes made to the OHP in 2003 effectively reduced or eliminated access to health care services for many Oregonians. These changes put further stress on an already vulnerable population placing them at higher risk for health disparities. My study examines how policy changes and implementations to the OHP impact those who now turn to the ER for primary care, as well as the impact policy change has on those working in the ER. Guided by the theoretical framework of CMA and structural violence my study attempts to understand the human experience of policy change. Relying on qualitative anthropological research methods my study provides a narrative to the numbers put forth in quantitative research.

### **Theoretical Framework**

#### ***Critical Medical Anthropology***

Medical anthropology strives to understand the causes of health and illness as they are impacted by the interaction of genetic inheritance, environment, and socioeconomic circumstances (Brown 1998). By examining how the implemented changes of the OHP have impacted those now relying on the ER for primary care, my study focuses on the socioeconomic circumstances that contribute to health disparities. Critical medical anthropology (CMA) is defined by Merrill Singer as the effort to understand and respond to issues related to health in terms of political economy and social inequality (Singer 1998). An important aspect of CMA is the discipline's desire

to understand the role power plays in an individual's access to health. Singer accurately asserts that this effort is anthropological "...in the sense that it is holistic, historical, and immediately concerned with on-the-ground features of social life, social relationships, and social knowledge, as well as with culturally constituted systems of meaning," (Singer 1998:226).

At the core of CMA is the contribution by researchers to movements that evoke health reform by transforming health related issues into political issues and into political action. Singer refers to this political action as critical praxis (1998). Singer differentiates between two types of praxis: system-correcting praxis and system-challenging praxis. System-correcting praxis is the execution of minor actions that do not necessarily address the structure of power within a system (Singer 1998). System-challenging praxis attempts to expose social inequity and to implement change in the unequal power dynamics that structure social relations (Singer 1998). Inherent to system-challenging praxis is the enhancement of democratization, the demystification of medical knowledge, and the recognition that disease must be understood in terms of sociopolitical processes (Singer 1998). Perhaps the most important aspect of CMA is the need for researchers to move beyond academic fields and to place research into applied fields (Singer 1998). It is this aspect of CMA that requires the researcher to leave the ivory tower and to participate in system-challenging praxis.

### ***Structural Violence***

Structural violence, an important subset of CMA, is defined as "extreme and relative poverty, social inequalities ranging from racism to gender inequality, and the

more spectacular forms of violence that are uncontested human rights abuses, some of them punishment for efforts to escape structural violence,” (Farmer 2005:6). Rooted in the political economic structure of a society, structural violence is an invisible and systematic violence that is implemented and continued by the perception that this violence is the norm. This systematic violence can come in the form of poverty, poor economic opportunities, systematic social deprivation, or the neglect of public facilities (Farmer 2005). Farmer succinctly explicates structural violence as: “violence exerted systematically--that is, indirectly--by everyone who belongs to a certain social order,” (Farmer 2004:307). Gender inequalities and racism are two over arching examples of structural violence (Farmer 2004). Clinical medicine strives to understand disease in terms of molecular properties and it is this exclusive focus which leads to the desocialization of scientific inquiry and inquiry into trends that are, in fact, biosocial (Farmer 2006). Structural violence focuses on the social determinants of disease and attempts to understand those social forces responsible for disease that are beyond a patient’s control (Farmer 2006).

The entirety of my study is continually informed by the interaction between CMA and structural violence. Striving to understand how policy changes made to the OHP have impacted both patients and staff, my study attempts to uncover the role power relations play in the distribution of health care to vulnerable populations. Furthermore, this study attempts to ascertain how the political- economic structure inhibits those vulnerable populations from receiving adequate health care. Both critical medical anthropology and structural violence call for researchers to move

beyond the understanding of how power relations perpetuate inequality and move towards an active movement of social change, both of which are inherent to my study.

Relying on the theoretical guidance of CMA and structural violence, I examine the power structure of Oregon's Medicaid program and how newly implemented policy contributes to the continuation of health disparities. I also explore how policy can contribute to the stereotypes of lower income individuals and the preconceived notions of hospital staff. Through the utilization of participant observation, interviews with patients, and surveys distributed to staff members, my study explores issues that are important to the stakeholders in this study: hospital staff, the OHP policy officials, and most importantly, Oregonians impacted by implemented policy changes.

Ervin (2005) contends that while policy-making and implementation are social and political processes they are also cultural because they are ideologies of the way society is assumed to work and, therefore, are culturally produced. By studying how health care policy impacts the lived experience I want to humanize the impact of policy implementations. I hope the voice I give to the numbers associated with the uninsured will be heard loud and clear by policy officials and hospital staff. This study attempts to understand how the lives of the under and uninsured are impacted by the power of policy implementation. Furthermore, this study is innately anthropological because it seeks to understand and explain the lived human experience as it is impacted by policy that has been constructed in the context of American society.

## Data Collection

Research took place over nine months with five months dedicated to a review of the literature and my internship. The internship allowed me to understand how the people in the ER worked and to formulate my research questions. The last four months consisted of interviews with patients, the distribution of surveys to staff, and the analysis of the data. The openness and flexibility of qualitative research (Charmaz 2004) allowed me to explore the experiences of patients as they told me their story, something that no survey could gather. Rather than attempt to fit the life experience of patients into preconceived categories found in established literature I was able to discover the themes as they emerged from the data. My study incorporates a wide range of data collection methods including participant observation, semi-structured interviews with patients, and distribution of surveys to hospital staff.

Participant observation is “a strategic method that lets you learn what you want to learn and apply all the data-collection methods that you may want to provide,” (Bernard 2000:334). Through participant observation a research attempts to understand the lived experience of the participants (2000). Participant observation allowed me to see first-hand how policy implementation impacts those seeking care in the ER, as well as the staff of the ER. Bernard (2000) explains that participant observation allows the researcher to “make strong statements about cultural facts that [the researcher has] collected,” (325). In other words, participant observation allowed me to fully understand the meaning of the observations I made about the culture of the emergency room (Bernard 2000). Furthermore, “qualitative and quantitative data inform each other and produce insight and understand in a way that cannot be

duplicated by either approach alone,” (Bernard 2000:325). Bernard (2000) recognizes that participant observation is a powerful method in social science research, especially when combined with other social science research methods. Based on the participation observation portion of my research I formed the questions that ultimately became my interview guide for interviews with patients and the questions for the survey distributed to the staff. Continual feedback between participant observation and survey data works to validate information I learned as a “Family Patient Liaison.” Acting as a “Family Patient Liaison” placed me in direct contact with those patients who walked into the ER. I was able to hear the reason why a patient was seeking care as well as interact with the patient. Many patients revealed their frustrations with the ER to me and their overall disillusion with their lack of health care options. While interacting with patients I never revealed my academic interest in the state of the OHP. Rather, I allowed the stories of patients to act as the starting point for the development of topics to explore in semi-structured interviews.

Interaction with the ER staff aided me in the development of topics I wanted to explore in the survey distributed at staff meetings. On many occasions I spent part of my break time in the ER staff’s break room where I was able to further interact with the staff in a more relaxed and casual environment. Having regular interaction with the staff during my “Family Patient Liaison” shifts in the ER allowed me to establish a rapport. This rapport became important in the staffs’ recognition of me at the meetings in which I distributed the survey, an important part of participant observation (Bernard 2000). The participant observation portion of the study allows for a better understanding of how the ER operates, the pressures exerted upon the staff, and

concerns expressed by patients. The culmination of the participation observation period allowed me to formulate the research questions for this project and topics to explore in semi-structured interviews with patients and surveys distributed to staff.

To understand the perspectives of patients I relied on semi-structured interviews conducted in each patient's private room. Because interviews with patients were anonymous there was no way to follow up with patients, leaving me with only one opportunity to speak with the patient. Semi-structured interviews are best utilized when there is only one opportunity to speak with an informant (Bernard 2000). I relied on semi-structured interviews in this study to best utilize my time with patients and to better understand their perspectives. My interviews with patients were guided by an interview guide (Bernard 2000), which allowed me to further explore topics brought up by a patient during the course of the interview. Unlike the staff members of the ER, I did not have the opportunity to build any rapport with patients. Considering that the patients participating in my study discussed very personal issues with me I found it vital to utilize an interview guide so the interview would seem less like of a formal interview and more like a personal conversation. The questions used for patients focused on whether or not they were or had been on the OHP, why they were seeking treatment in ER and how being under or uninsured impacts daily life.

The distribution of an anonymous survey to staff members consisted of both closed-ended questions relating to demographic information and open-ended questions to understand the personal opinions of staff members regarding patient utilization of the ER and witnessed abuse of the OHP. Utilization of a survey allowed me to gather data from a large group of respondents in a short amount of time and ensured that no



interviewer bias would interfere with the responses (Bernard 2000). By distributing surveys to those staff members attending staff meetings I wanted to access key informants. Traditionally in anthropology key informants are those people who guide the researcher through the lived experience of a particular culture (Bernard 2000). Considering that my research took place in a busy, high stress environment I was unable to have staff members of the ER walk me through the day to day routine. By pursuing staff members in attendance at the non-mandatory staff meetings I wanted to find those staff members dedicated and passionate about their work. My intention was to access the knowledge of these staff members as it relates to those clients of the OHP seeking primary care in the ER with the postulation that those who voluntarily attend meetings are the most knowledgeable.

### **Participants-Patients**

Upon being admitted to the ER the registration clerk is able to see whether the patient is privately insured, uninsured, or currently on the OHP. After a patient was admitted, the registration clerk provided me with the room numbers of the patients being seen for a primary care concern and is either uninsured or currently enrolled in the OHP. By writing down just the room number a patient's anonymity was insured. I approached the patient in his or her private room while the patient waited to be seen by the nurse or doctor and introduced myself. I then inquired whether or not the patient was interested in participating in a short interview regarding his or her time in the ER. If interested, I gave a copy of the informed consent document and began the interview. If at any time during my interview a doctor or a nurse entered the room I stepped outside and waited across the hall until the doctor or nurse left. While waiting

for the doctor or nurse to leave I made sure to stand out of earshot to ensure that I would not overhear the conversation. I conducted a total of 17 interviews with patients, each lasting between ten and fifteen minutes. While not every person I approached for an interview was interested in speaking with me those that did expressed gratitude because I was someone interested in listening to their story.

### **Participants-Staff**

The staff members of the ER were recruited through a brief, anonymous survey distributed in a packet to those staff members attending one of three staff meetings. I was introduced by the ER manager at the beginning of the meeting. I spoke for five minutes explaining who I was, what my research aimed to understand, and what was included in the packet. Each packet included an informed consent document, the survey, and a preaddressed stamped envelope for the return of the survey. Out of the 43 surveys distributed to the staff 13 completed surveys were returned. The low response by staff members could be due to the fact that staff members did not want to take the time to complete the survey or the assumption that other staff members would complete the survey. While I cannot say with certainty how the data would be impacted if all staff members filled out and returned the surveys I can say that based on the participant observation portion of my research that the returned surveys most likely are a good representation of the opinions of the of the ER.

The survey consisted of a short quantitative section, a short qualitative section, and an area for the staff member to indicate whether or not he or she was interested in a follow-up, in-depth interview to further discuss his or her experiences and

perspectives. The short quantitative section was designed to understand the demographic information of the respondent including number of years working in the ER, recent experience with patients who are uninsured or on the OHP, and whether or not the participant refers uninsured patients to obtain more information regarding the OHP. The qualitative section allowed for the participant to write about his or her experience as a health care professional who encounters uninsured or OHP patients. Topics in this section included: any blatant abuse of the OHP witnessed by the participant, whether or not the participant feels the OHP helps those who are enrolled, and what, if any, changes can be made that would improve or benefit those enrolled in the OHP. Giving the participants the option of remaining anonymous allowed them to have a sense of security as they discussed topics that might otherwise be uncomfortable to discuss in a one-on-one interview (Bernard 2000). In addition to having access to a large group, this research strategy allowed the respondent to decide whether or not he or she would be interested in participating in a more in-depth interview.

## **Data Analysis**

### ***Grounded Theory***

To analyze the qualitative data gathered during patient interviews and surveys returned by staff members I relied on grounded theory. Grounded theory, first put forth by Glaser and Strauss in their 1967 book “The Discovery of Grounded Theory: Strategies for Qualitative Research,” allows for the development of a theory or theories that is grounded within data that is systematically gathered and analyzed

(Strauss and Corbin 1994). Through the use of systematic procedures, grounded theory enabled me to perform qualitative research in an effective and efficient manner by aiding in the structuring and organization of data-gathering and analysis (Charmaz 2004). I continually read over the interview notes and the qualitative portion of surveys looking for reoccurring topics. I coded interview notes and survey responses to develop categories that eventually developed into the themes presented in this study. The themes presented in this study were themes that both emerged from the data and themes that I, as the researcher, helped to co-construct. The themes that emerged from the data were themes that I was not expecting and because I was not expecting them I made sure to fully explore these concepts in further interviews with patients. Themes that I helped co-create were those themes I expected to be present in the realities of the patients and the staff and I specifically structured the initial interview guide and the survey to see if these concepts played a role in the reality of patients impacted by policy change and the staff of the ER who treat these patients.

Grounded theory relies on a continual analysis of the data by the researcher to ensure that the research is focused and meaningful (Charmaz 2004). Grounded theory strives to produce theory that is “conceptually dense” (Strauss and Corbin 1994:278) through the emergence of key themes from the data rather than the utilization of preconceived categories (Charmaz 2004). As the themes emerged from the data I restructured my interview questions with patients to explore the category and to gather data to refine and elaborate my emerging theory, a concept known as theoretical sampling (Charmaz 2004). I continued sampling until no new properties emerged from the data, until the category was saturated, helping to focus my analysis (Charmaz

2004). The use of theoretical sampling helps to explicate categories and it differs from other forms of qualitative sampling because it is not meant to represent a population or increase the statistical generalizability of results (Charmaz 2004).

The utilization of grounded theory in anthropological research is pivotal because the gathering of data revolves around the perspective of the experiencing person (Charmaz 2004). By understanding the perspective of the experiencing person, grounded theory attempts to portray the lived experience of an individual's thoughts, feelings, situations and actions (Charmaz 2004). The use of grounded theory allows me to better understand of the lived experiences of people impacted by policy change. The utilization of grounded theory allowed me to fully understand the perspectives of the patients. I read and reread interview transcripts at the end of each research day making notes in the margins, allowing the themes to emerge from the data. Based on the themes that emerged I adjusted my interview guide to incorporate the exploration of emerging themes to learn more from the perspective of the patients.

## **Limitations**

There are several limitations to this study. First, the information provided by patients in the semi-structured interviews is potentially inaccurate. While the patient is most likely telling the truth as the patient sees it the information provided by the patient might not be accurate (Bernard 2000). While the event patients recall are the truth the way in which the events are perceived by the patient might be different from the way in which others interpret the events. Because of participant selection it can be

assumed that the opinions and experiences of the patient population does not include the OHP recipients who did not utilize the ER on days I interviewed.

The results of this study are unique to the community of Salem, Oregon. The perceptions of staff members are influenced by the history and context in which the community of Salem has become. The biggest disadvantage in the staff portion of my study is the lack of control over how the staff members interpreted the questions (Bernard 2000).

The recruitment of staff members by means of a staff meeting limits the staff participant population to those staff members in attendance and those staff members who took the time to fill out the survey. Considering that only 13 of the 43 surveys distributed to the staff were returned it is important to note that the statistics represented in the staff results section are relevant to only the 13 surveys returned. By utilizing an anonymous survey there is no way to control for how the participant interprets each question (Bernard 2000). Because the surveys are designed to ensure participant anonymity there is no way to follow up with those who received a survey but did not return it to me.

Finally, while this study presents results that allow for an understanding of how policy changes impact the lived experience it does not claim that the results are statistically significant in a quantitative sense. The results of the study should not be generalized to describe the characteristics of the entire population of uninsured individuals, or those who are or were enrolled in the OHP. Similarly, the results of the

study exclusively reflect the experiences of those patients and staff in the Salem Emergency Department who participated in the study.

## **Chapter 3 Patient Results**

The creators of the OHP envisioned the program helping those who are unable to obtain health insurance on their own and alleviating the stress of being uninsured. Implemented changes to the OHP in 2003 put into motion a structural reinforcement of how income disparity leads to health disparity. The creators of the OHP envisioned a program that assisted those who could not afford to provide health coverage for themselves. Those impacted by the changes were already part of a vulnerable population at risk for higher rates of health disparities. The clients of the OHP who were not dropped face tighter enforcement of premiums, lockout periods for late payment of premiums, co-payments for physician visits, lab visits, prescriptions, ED visits, and hospitalizations, and primary care physicians who are allowed to refuse patients unable to pay at time of visit (Lowe 2006). This chapter organizes the themes that emerged during patient interviews in my study and explains the way in which the OHP now systematically contributes to the health disparities of the population the OHP was designed to help.

### **Personal Agency**

One of the main themes that emerged in my research is the difficulty of navigating the system of the OHP. Those who were not cut from the OHP continually encounter difficulty securing a PCP and understanding the protocols of the OHP. The personal agency of the OHP clients to decide when to visit a PCP is taken away by the newly implemented changes. Personal agency is the idea that people are not just passive cogs in the societal system but play a role in shaping experience through



action, choices, and planning (Bandura 2001). The idea that individuals are an active part of the social system is significantly influenced by an individual's sociostructural network: "authorized systems of rules, social practices, and sanctions designed to regulate human affairs," (Bandura 2001:14). Implemented changes to the OHP complicated the authorized system of rules and changed the acceptable social practices of those seeking care. The nature of personal agency is greatly influenced by the types of physical and social environments individuals choose and create (Bandura 2001). What good is health insurance if an individual is unable to establish a relationship with a primary care physician and receive continued care?

One of the goals outlined by the OHP is to: "improve the quality of health care and receipt of preventive services by low-income Oregonians, thereby improving their health," (The Oregon Health Plan 2007). The inability of OHP clients to secure PCP explicitly violates this goal and impedes an individual's obtainment of optimal health and the ability to exercise personal agency. The relationship which forms between a patient and a doctor is shown to have a positive impact on health care use and outcomes (Gill et al. 2000). Continuity of care with a physician leads to increased trust and knowledge between a doctor and a patient, effectively encouraging patients to seek care from their PCP rather than the ER (Gill et al. 2000). Gill and colleagues (2000) show that a continuity of care between a patient and a doctor increases the doctor's knowledge of the patient's medical history and a better understanding of medical problems and the interaction of medical problems for a patient. This knowledge fosters a doctor's interpretation of a patient's complaint and if there is a necessity of urgent care. Patients who do not have the ability to exercise personal

agency in the choice of seeking care or advice from a PCP are forced to seek care in the ER.

Patients who are without access to a PCP because of the inherent structure of the OHP are left with no other choice but to visit the ER for any and all health concerns. Gary, a 37 year old man visiting the ER for continued testicular pain associated with an accident he was involved in two years ago, explained that he is currently on the “open card plan.” Not allowing him to have a PCP, the open card plan forces him to visit the ER for any and all health concerns. Being on the open card plan is frustrating to Gary: “I feel like I’m in a never ending cycle of continuous catch 22s.” On many occasions, Gary has asked his OHP case worker to explain the open card plan to him. Each time his case worker has been unable to. Gary revealed just how difficult it is for someone in poor health to keep up with the complexity of the system: “It’s so fucking hard to try and stay on top of everything, every little minor change that changes my care, especially when I feel as bad as I do.” With no other option Gary continually turns to the ER for his primary care.

When a patient is unable to exercise personal agency due to a lack of direct control over conditions and institutional practices the patient is likely to exercise proxy agency in the healthcare system (Bandura 2001). Proxy agency is the attempt to access those members of a community who have access to expertise or resources or who have the ability to gain influence and power to aid the individual in the obtainment of healthcare (Bandura 2001). In the healthcare system, patients without personal agency turn to healthcare professionals for the aid in obtaining optimal health. The lack of personal agency the clients of the OHP experience is fully

exemplified in the clients' powerlessness in seeking primary health care from a PCP. This lack of agency compels patients to seek care in the ER, placing a substantial drain on medical resources which is recognized by the ER staff as abuse of the system and places the patient at risk for the moral and personal scrutiny by the staff.

With no option of exercising personal agency in terms of primary health care some patients create their own agency through the option of paying for procedures not covered by the OHP. At the age of four John's son Andrew suffered from a groin hernia and continual infections of his penis. The OHP officials informed John that three different doctors needed to give three separate opinions before Andrew could undergo the routine surgery to fix the hernia and perform a circumcision. After three separate doctors had given their separate opinions, the OHP approved the surgery, but refused to cover the circumcision stating that a circumcision is cosmetic. John, concerned about the infections, decided to pay for the circumcision out of pocket: "I refuse to risk my son's health because someone has a red 'denied' stamp in his hand." Paying for his son's circumcision allowed John to take control of the situation and exercise personal agency that the OHP obstructed.

## **Community Health**

When I began interviews with patients I expected the topic of "health" to play a role in the perception of patients but I was not expecting the role "community health" plays in the reality of those impacted by changes made to the OHP. The dialogue of "community health" is better contextualized in terms of social capital: "relationships and structures within a community that promote cooperation for mutual

benefit,” (Minkler and Wallerstein 2006:35). Clients of the OHP impacted by changes in 2003 understand the important role of relationships and structures (productive members of society and the structure of health care) and how these structures and relationships impact the mutual benefit of community health. Coleman (1988) discusses social capital as a means of making resources available to individuals that, when utilized, help individuals achieve their interests. Implemented changes to the OHP effectively reduced health care resources for those in Oregon who had no other source of health insurance, in effect diminishing contributions to the community and eliminating the opportunity to achieve optimal health.

June, a middle aged woman being seen for sciatic nerve pain, expressed how being sick impacts every aspect of her life, especially her community: “If you aren’t good in your head you can’t be good in general... You know, you stop doing good at work and everything in your life suffers: relationships, performance, stuff like that. It makes it hard to be an overall good person.” Being sick and uninsured will undoubtedly impact many different areas of an individual’s life, making any contribution to a surrounding community difficult. Putnam, (2000) in his overview of social capital, establishes the importance of health and well-being to social connectedness. As indicated by June when a member of any community is sick that individual will become removed and lose connections with other members of the community leading to diminished social capital. Furthermore, research indicates that those who are disconnected from a community have a greater risk of illness and dying early (Nakhaie et al. 2007).

Included in social capital are norms of reciprocity, density of civic association, and an interpersonal trust between citizens, all of which facilitate cooperation for mutual benefit (Kawachi et al.1999). Bragg Leight points out that social capital is defined by its function:

It is not a single entity but a variety of different entities, with two elements in common: they all consist of some aspect of social structures, and they facilitate certain actions of actors--whether persons or corporate actors--within the structure. Like other forms of capital, social capital is productive, making possible the achievement of certain ends that in its absence would not be possible. (S98)

Based on this definition a society without social capital is unable to achieve outcomes such as optimal health. Social capital exists in the relationships of community members and these relationships are dependent upon interpersonal relationships that are impacted by health (Bragg Leight 2003). Further elaborating on the concept of social capital, Bragg Leight (2003) states: “The concept of social capital constitutes both an aid in accounting for different outcomes at the level of individual actors and an aid toward making the micro-to-macro transition,” (S101). Placed in context of this study, a community containing uninsured individuals (and thus at risk for disease) will be unable to join together to enact social or policy change to endorse different outcomes for individuals. Furthermore, members of communities will experience difficulty in the contribution to the community.

The concern for community health extends to include the impact the system has on uninsured single fathers who attempt to provide for their children. Tabitha, a 48 year old woman being seen for non-injury related knee pain, has been on the OHP since it began and actively helps those in her community, many of which are also on

the OHP or are uninsured. Tabitha explained to me how many of the single fathers she knows have “invisible income:” when a single father is supporting his children but the state only takes into account his lump sum income, making the father ineligible for the OHP. Tabitha is passionate about how unfair the system is for single fathers and what it is doing to her community:

These fathers are just trying their best to provide for their children but if they can't have health insurance how can they keep a job? Not being healthy takes away from their ability to provide for children and if the fathers aren't healthy then we will have a whole society filled with unhealthy and unproductive men.

Tabitha recognizes the connection between individual health and its impact on a community as a whole. Single fathers without health insurance are at risk for becoming ill and missing work. By missing work these single fathers jeopardize their jobs and thus the monetary means of supporting their children. Unhealthy and unproductive men are in no position to contribute or build the social capital of their communities.

Directly linked to the concept of social capital is human capital, which includes education, jobs, income, and housing (Bragg Leight 2003). A limitation in human capital is shown to place certain people at higher risk of illness (Bragg Leight 2003). Those with low income, including those enrolled in state assisted health insurance programs, are the most consistent predictors of disability and disease among vulnerable populations (Bragg Leight 2003). John, the 26 year old single father being seen for a basketball injury, expressed concern for how his employer and coworkers will be impacted if his employer provides insurance:

If I did buy my own insurance my employer would pay for part of it and if all the guys at my job did that there would be fewer jobs and we'd have to work

longer hours to get more pay and that just won't work. I would be willing to pay into a pool and help others as long as I get help, too. With none of us having health insurance we all get sick and make each other sick, which is sick.

John's concern for how employer provided insurance will impact not only himself but his coworkers is indicative of his concern for community health and wellbeing. When one member of a community is sick he or she can potentially impact the health of others, ultimately reducing a community's social capital. People lacking health insurance are constantly at the risk of diminished work ability and thus poorer income and are unable to be fully functioning members of the community, leading to an overall reduction of social capital.

A community with diminished social capital is constantly at risk for diminished health status. Kawachi and colleagues (1999) conclude that social capital can impact health behaviors of communities by encouraging a distribution of health related information, leading to increased chances of a community implementing healthy norms of behavior, as well as, an application of social control over health related behaviors which are deviant. With diminished social capital it can be assumed that a community has diminished social relationships, a factor that is best summarized by House (1988):

Not only may social relationships affect health because they are or are not supportive, they may also regulate or control human thought, feeling, and behavior in ways that promote health. (543)

With diminished social capital that results in diminished social relationships, members of a community have many factors working against them in the obtainment of optimal health.

A newer aspect of social capital is the concept of bridging social capital: the connection communities have with external resources and local government (Warren et al. 2001). An important aspect of bridging social capital, as expressed by Warren and colleagues (2001) includes the recognition that: “Social capital is not an alternative to providing greater financial resources and public services to poor communities. Rather, it constitutes an essential means to increase such resources and to make more effective use of them,” (2). The implemented changes to the OHP and the subsequent impact these changes exert on individuals in Oregon are the direct result of the so-called disconnect between a community and its external resources and local government. Changes made to the OHP have forced both those who are still covered and those who lost coverage to turn to the ER as the only resource for primary health care effectively placing a strain on ER staff.

### **Feelings of Suffering, Hope, and Hopelessness**

Many patients in my study discussed feelings of hopelessness and suffering as they relate to being uninsured or underinsured. By not having health insurance and unable to sustain continued care with a doctor individuals are forced to provide care at home. Once self provided care proves ineffective many patients turn to the ER for care. Continually visiting the ER and being seen by a different physician has great consequences for the patient. These consequences include demoralization, a breakdown of coping, and feelings of hopelessness.

Clarke and Kissane (2002) define demoralization as: “Personal experience of not coping and not knowing what to do; a frightening experience that attacks one’s



self-efficacy and esteem,” (737). Directly linked to this concept of demoralization is suffering, which “grows from any loss of a person’s sense of control over their symptoms, and hope concerning their prognosis, and their expectation of other people’s response to them as an ill person,” (737). Chris, a 27 year old man being seen for chest pains, has no health insurance. According to Chris, when he does get sick he suffers: “When I get sick I just suffer though. What else can I do? My wife does the same and we just get through it.” Chris’ rhetorical question of “what else can I do?” indicates his awareness that there are not many other options. Because Chris is seeking care in the ER he understands that there is only so much he can do to maintain good health on his own; there usually comes a time when medical attention is needed and, for the uninsured, often proves costly both monetarily and in terms of personal wellbeing.

Hope is defined as: “A construction of, and response to, the perceived future in which the desirable is subjectively assessed to be probable,” (Nunn et al. 1996:531). In her overview of hope, Jenmorri (2006) finds that hope is linked to growth, health, and transformation. Tina, a 38 year old woman being treated for liver problems, was on the OHP until cutbacks in 2003. She was dropped just days before her scheduled liver transplant. According to Tina, not having health insurance is “horrible”. Tina says she has heard rumors of the OHP opening up to accept adults in the near future: “All I can do is hope, that’s all that I can do which doesn’t do much.” Tina’s statement reflects her awareness that the simple act of hoping will not bring her any closer to health coverage, but what she does not realize it just how important the simple matter of having hope really is. Hope and the faith in possibility provide the

needed support for the negotiation of life challenges (Jenmorri 2006). The lack of control Tina has over her insurance status has forced her to place all of her faith and self-worth into the hope that OHP will be accepting new clients. Having hope “may provide a framework for pathways to change, a ground from which one can imagine possibilities in situations of hardship and start to take action,” (Jenmorri 2006: 43). But what happens when an individual is no longer able to have hope? What happens when one has the feelings of being hopeless?

The loss of hope can have a great impact on an individual’s perception of his or her worth in society. Clarke and Kissane (2002) explain that a breakdown of coping is at the core of demoralization. When one can no longer understand what he or she can do, helplessness and distress follow (Clarke and Kissane 2002). According to Gary, the man being seen for testicular pain, “feeling bad makes everything seem helpless but I’m in a place where OHP has made it clear that I’m helpless and I feel hopeless.” Beck and colleagues (2003) recognize that feelings of hopelessness present a problem in the forming of relationships within an individual’s community. As was explored previously, relationships within a community impact the building of social capital and increase the health of a community. The structure of the OHP reinforces Gary’s feeling of helplessness; feelings of helplessness that lead to feelings of hopelessness and a degradation of self-worth.

The direct link between health disparities and income disparities is overwhelmingly present in my study. Policy implementation that perpetuates the invisible and systematic violence (Farmer 2005) against vulnerable populations is blindly accepted because this injustice has become systematic. An individual’s

obtainment of optimal physical and mental health is vital to the successful workings of any community but those who go without health care are often left without a voice.

The lived experience of policy implementation is an aspect that is rarely considered by policy makers. As presented in this chapter, implemented policy changes manifest in the loss of personal agency, diminished social capital, and hopelessness experienced by patients.

## **Chapter 4-Staff Results**

A major goal of CMA is to reveal and respond to issues that relate to health in terms of social inequality (Singer 1998). Understanding the perspective of the ER staff is an important step toward understanding the social inequality that is inherent in the system of the OHP and is vital to fully understand how the clients of the OHP are impacted by policy changes. Understanding the perspective of the ER staff is a system-challenging praxis (Singer 1998) because it reveals the origins of social inequality experienced by those seeking primary care in the ER. This chapter outlines the results of the survey distributed to the staff. The first section is dedicated to the results from the quantitative part of the survey. The second section reports the results from the qualitative part of the survey and is divided into the themes that emerged from the data.

### **Quantitative Results**

The results from the quantitative portion of the 13 surveys returned by the staff members are shown below. It is important to note that 90% of staff members responding feel that the OHP does benefit those enrolled and 90% of staff responding report witnessing blatant abuse of the OHP. More than 75% of staff members who responded report an increase in the ER of uninsured and clients of the OHP.

Table 1. Summary of Staff Survey Results

Information about OHP was given at time of hiring	36%
Information about OHP was gained through experience of working in the ER	18%
OHP does benefit those enrolled	90%
Noted increase in amount of patients utilizing ER for primary care	81%
Noticed increase consists of uninsured and those on the OHP	78%
If treating an uninsured patient, staff member	
Informs patient of the OHP	45%
Does not inform patient of the OHP	25%
Witnessed blatant abuse of the OHP	90%
Abuse consisting of:	
Patients viewing the OHP as a free ticket to health	45%
Utilization of ER as primary care	36%
Moving to Oregon to enroll in the OHP	36%
Patients not contacting primary care physician prior to ER visit	27%
Some patients are more deserving of the OHP	27%

## Qualitative Results

The qualitative results of the survey in my research indicate that the clients of the OHP who seek primary care in the ER are perceived by the staff as abusing the system. This perception is in direct opposition to the 90% of responding staff members who feel the OHP does benefit those enrolled in the program. There are two major themes which emerged from the qualitative portion of the survey distributed to the staff: the blaming of the OHP recipients and the abuse of the ER.

### *Blaming OHP Recipients*

Throughout the participant-observation portion of this research many staff members of the ER commented on the number of the OHP clients who seek primary care in the ER. Staff members expressed frustration regarding pregnant women who are automatically enrolled in the OHP, suggesting that they are taking advantage of the system, especially women who have children by more than one man. One staff

member simply stated “it’s a moral problem.” This comment suggests the staff member’s belief that the state should not assist those whose morals are not in alignment with a set standard and the utilization of personal preferences and opinions in judgment of patients seeking care in the ER. The staff members of Salem ER are continually required to rely on professional judgment calls while treating patients. These judgment calls include the assessment of a patient’s condition, the steps to be taken in treatment, and how to provide the best and most adequate care. A staff member who allows personal judgment to impact the care provided to a patient not only threatens the care provided to the patient, but it also reinforces the vulnerable population classification of the uninsured as sinners.

Society places vulnerable populations into two distinct categories: sinners and victims (Mechanic and Tanner 2007). These two categories are dependent upon society’s discernment of behavior that is either uncontrollable (victim) or a direct result of an individual’s personal choices (sinner) (Mechanic and Tanner 2007). Victims, such as children or the elderly, are thought to be the “deserving poor” and thus deserving of federal and state assistance, while those perceived as to blame for personal choices are often stigmatized and offered less compassion (Mechanic and Tanner 2007). Many staff members reported that the OHP especially helps children, viewing the children as deserving of coverage. The view of persons on the Oregon Health Plan as “sinners” continually impacts the perception of those working in the ER. Patients covered by the OHP who utilize the ER are often blamed for their own condition and seen as not deserving coverage in the eyes of some staff members. An

RN, at Salem Hospital for 26 years, indicates her feelings regarding those who do and those who do not deserve to be on OHP:

I am sure it helps those who are enrolled but it is not helping those who deserve to be on it and can't qualify for it. I think too many are on it who do not need to be on it or deserve to be on it. I hate what it has done to Oregon health care. I hate the Oregon Health Plan as it is today. I hate when I see all the Hispanic population on it and the Americans (Oregonians) not on it who should have more right to it-especially those who can't get their medication for diabetes/ hypertension/ heart disease. You should be able to speak English to be on it. You should be a resident of Oregon for a period of time before you qualify. You should have a job or some excellent reason why you don't have a job to qualify. Diabetic patients should be able to qualify easier as they must have their medications. You should be legal to qualify. Pregnancy should not just get you on it automatically. Citizens of the USA need to be more accountable. The right of entitlement is ridiculous...Some should only get assistance with medications and have to pay the office visit/ER visit out of their pocket. That makes a lot more sense to me. Body mass index should be used as a qualifier-obese patients need to have a reason to loose [sic] weight and maybe this could be one of them. It should not pay for gastric bypass surgery. Patients need to close their mouths to needless calories and poor diets. Where is personal accountability and self control in the equation?

This statement reflects this nurse's perception of and frustration with clients of the OHP, a perception that is clouded by personal bias. This nurse's distinction between

those who deserve coverage and those who do not demonstrates a binary classification which can lead to unfair treatment of patients and a reinforcement of patients' feelings of hopelessness.

### ***Convenience of the ER***

Utilizing the ER for convenience is expressed by many staff members as blatant abuse of the OHP and includes utilizing the ER for primary care, the expense of ER visits and the ER as a 'free ticket.' First and foremost, Bezzina and colleagues (2005) recognize that: "There is a lack of agreement on how to judge 'inappropriate' or 'primary care' presentations...Decisions as to which patients are appropriate depend (not surprisingly) on the criteria used," (474). This lack of agreement is due, in part, to the overlap between the services provided by the ER and the services provided by other specialties (Bezzina et al. 2005). Because the boundaries between the services provided by the ER and the services provided by other specialties "are not clearly defined margins but a firm core with flexible borders requiring adjustment according to available resources," (Bezzina et al. 2005:476).

The changes made to the OHP effectively modified resources available to clients and thus it is crucial for the staff of the ER to adjust their perceptions that primary care patients seeking care are inappropriate. One medical receptionist reports: "People come in for minor illnesses/injuries for treatment i.e.: bruises, abrasions nausea and vomiting for short periods of time (less than 4 hours), general stomach pain, coughs and sniffles, prescription refills, lab work, pregnancy test." A nurse working for Salem Hospital for 26 years states: "Some patients having the OHP



repeatedly would use the ER as their primary health clinic instead of following up with their primary doctor/assigned to them for non-emergent situations (drug refills, chronic pain issues, ongoing medical complaints).” The above passages are indicative of the staff’s perception that the uninsured and clients of the OHP abuse the ER by relying on it for primary health concerns. What the staff does not realize is that while some abuse does occur, the changes made to the OHP force patients to exercise proxy agency by seeking care in the ER.

Patients visiting the ER for primary care do not view their visit as an abuse of the system but believe their health concern to be urgent (Lucas and Sanford 1998). Research indicates that the utilization of the ER could be an indicator that these patients have health care needs that have not been met by other health care resources (Lucas and Stanford 1998). Considering that the implemented changes to the OHP disrupted the care of clients through reductions in benefits or disenrollment many of these patients experienced times of no health care coverage at all, possibly complicating preexisting conditions.

Some staff members feel that a major problem with the ER being utilized as primary care is the expense of the actual visit. Staff members indicate that many patients utilizing the ER for primary care have conditions that would be more effectively treated in a clinic or by a primary care physician. One medical receptionist reports: “So many people abuse the ED with frequent (almost weekly visits) it puts such a drain on the resources. [It] seems senseless to deplete the resources of the OHP with expensive ED visits when UCC or PCP’s are so much more reasonable.”

Research indicates that primary care concerns treated in the ER are, in the long run,

more expensive than the same treatment performed by a primary care physician or at an urgent care clinic and can “negatively affect quality of, continuity of, and patients’ satisfaction with care,” (Cunningham, 2006:W325). The treatment of primary care in the ER places a substantial drain on resources and, in effect, places a strain on the OHP and the amount of services the OHP can provide to its clients. This drain on resources is not lost on patients. In fact some patients recognize the expense of a visit to the ER. As one patient put it: “I know my visit is costing tax payers a lot of money but I’ve got no other choice.” This patient understands the cost of his visit but the system of the OHP does not give clients many options and if there are other options available to patients these options are not promoted by the OHP or the ER.

Almost half of the hospital staff members who responded feel that OHP is utilized as a free ticket to health care and report that patients state this as their reason for visiting the ER: “[I] have had people tell me they come to the ER instead of their doctor because no co-pay and ‘it’s free,’” RN, 34 years at Salem Hospital. One medical receptionist working at Salem Hospital for 7 years states: “Patients come in and say it doesn’t matter I’m on the Oregon Health Plan. They don’t care because they aren’t paying for it.” While some patients covered by the OHP are abusing the system, staff members in the ER become frustrated with all patients seeking primary care. The policy implementation of the OHP effectively ties the hands of the ER staff, requiring them to provide treatment for complaints that the staff believes would be better treated by a primary care physician and that these patients are taking time away from those in need of immediate attention. This situation in the ER is not one that can be easily changed by staff members leading staff members to feel they cannot cause

positive change, an indicator that the staff could be suffering from a condition known as burnout.

Pines and Aronson (1988) define burnout as: “A state of physical, emotional and mental exhaustion caused by long-term involvement in emotionally demanding situations,” (9). A gradual wearing down of workers, burnout occurs when workers feel overwhelmed and unable to cause positive change (Figley 1995). Based on the participant observation portion of this study, when an ER is inundated by patients seeking primary care, the staff of the ER finds themselves having to switch gears and make decisions that are better suited for primary care physicians. The day to day events in an ER are unpredictable and chaotic continually requiring fast thinking and immediate response from ER staff. After years of working under these conditions, medical practitioners often suffer from burnout. Staff members suffering from burnout, while tired of helping and being compassionate, are not completely desensitized to the events taking place in their environment.

Consequences of burnout can lead to emotional exhaustion, leaving staff members feeling drained and with little sense of accomplishment and can compromise patient safety because it can lead to the reduced quality of medical care provided by a staff member (Lederer et al. 2006). Because of the possible consequences of burnout the staff of the ER is susceptible to harm, the very essence of being a vulnerable population: “the susceptibility to harm [resulting] from and interaction between the resources available to individuals and communities and the life challenges they face,” (Mechanic and Tanner 2007:1220).

In keeping with Mechanic and Tanner's (2007) definition of vulnerable staff members in the ER continually dealing with the symptoms of burnout can be considered a vulnerable population. Burnout effectively challenges a medical practitioner's ability to sustain professional and personal relationships and provide effective services (Figley 1995). This places the staff in a position to suffer the consequences of burnout: high job turnover, absenteeism, low morale, and other markers of job stress (Pines and Aronson 1988). Changes to the OHP challenge the resources available to its clients effectively placing strain on vital resources of the ER: the staff. With 90% of responding staff indicating that the OHP does benefit enrollees the frustration exhibited in the qualitative responses is as much a response to patients as it is to the structure of the OHP.

### **Recommendations from staff**

A portion of the survey distributed to hospital staff asked for the respondent's opinion on how the Oregon Health Plan could be improved or changed to better help those enrolled. I included this portion in the survey to understand the concerns of the staff and to help in the formation of my own recommendations (which are included at the end of my thesis). From the recommendations three themes emerged: contracting more doctors in the surrounding community, an increase in preventative care and education, and tighter restrictions for the clients of the OHP.

#### ***Contracting more doctors in surrounding community***

Almost half of the staff members who responded indicate that the OHP would

benefit by contracting more doctors in the surrounding area to take on patients. One RN stated:

People (some of them) on OHP continually utilize the ED and do not have a primary MD. It is very difficult for them to find a provider. If so, what type of agreement can be made with the MDs in the area to pick up these patients? Also, these patients are referred to an internal MD typically for follow up. However, they are often refused according to them and then they return to the ED... There must be a way to work this out with the area MDs to alleviate this huge financial burden to all involved. Expand their MDs network. Encourage MDs to accept patients to help lower costs to all. The more people on OHP utilize the ED because they do not have a primary MD the higher our taxes become. It is a vicious cycle.

Having more doctors in the area to see patients covered by OHP would ensure a continuity of care and provide services to patients for a lesser cost than those same services provided in the ER. At first glance the recommendation to contract more doctors in the surrounding community seems logical but when placed within the context of my study the problems with this recommendation become apparent. First, patients indicate that the current policy of the OHP inhibits clients from being assigned a PCP. Second, while the obtainment of a primary care physician is important for the continuity of care, recent research indicates that it does not always prevent patients from visiting the ER for primary care (Lucas and Sanford 1998). While a patient might have access to a PCP if that patient considers the health concern

to require immediate attention care will be sought in the ER regardless of whether or not the health concern actually requires immediate attention.

### ***An Increase in Preventive Care and Health Education***

Almost one-third of staff members who responded indicate the importance of preventive care and education as a key component of the OHP that needs to be better developed. In fact, the OHP recognizes the importance of preventative care in the goals of the program: “Improve the quality of health care and receipt of preventive services by Oregonians, thereby improving their health,” ([http://www.oregon.gov/DHS/healthplan/about\\_us.shtml](http://www.oregon.gov/DHS/healthplan/about_us.shtml)). Studies show that an increased use of preventive services, including the changing of lifestyle behaviors (physical inactivity, cigarette smoking, excessive alcohol intake, and unhealthy dietary practices) have great potential in the decrease of morbidity and mortality in populations (Hung 2006), and thus requiring a decrease in the utilization of health care services.

### ***Tighter Restrictions for the clients of the OHP***

More than one third of staff members who responded recommend that tighter restrictions be enforced for the clients of the OHP. Recommended restrictions from staff members include restricting the use of the ER for true emergency situations, better monitoring of the OHP for abuse, more severe consequences for abuse, and the implementations of mandatory co pays for ER visits. In their study of frequent users of the ER Lucas and Sanford (1998) report that restricting access to the ER through copayments, financial incentives, approval requirements, physician gatekeepers, and

retrospective denial of payment for visits does not deter patients from seeking primary care in the ER. This is in keeping with patients believing that ER visits are appropriate and in need of immediate attention.

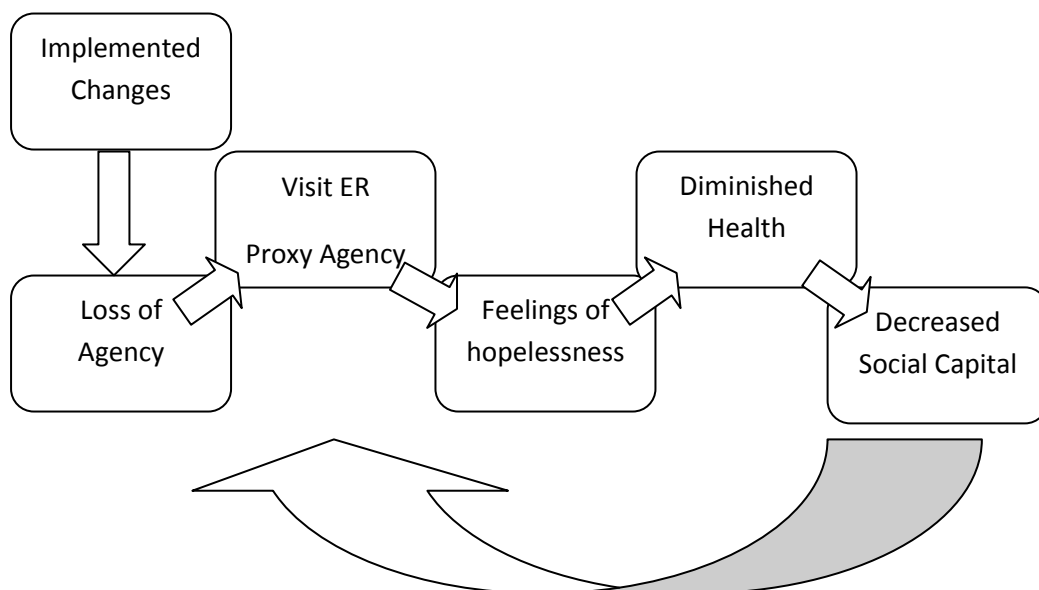
Some staff members of the Salem ER have come to place blame on the recipients of the OHP because these staff members are not in a place to change the system, but must continue to work within the system. Not aware of the policy of the OHP the staff of the ER views primary care seeking patients as inappropriately visiting the ER. Working in a stressful environment, the staff is at risk for suffering from the effects of burnout. The recommendations provided by the staff allow an understanding of what the staff perceives as areas of the OHP that need to be improved and allows a better understanding that the staff is unaware of the policy of the OHP.

## **Chapter 5-Recommendations and Conclusion**

The purpose of this study is to understand how recently implemented policy changes to the OHP have impacted those who now utilize the ER for primary health care. This study also examines the perspectives of the hospital staff. Through the use of grounded theory key themes were identified. The themes that emerged from my research indicate that the implemented changes made to the OHP in 2003 set into motion a cycle that perpetuates the health disparities which result from income disparity. As indicated in the diagram below, these changes force the vulnerable population of the poor to experience a loss of agency in terms of seeking treatment from a PCP. Because there is a loss of personal agency those who are ill exercise proxy agency and seek treatment in the ER. The staff of the ER, inundated with patients seeking primary care, becomes frustrated. This frustration is very apparent to the patients, reinforcing feelings of hopelessness created by the structure of the OHP. Feelings of hopelessness inhibit an individual's ability to form relationships with others in the community, preventing the building of social capital. With a loss of social capital comes an overall diminishment in health, forcing a visit to the ER and the continuation of the cycle.



Figure 2. Cycle of Health Disparities



## Recommendations

### *Educate Staff Regarding the OHP Policy*

The frustration expressed by staff members regarding patients who utilize the ER for primary care is indicative of a lack of connection between how the staff perceives the clients of the OHP and the reality of the current status of the OHP. Considering that more than one third of staff members who responded indicate that no information regarding the OHP was given at the time of hiring further enforces this disconnect. Patients who are unable to secure a PCP because of current policy is further complicated by the fact that ER staff members are unaware of the implemented policy changes made to the OHP, fueling misconceptions of those seeking primary care in the ER; misconceptions which have the possibility to cloud the judgment of

staff members. Taking into account the fact that the ER serves as a vital safety net for the under and uninsured population of Oregon it would be beneficial to keep ER staff apprised of current health care policy. I recommend that the staff of the ER be continually educated regarding the policy of the OHP for two reasons. First, almost two thirds of surveys returned by the ER staff indicate that information regarding the OHP was not given at the time of hiring, leaving the staff members to gain information either on their own or not at all. Second, throughout my interaction with the staff during the participant observation portion of this study, staff members indicated that they knew little or nothing at all regarding the implemented policy changes. Because the entirety of the OHP policy is dynamic and continually changes based on the state's budget the education of the staff would require a staff member who would be in communication with OHP policy officials. This can be accomplished through the dissemination of a brief and easy to read email that quickly explains any new policy that has the potential to impact the ER. Educating the staff can easily be accomplished through the distribution of memos containing easily discernable information regarding policy changes impacting the ER and requiring the charge nurses to announce and briefly explain policy changes at the briefing before each shift.

### ***Improve Health Literacy for the OHP Clients and Educate Public***

Patients who visit the ER for primary care reveal that they are either unaware of other options, or do not understand that their needs can be met by establishments other than the ER. Research indicates that a lack of health literacy skills contributes to the misuse of health care services (Howard et al. 2005). Health literacy is: "The

degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions,” (Andrulis and Brach 2007:S122). Low levels of health literacy contribute to patients receiving fewer preventative services, overall worse health outcomes, and higher utilization of health care services (Howard et al. 2005).

The OHP and its clients would greatly benefit from the implementation of health literacy interventions in ERs. Howard et al. (2005) report that many interventions have potential for improving health literacy rates in various clinical settings: health education programs for students, efforts to aid the communication between providers and patients, and educational tools intended for patients with low health literacy. As a way to decrease patient use of the ER for primary care educational materials written specifically for individuals with low health literacy can be distributed in the form of mailed pamphlets to the OHP recipients and distributed in physician offices, health clinics, and in the ER. There is the potential for staff members to briefly explain to patients at the end of treatment of other options for care that are available in the community or at home care.

Patients seeking primary care in the ER could possibly be turning to the ER because other options for treatment are unknown. In their study of inappropriate utilizations of the ER, Carret and colleagues (2007) conclude:

Education efforts are...crucial and should focus on how to use health services appropriately, as well as explain to the public about the type of care provided in the ER and the risks and disadvantages of using these services as the primary source of care (8).

The utilization of a media campaign to educate the public about what additional services are available in the community to treat primary health concerns can work to inform the public of other community resources that provide medical care. While it has been established that patients will visit the ER for care of conditions they feel need immediate attention the dissemination of information regarding community resources has potential to alleviate the visits of some primary care seekers. An educational campaign would require further research to better understand the best way to reach those patients seeking primary care treatment in the ER. Further research that includes a multisite approach and involves more participants would contribute to the overall understanding of why patients seeking primary care visit Oregon ERs and how to educate these patients regarding other options. By conducting further research at different Oregon ERs a more comprehensive understanding of how to reach the public can be achieved. The inclusion of community resources would be vital in the understanding of how to best educate each community. This further research would require a researcher not associated with hospitals throughout Oregon because, as one staff member revealed to me, this could be seen as a conflict of interest.

## **Conclusion**

This study explores the lived experience of policy implementation as it impacts past and present clients of the OHP and the perception of staff members working within the system of the OHP. As Farmer (2005) argues, the political and economic structure of a society that contributes to poverty and inequality often leads to diminished health. Changes made to the OHP, while complicating the system, saved it from running out of funding and ensured that the program would have the capability

of continuing to serve many clients who would otherwise be without any type of insurance. The intention of this study is not to criticize those working the ER but to explain how the changes made to the OHP have placed both patients and staff members in a cycle that reinforces the health disparities that result from income disparities. Patients who experience a loss of personal agency, feelings of hopelessness, and diminished social capital are now continually at risk for diminished health. Attempting to receive care in the ER, these patients are greeted begrudgingly by a staff dealing with its own suffering. Placed in a position where they are unable to create positive change for those patients who have nowhere else to go, the frustration of the staff of this ER manifests itself in the perception of these patients as abusers of the system of the OHP. The consequences of changes made to the OHP in 2003 are still resonating in every community in Oregon.

Informed by the theories of CMA and structural violence my study brings to light how changes to the OHP greatly contribute to health disparities in Oregon. The studying of and responding to issues related to the health of past and present clients of the OHP in terms of political economy and social inequality embodies the core principle of CMA (Singer 1998). The findings of this study contribute to the overall understanding the role power plays in the obtainment of health care in Oregon and how invisible and systematic violence works against vulnerable populations in the obtainment of adequate health care. Staying true to the theoretical framework of CMA and structural violence, I move beyond the boundaries of my thesis and provide recommendations and avenues for further research that, in the light of this study, can help to alleviate the astounding consequences of policy change and help end the silent

suffering (Farmer 2006) of the medically needy in Oregon. While the implementation of the recommendations presented in this chapter might be perceived as a daunting task it is important to remember the vision of the OHP founders: to keep Oregonians healthy through the expansion of health insurance to those who cannot afford it.

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## Appendix

Dear Participant,

Thank you for taking the time to complete this anonymous survey. Please use the provided envelope to return the survey to me at your earliest convenience. **If you would be interested in an interview, please fill out the portion at the end of survey.** Thank you again for your time.

1. What is your position at Salem Hospital? (Example: doctor, nurse, etc.)

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2. How long have you worked at Salem Hospital? \_\_\_\_\_

3. Are you currently, or have you ever been, on the Oregon Health Plan?

Yes \_\_\_\_\_ No \_\_\_\_\_

**For the following questions please think about your experience at Salem Hospital.**

4. Over the past two years (since 2005) have you noticed an increase in the number of patients who are utilizing the emergency room for primary health care? Yes \_\_\_\_\_ No \_\_\_\_\_

5. The patients who are utilizing the emergency room for primary health care, are the majority of them either uninsured or on the Oregon Health Plan?

Yes \_\_\_\_\_ No \_\_\_\_\_

6. When treating a patient, are aware of their insurance status?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, and the patient is uninsured, do you ever recommend that they seek information on whether they qualify for the Oregon Health Plan? Yes \_\_\_\_\_

No \_\_\_\_\_

7. When you began at Salem Hospital, how were you first introduced to the policy of the Oregon Health Plan? (For example, was it explained to you in an orientation? a handout? Through information interactions with other staff members?) Please describe

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**10. What changes do you feel would improve or benefit the Oregon Health Plan?**

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If you require more room please feel free to use the back or attach an additional sheet of paper.

**If you would like to meet with the researcher for a more in-depth, one on one confidential interview please include your name and contact information below.**

**Name** \_\_\_\_\_

**Phone number** \_\_\_\_\_

**--OR--**

**Email address** \_\_\_\_\_

