



Getting Health Care
When You Are
Uninsured:
*A Survey of Uninsured Patients
at Two Community Clinics in
Miami-Dade County, Florida*

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If you have any additional questions, or would like to learn more about our work, please contact us.

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The Human Services Coalition of Dade County, Inc. (HSC) is a coalition of more than 4,500 organizations and individuals working together to improve people's access to health and human services and to enhance their economic security. HSC is changing the face of public policy by increasing community knowledge of resources, building the capacity of community members to effect change, and engaging community members in strategic action. Since its inception, HSC has provided innovative new opportunities for outreach and advocacy on a broad spectrum of human service concerns, including health needs, quality education, homelessness, elder care, mental health, housing, violence prevention, needs of the disabled, and many more. Where no avenues for community participation exist, HSC has pushed for their creation. Where status quo solutions have not served the public's agenda, HSC has worked diligently to open new doors.

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EXECUTIVE SUMMARY

The number of uninsured Americans rose significantly over the last decade—according to current estimates, 43 million people are now without health insurance. While it is often assumed that the uninsured can easily obtain health care, much research demonstrates that lack of insurance leads to reduced access to health care and poorer health outcomes. Moreover, recent changes in the healthcare market have exposed healthcare providers to financial pressures that may be limiting their ability to provide care for the uninsured. However, access to care for the uninsured varies greatly across regions and communities.

The Community Access Monitoring Survey (CAMS) project, an initiative of The Access Project, provided support to organizations in 24 communities to survey uninsured patients receiving care at local facilities. The goals of the project were to investigate the effectiveness of local facilities in responding to the needs of the uninsured and to document barriers the uninsured face when seeking care.

This report summarizes national data on the impact of health insurance on access to care and health outcomes, and presents the results of the survey in one community, Miami, Florida. The survey was conducted in the summer of 2000 and gathered information from 372 uninsured patients who obtained health care at the Jefferson Reaves Health Center (JRC) or the Dr. Rafael Peñalver (Peñalver) Clinic in the previous year. The report also compares their experiences with those of uninsured patients surveyed at other CAMS sites across the country who received care at similar facilities.

Three out of four respondents for both JRC and Peñalver visited the clinic more than once in the past year. Nearly half of the JRC respondents and a quarter of the Peñalver respondents visited their clinic for treatment of a chronic condition. The survey results indicate:

- ◆ Respondents for JRC and Peñalver were less likely to report that their clinic was open to treating uninsured patients than respondents for all urban and suburban clinics that were part of the CAMS study nationally. For both respondent groups, a smaller percentage than the average said their clinic was open and accepting even if they were unable to pay, or that it had a reputation for providing “a lot” of care to the uninsured. A significant minority of Peñalver respondents thought the clinic provided very little or no care to people who could not pay.
- ◆ Nearly all Peñalver respondents were satisfied with the care they received from physicians; a smaller percentage of JRC

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respondents were satisfied. Respondents for both clinics were less likely than respondents nationally to be satisfied with the service they received from receptionists and nurses. JRC respondents were also less likely to report that they were always treated with respect by clinic staff.

- ◆ Respondents reported a variety of problems with access to clinics services. One-third of Peñalver respondents said the clinic's hours were a problem at least sometimes, while a similar percentage of JRC respondents said that convenience to public transportation was a problem. Many respondents for both clinics reported that their locations were a problem at least sometimes. A majority of respondents for both clinics reported that waiting times—both to get an appointment and on the day of the appointment—were significant issues.
- ◆ Language was not a barrier for Peñalver respondents: most reported that either the doctor or nurse spoke their language or that interpreters were available and their ability was good. However, among those JRC respondents who said they needed help with translations, a number reported that interpreters were either unavailable or required a long wait.
- ◆ Three-quarters of respondents were prescribed medications, and most said they paid for them out-of-pocket at a drug store. Half reported needing help to pay for them, and just under one in ten were unable to fill any of their prescriptions because of cost. Most who needed help said they were not offered any form of assistance by staff (88 % at Peñalver and 54% at JRC).
- ◆ More JRC and Peñalver respondents than average reported that it was very difficult to pay for medical care, and more than half said they needed assistance. Of those who said they needed help, half of the JRC respondents and four-fifths of Peñalver respondents said they were not offered assistance by clinic staff. While an average of 26 percent of respondents for urban and suburban clinics included in CAMS nationally reported having their bills waived, less than 10 percent of the respondents for either clinic reported this experience.
- ◆ One-sixth of all Peñalver respondents said that their bill paying experiences would deter them from seeking care there in the future. For respondents with outstanding debt to their clinic, one-third of Peñalver respondents and one-fifth of JRC respondents said that the debt would cause them not to seek care there in the future. Although most respondents for both clinics said they would use their facility if they had health insurance, one-quarter of Peñalver and one fifth of JRC respondents would seek care elsewhere if they had insurance.

INTRODUCTION

In 1998, 44 million people in the United States were uninsured, representing a 38% increase in the number of uninsured since 1987.¹ While this number fell slightly between 1998 and 1999, according to current estimates 43 million people are still without health insurance.² The ability of the uninsured to gain access to health care is thus a major national issue, but it is at the community level that the consequences are most apparent.

Many assume that even when people are uninsured, they are readily able to obtain health care. A 1999 survey of college-educated people in the United States found that 57 percent believed that uninsured people are able to get the care they need from doctors and hospitals, up from 43 percent in 1993.³ However, research has consistently demonstrated that individuals without insurance see health providers less frequently, receive fewer preventive health services, and delay care. As a result, when the uninsured do get care, they often require more expensive care. For example, the uninsured tend to come into the hospital more severely ill, and are hospitalized more frequently for conditions that could have been treated on an ambulatory, and less costly, basis.

Structural changes in the health care environment over the last decade have only increased the barriers to care facing the uninsured. Managed care companies have negotiated aggressively with health care providers to reduce their fees; as a result, providers have fewer financial resources available to subsidize care for the uninsured. At the same time, the number of uninsured has risen, increasing the demand for services, while various direct and indirect public subsidies that in the past helped support care for the uninsured have been eroding. All types of health care providers are affected by these changes, but perhaps the hardest hit are the "safety net" providers—those that, either by legal mandate or explicitly adopted mission, are dedicated to providing health care regardless of patients' ability to pay—as they generally treat the largest number of uninsured patients.

The situation, however, is not uniform across communities. Comparing the provision of care in different metropolitan statistical areas (MSAs), the author of a recent study said, "One of the most striking findings from our analysis is the tremendous variation in the provision of uncompensated care by MSAs across the country. Our MSA-level analysis indicates that there are pockets in the country where the uninsured have very limited access to hospital care."⁴

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COMMUNITY ACCESS MONITORING SURVEY PROJECT

To gather information about the barriers to care facing the uninsured in particular communities and at particular facilities, The Access Project initiated the Community Access Monitoring Survey (CAMS) project. The CAMS project funded 24 organizations across the country to survey uninsured individuals who received care at key facilities in their communities.

PROJECT GOALS

The goals of the project were to

- ◆ Learn directly from those without health insurance about their experiences and perceptions when obtaining health care
- ◆ Investigate the effectiveness of local facilities in responding to the needs of the uninsured
- ◆ Document barriers to care for the uninsured
- ◆ Use survey data to stimulate dialogue and promote change
- ◆ Put a local face on the problem of the uninsured

THE SURVEY DESIGN

The survey instrument was developed by Dennis Andrulis, Ph.D., Research Professor at SUNY Health Science Center in Brooklyn, NY. It was used to gather information about the experiences of over 10,000 uninsured patients at 58 facilities nationwide, and results were reported for each of the participating communities. The survey asked respondents a range of questions about their experiences when they received care at a particular facility while they were uninsured, such as their perceptions of the facility's willingness to provide care, satisfaction with interactions with staff, waiting times for appointments, ability to obtain needed medications, and difficulties paying for care.

Survey Limitations

The survey was designed to gather data about key providers that care for the uninsured in various communities. It was not intended to provide definitive conclusions, and readers should be aware of the limitations of the methodology.

The survey was based on a convenience rather than a random sample. Respondents were recruited at a variety of local sites, such as homeless shelters, employment offices, and housing projects, sometimes with the intent of collecting information from a particular group or groups, and the number of people who were eligible but refused to participate was not recorded. For these reasons, survey



responses cannot be generalized either to all uninsured people or to all uninsured patients who used a given facility--rather, they reflect the experiences only of those surveyed.

In addition, while all surveyors received uniform training in administration of the survey, it was not possible to evaluate actual implementation at each site. The authors also did not have access to other sources of data, such as medical records, that might have added to or verified individuals' reports, and they were not able to assess environmental factors, such as the volume of uninsured patients treated, operating budget, and staff size, which might have affected a facility's provision of care. Finally, the surveys gathered information only from uninsured individuals who were able to access care at particular facilities; they did not capture either the numbers or the experiences of those who were unable or never tried to access care.

Intended Uses of the Survey

The survey was intended to provide information on a frequently overlooked topic, the actual experiences of the uninsured when they obtain care. Notwithstanding its limitations, the authors expect that the results will be useful to providers, local officials, community representatives, and others in suggesting issues related to the provision of care for the uninsured in their communities that may benefit from further discussion or more rigorous and comprehensive study. It is hoped that this information will assist communities in improving access to care for their uninsured residents.

ABOUT THIS REPORT

This report, along with reviewing some of the general research documenting the impact of lack of insurance on healthcare access and on health outcomes, describes the survey results at one CAMS site, Miami, Florida. The survey was conducted by the Human Services Coalition of Dade County in the summer of 2000, and gathered information from 372 uninsured individuals who received care at the Jefferson Reaves Health Center or the Dr. Rafael Peñalver Clinic in Miami in the previous year. Along with providing the results of the survey for these facilities, the report compares the results with aggregate responses at all similar facilities surveyed as part of the CAMS project nationwide. A report presenting the overall findings for all surveyed sites will be released in Spring 2001.



LACK OF INSURANCE IS DANGEROUS TO YOUR HEALTH

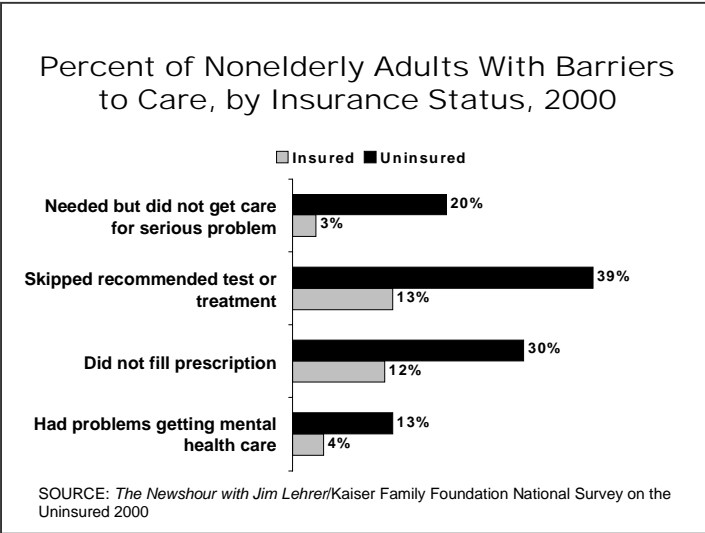
With great consistency, national research has demonstrated that insurance status affects the amount and type of care individuals receive. Lack of health insurance is related to both reduced access to care and to poorer health outcomes. In addition, many of the changes in the health care market over the last decade have increased the difficulties the uninsured face in obtaining care.

LACK OF INSURANCE AND ACCESS TO CARE

Research has shown that lack of insurance is associated with reduced utilization of health services. Some studies have found that:

- ◆ One third of uninsured U.S. residents reported problems of access to care, and about two-thirds had delayed care, because of problems in paying for health services;⁵
- ◆ The uninsured were almost six times more likely than the insured to have postponed health care for a serious condition because they couldn't afford it;⁶
- ◆ Uninsured pregnant women were at greatest risk for starting prenatal visits late and having an inadequate number of visits compared to both privately insured women and those with Medicaid;⁷
- ◆ Among persons with severe mental illnesses, the uninsured were less likely to access needed health care than those covered by insurance;⁸
- ◆ Uninsured adolescents were twice as likely as insured adolescents not to have had a doctor's visit in the past year;⁹
- ◆ Lack of insurance was related to substandard care, such as using fewer procedures and having shorter inpatient stays.^{10,11}

A recent national survey by the Kaiser Family Foundation, for example, found that the uninsured were much more likely than the insured to not have gotten care for a serious problem, skipped a recommended test or treatment, not filled prescriptions, and had problems getting mental health care.¹²



LACK OF INSURANCE AND HEALTH OUTCOMES

Research has also found that lack of health insurance correlates with poorer health outcomes. Some studies have shown, for example, that

- ◆ Children living in poverty were more likely to receive lower quality care and to die in infancy;¹³
- ◆ Uninsured children were much more likely not to have received medical care for common conditions like ear infections—illnesses that if left untreated could lead to more serious health problems;¹⁴
- ◆ The uninsured were more likely to be hospitalized for conditions that could have been avoided, such as pneumonia and uncontrolled diabetes.¹⁵
- ◆ Patients without insurance were more likely to die in the hospital,¹⁶ suggesting that they had postponed care until it was too late;
- ◆ Uninsured women were at significantly greater odds of late stage diagnosis of cervical cancer;¹⁷ while those with breast cancer had lower survival rates;¹⁸
- ◆ Young adults without insurance had higher mortality rates because they were unable to obtain needed care.¹⁹

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BENEFITS OF IMPROVED ACCESS TO HEALTH CARE

While lack of insurance is a serious barrier to receiving care, making health services available to the uninsured has been shown to lead to significant improvement in the use of critical services and in health status. One recent study found, for example, that uninsured individuals who obtained insurance coverage had better access to care based on indicators such as having a usual source of care, higher satisfaction with providers, and a greater number of physician visits in the previous year.²⁰ Another study in the Seattle area found that having insurance was strongly related to ease of access to care, and was the strongest predictor for having a regular source of care.²¹ When previously uninsured individuals were enrolled in a managed care program, investigators found their use of health care services similar to that of a commercially enrolled group.²²

Increased access to care for individuals infected with HIV represents one of the most recent dramatic instances of improvements in both mortality and morbidity. According to the Centers for Disease Control and Prevention, the first decrease in AIDS-related opportunistic infections occurred in 1997.²³ One of the major reasons cited was increased availability of new anti-retroviral therapies. The proportion of patients using this treatment regimen—for which many rely on public sector support through Medicaid and other programs—increased from 24% to 60% in just one year (1995 to 1996). This dramatic change is one demonstration of how access to critical treatments can make the difference between life and death.

Making health related services available to the uninsured at little or no cost has also led to improved outcomes. For example, the Women, Infants, and Children program, which provides food assistance to low-income children starting with the prenatal period, has helped reduce the prevalence of iron-deficiency anemia in infants and children.²⁴ Similarly, a study in Wisconsin showed that children at an initial preventive health visit who did not have access to the free Early and Periodic Screening, Diagnosis, and Treatment program had a greater number of medical and dental health problems and fewer preventive dental care visits than their contemporaries who had had continual access to the program.²⁵



THE HEALTH CARE MARKET AND CARE FOR THE UNINSURED

Over the last decade, changes in the health care market have significantly affected the provision of care to the uninsured.²⁶ Rising premiums and eroding employer-offered coverage have left increasing numbers of workers, especially low-income workers in small firms, without access to affordable health insurance. The rising numbers of uninsured increase the demand for uncompensated care on "safety net" providers—those that are charged by legal mandate or by mission with providing care to all regardless of ability to pay—as well as on other charity providers.

This increased demand is occurring simultaneously with other market changes that make it more difficult for providers to respond. An increasingly competitive health care environment, increased efforts to contain costs, and the growth of managed care have reduced the financial resources available to providers to subsidize care for the uninsured.

For example, many states have enrolled Medicaid recipients in managed care plans in an effort to reduce costs. These plans generally negotiate with providers for lower fees and also contract with multiple providers to provide services to Medicaid clients in order to obtain the best rates. However, while these changes may help reduce the overall costs of the program, they can have indirect effects on the ability of charity providers to care for the uninsured. Because major charity providers usually treat large numbers of both Medicaid and uninsured patients, they have traditionally depended on Medicaid revenues to help subsidize care for those who are unable to pay. If their Medicaid revenues decline, both because they see fewer Medicaid patients and because they receive lower fees for those they do treat, less money is available to cross-subsidize uncompensated care for the uninsured.

Research studies have in fact found that the penetration of managed care plans in a market and pressure on reimbursements are associated with reduced access to care for the uninsured. They have shown that

- ◆ In general, access to health care for low-income uninsured people is lower in states with high Medicaid managed care penetration, compared to uninsured persons in states with low Medicaid managed care penetration; access to care for low-income uninsured persons is also lower in areas with high uninsurance rates.²⁷

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- ◆ Physicians involved with managed care plans and those who practice in areas with high managed care penetration tend to provide less charity care.²⁸
- ◆ Between 1988 and 1997, while national hospital costs for uncompensated care remained around 6% of annual operating costs, the ratio of per capita expenses for the uninsured to per capita expenses overall declined by 22%. This change, which was associated with reductions in Medicaid reimbursement rates, indicated that the uninsured were losing ground compared to the insured in the number, level, or quality of services received.²⁹

In this environment, some safety net providers have in fact been forced to close, raising the question, "Where..will the safety net reside for the large number of uninsured in the community who do not qualify for [public] programs?"³⁰



COMMUNITY CONTEXT

Note: Information in this section was provided by the Human Services Coalition of Dade County.

Miami-Dade County is home to a large uninsured population. The 1999 Florida Health Insurance Study (FHIS) found that 25 percent of Miami-Dade County residents (approximately 450,000 people) under the age of 65 have no health insurance. Most of these uninsured people live in or near poverty: 58 percent have incomes below 150 percent of the federal poverty level (about \$25,500 per year for a family of four in 1999).³¹

The Public Health Trust (PHT) of Miami-Dade County is an independent entity established by county ordinance. The PHT operates Jackson Memorial Hospital (JMH), Corrections Health Care Services, and various other community health resources. Low-cost primary care in Miami-Dade County is available at thirteen community clinics that the county health department operates but in which PHT provides most of the primary care services; at twelve clinics operated directly by the PHT; at six federally qualified community health centers; and at a few community clinics operated by voluntary organizations, notably the Good News Care Clinic, the Open Doors Clinic, the Families R Us Clinic, and the Kiwanis Health Concern. PHT thus operates or provides primary care services in the overwhelming majority of the community clinics in Miami-Dade County. According to the PHT, approximately \$18.4 million of its annual budget of over \$800 million was spent on primary care during Fiscal Year 1998-99.

More than \$220 million of the PHT's revenues come from local property and sales taxes expressly dedicated to providing medical care for indigent county residents.³² In practice, the PHT has used these funds to pay for care for indigents provided at either JMH or one of the PHT-operated clinics. Given the large size of the county, advocates have raised concerns that uninsured low-income residents in some parts of the county may face significant geographical barriers to accessing affordable care.

In addition, because of concerns over the practice of providing care only at JMH or its associated PHT-clinics, the Florida legislature enacted a law in its 2000 session requiring the creation of a new, independent health trust to administer a percentage of the local tax revenues dedicated to indigent care.³³ However, the Miami-Dade County Commission has not implemented the law, claiming that it

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contravenes the county's Home Rule Charter. (See Miami-Dade County Ordinance No. 00-111, enacted September 19, 2000.) In February 2001, seven hospitals in Miami-Dade County that would benefit from implementation of the new law filed suit to require the County Commission to enforce it. As of this date, the case has not yet been decided.

The CAMS survey documented the experiences of uninsured people who received health care services at two PHT-run Miami-Dade community clinics, the Jefferson Reaves Health Center and the Dr. Rafael Peñalver Clinic. The clinics are located in low-income areas in central Miami-Dade County. The Jefferson Reaves Center is in a primarily African-American community, and the Dr. Rafael Peñalver Clinic serves a mainly Central American community. Between October 1998 and September 1999, Jefferson Reaves saw 6,423 patients who made 26,083 visits, while Rafael Peñalver saw 6,917 patients who made 19,649 visits.³⁴ In the year ending September 30, 2000, Jefferson Reaves had 22,565 and Rafael Peñalver 32,866 visits.³⁵

Some members of these communities, particularly those who are uninsured, report having been hindered in their efforts to obtain primary care at the PHT clinics due to factors such as immigration status and inability to pay required fees.^{36,37} Many low-income immigrants are no longer eligible for Medicaid because of the restrictions of the 1996 federal welfare reform law. The PHT policy is to charge the full cost of services to people living in the county who cannot demonstrate that they are county residents. At the time of the survey, it was also PHT policy to charge the full cost of services to immigrants without proof of lawful residency in the United States.³⁸

Another financial barrier was a PHT requirement that people with incomes at or below the federal poverty level (\$17,050 per year for a family of four) pay a minimum of \$10 per visit for outpatient care. Since the CAMS survey was undertaken, the PHT announced that it has eliminated the \$10 fee for people with incomes below the federal poverty level. In addition, the PHT has agreed to begin charging low-income immigrants at the same rate as non-immigrants.³⁹ The Human Services Coalition and other members of the Immigrant Health Access Task Force continue to monitor access to PHT services to ensure that these policy changes are appropriately implemented.

SURVEY METHODOLOGY

The Human Services Coalition (HSC) recruited surveyors by calling and sending notices to community-based organizations, public housing associations, churches, and social service agencies in the Little Havana and Overtown sections of Miami. Many of those recruited were low-income HSC members who had previously participated in HSC's Dade Days or Families in Touch programs. Twenty persons attended a one-day session in survey administration conducted by trainers from the Health Training Innovations Program of The Medical Foundation in Boston, Massachusetts. Fifteen of the trainees actually conducted the surveys.

The surveys were conducted in May and June 2000. To be eligible to participate, respondents had to have received care at the Jefferson Reaves Health Center or the Dr. Rafael Peñalver Clinic in the previous year while uninsured. Surveyors identified respondents as they exited the clinics, in the neighborhoods surrounding the clinics, and through door-to-door soliciting and contacts at community-based organizations, churches, and shelters. Respondents were interviewed in private and assured of the confidentiality of their responses. Respondents were asked if they were willing to provide their names only after the survey interview was completed, and no names were written on the survey forms.

Completed surveys were obtained from 185 respondents who had received services at Jefferson Reaves Health Center and 187 respondents who had received services at Dr. Rafael Peñalver Clinic. The Access Project arranged for entry of the data by an independent firm. The data were analyzed by Dennis Andrulis and Christina An, of the State University of New York, Health Science Center at Brooklyn, and by Nanette Goodman, a health consultant.

Because respondents were not randomly selected, the survey results cannot be generalized to the entire population of uninsured persons or of individuals receiving care at the two clinics. *The results reflect the experiences only of those surveyed.*

It should be noted that the survey did not capture the experiences of uninsured individuals who attempted but were unable to access care at the clinics, but only of uninsured patients who *were* able to access care. Surveyors kept a separate record of any individuals who said they had attempted to access care at either of the clinics but were denied services.

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SURVEY FINDINGS

This section describes the survey results for respondents who received care at either Dr. Rafael A. Peñalver Clinic (Peñalver) or Jefferson Reaves Health Center (JRC) while uninsured. The results are compared with averages for all urban and suburban clinics (AUSCs) included in CAMS nationwide. All comparisons were statistically significant unless otherwise indicated (ns = non-significant).

Note: For the purpose of analysis, all facilities included in the CAMS project were grouped by type (hospital or clinic), and by location (urban/suburban or rural.) These designations were determined by the organizations that sponsored the surveying. See Appendix B for a list of all facilities included in the project nationally.

RESPONDENT CHARACTERISTICS

Respondents varied in age, ethnicity and gender. Nearly all the Peñalver Clinic respondents were Hispanic while a majority of the JRC respondents were Black.

The racial/ethnic composition of the two respondent groups differed from each other as well as from the AUSC average. Nearly all of the Peñalver Clinic respondents identified themselves as Hispanic. Three of five JRC respondents identified themselves as Black and one-fourth said they were Hispanic.

Nearly all the Peñalver respondents and 15% of the JRC respondents chose to take the survey in Spanish.

Three of four (74%) respondents for Peñalver were women, a much higher proportion than for either JRC or the average for AUSCs (57% and 68% respectively).

USE OF HEALTH SERVICES

A disproportionate number of JRC respondents reported that they sought care for a chronic problem compared to Peñalver respondents and to AUSC respondents generally. Three of four respondents for both facilities used the clinic more than once in the past year.

Nearly half (45%) of the JRC respondents reported that they sought care to treat a chronic problem. In comparison, 26 percent of Peñalver respondents reported seeking treatment for a chronic problem. The average for AUSCs was 38 percent.



Repeat visits to the clinic were just as common for both respondent groups. About three of four respondents for both facilities stated that they had been to their respective clinic more than once in the past 12 months. The average proportion of respondents for AUSCs reporting multiple visits was slightly higher: 80 percent.

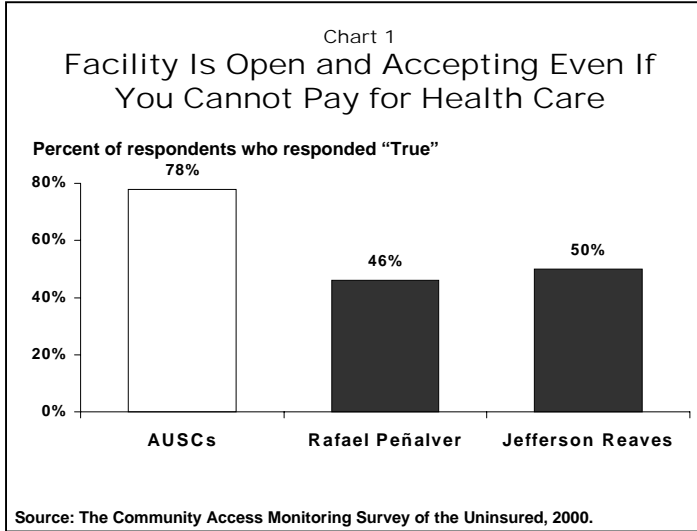
OPENNESS TO THE UNINSURED AND SATISFACTION WITH PROVIDERS

About half of the respondents for both Peñalver and JRC indicated that their respective clinics were open and accepting even if they were unable to pay. One-third believed that their clinic had a reputation for providing “a lot” of care to the uninsured. However, these proportions were much lower than the averages for AUSCs. JRC respondents were less likely than Peñalver or AUSC respondents to be satisfied with the service they received from physicians.

“Sometimes, because I’m missing a document, they don’t want to treat me.”
Peñalver Respondent

About one half of both respondent groups (Peñalver 46% and JRC 50%) reported that their respective clinics had been “open and accepting” to them even if they were unable to pay for their care. The average for AUSCs was much higher (78%). (Chart 1)

“You pay according to how much you earn and the service is good.”
JRC Respondent



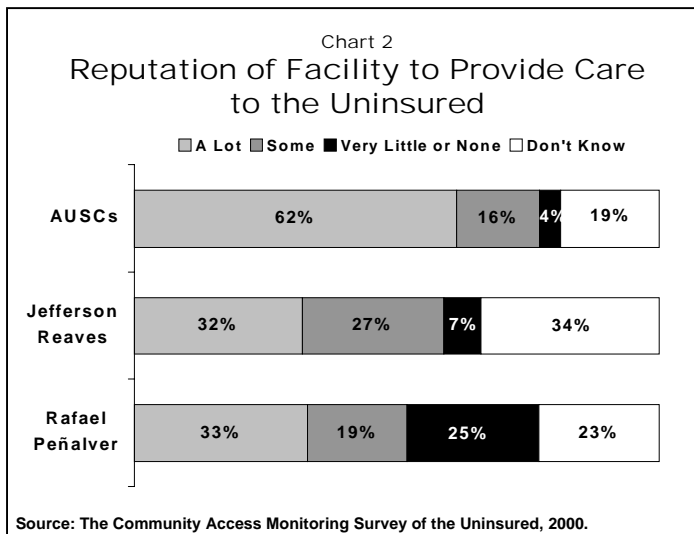
More than one in five (22%) Peñalver respondents reported that the facility “provides no care if you can’t pay.” In comparison, only two percent of respondents for JRC or AUSCs agreed with the statement.

“Without paying much I was well treated. I believe that with medical insurance, I would be treated even better.”
Peñalver Respondent

When asked about the clinic’s reputation in the community for providing care to the uninsured, about one-third of Peñalver and JRC respondents said their clinic had a reputation for providing “a lot” of

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care to the uninsured. However, the average for AUSCs was 62 percent. (Chart 2)



Moreover, one of four (25%) respondents for Peñalver stated that their facility had a reputation for providing “very little or no care for people who can’t pay.” This proportion was much higher than for JRC respondents (7%) or the average for AUSCs (4%).

More than 80 percent of each respondent group reported that they were “satisfied” or “very satisfied” with the care and service they received from receptionists and nurses. These figures were lower, however, than the averages for AUSCs (93% and 96%, respectively).

Notably, however, between 9 and 17 percent of respondents for both clinics reported that they were unsatisfied with the care and service they received from receptionists and nurses. These figures were higher than the averages for AUSCs. More than nine of ten (91%) respondents for Peñalver reported that they were either very satisfied or satisfied with the care they received from physician assistants. In comparison, the average satisfaction rating for JRC respondents and the average for AUSCs was 78 percent.

Nearly all—97 percent—of the respondents for Peñalver reported that they were satisfied or very satisfied with the care and service they received from their doctors. In comparison, 78 percent of JRC respondents said they were satisfied with their interactions with doctors. The average for AUSCs was 91 percent.

Notably, while 89 percent of Peñalver respondents reported that they were “always” treated with respect by staff, 64 percent of JRC



respondents said they were “always” treated with respect. The average for AUSCs was 84 percent.

ACCESSIBILITY

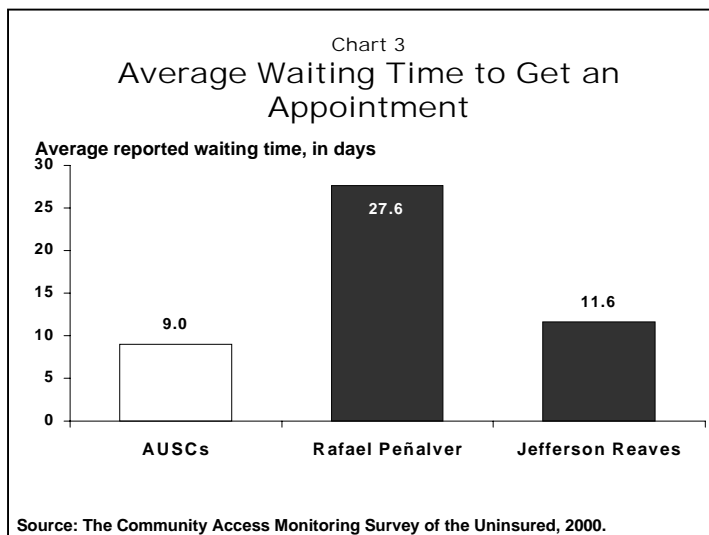
Many respondents reported that they had difficulty with access indicators such as location, convenience to public transportation, and waiting times.

Three of ten (31%) respondents for Peñalver and 18 percent of respondents for JRC reported that their respective clinic’s hours made accessing services a problem at least sometimes.

One-half (51%) of the respondents for JRC and 28 percent of the respondents for Peñalver reported that the location of their facility was a problem at least sometimes. These figures were higher than the average for AUSCs (21%).

Three of five (63%) respondents for Peñalver and 50 percent of the respondents for JRC reported that the waiting time to get an appointment was a problem at least sometimes. These proportions were higher than the average for AUSCs: 39 percent. Indeed, the average reported waiting time for Peñalver respondents was one month—28 days—while the average for JRC respondents was about 12 days and the average for AUSCs was 9 days. (Chart 3)

“You have to wait a long time for an appointment. When you do have an appointment you wait all day to be seen.”
Peñalver Respondent



The waiting time to see a provider on the day of the appointment was also an issue for most respondents. Fully two-thirds (66%) of Peñalver respondents and 70 percent of JRC respondents reported that the waiting time to see a provider on the day of the appointment was a

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problem at least sometimes. Reflecting these responses, the average reported waiting time for Peñalver respondents was over one and a half hours—98 minutes. This was considerably longer than the average reporting waiting times for either JRC respondents (53 minutes) or AUSCs (47 minutes).

“The transportation is really bad because you have to walk fifteen blocks to take the train.”
JRC respondent

Three of ten respondents for JRC reported that convenience to public transportation was a problem for them at least sometimes. In comparison, 14 percent of Peñalver respondents and an average of ten percent for AUSCs said that convenience to public transportation was an issue.

LANGUAGE NEEDS

Few Peñalver respondents reported that language was a barrier in accessing care. Among those who reported needing interpreter services, almost all said that either the doctor or nurse spoke their language or that an interpreter was available. Fewer JRC respondents reported needing interpreter services but those that needed them found the services less available and of lower quality.

Although all but one respondent for Peñalver chose to take the survey in Spanish, only 25 percent of the respondents reported that they needed an interpreter to assist them when they were treated at the facility.

“There was no need [for a translator] because they all spoke my language.”
Peñalver respondent

Among the Peñalver respondents who said they needed interpreter services, nearly all (95% or higher) reported that either the doctor or nurse spoke Spanish or that interpreters were available and their ability was very good. Furthermore, more than 90 percent of these respondents also reported that there were signs in Spanish in the waiting area and that they were provided with written information in Spanish.

Among the 12 percent of JRC respondents who reported needing help with translations, however, one-fourth found that either translators were completely unavailable or it would require a long wait to access the service.



OBTAINING PRESCRIPTION MEDICATIONS

Roughly three out of four respondents for both clinics had medications prescribed. Among these respondents, a majority reported that they used a drug store and paid out-of-pocket for their medications. Almost half said that they needed help paying for their medicines, but of these respondents, most said they were never offered assistance.

Seventy-five percent of Peñalver and 71 percent of JRC respondents had medications prescribed, in line with the average for AUSCs (70%). Among these respondents very few received their medications free (Peñalver 6% and JRC 12%). These figures were significantly lower than the average for AUSCs: 56 percent. The majority of respondents reported that they went to a drug store and paid for the medications out-of-pocket (Peñalver 74% and JRC 53%). The average for AUSCs was 34 percent. Eight percent of JRC respondents and 7 percent of Peñalver respondents said they were unable to fill *any* of their prescriptions due to costs.

"I don't have a good enough job to support myself and pay for my son's medicine."
JRC respondent

Two of five (41%) respondents for Peñalver and one-third of the respondents for JRC reported that paying for their medications was "very difficult," while the average for AUSCs was 27 percent. In addition, nearly one-half of the respondents for both facilities (Peñalver 46% and JRC 48%) reported that they needed help paying for their medications. The average for AUSCs was lower--36 percent.

"I had to stretch my medications--when three tablets were prescribed, I would take only two to stretch the cost."
JRC respondent

Among those respondents who said they needed help, 88 percent of Peñalver and 54 percent of JRC respondents said they were "never" offered any form of assistance by staff. In comparison, an average of 34 percent of AUSCs respondents who needed help said they were "never" asked if financial assistance was needed.

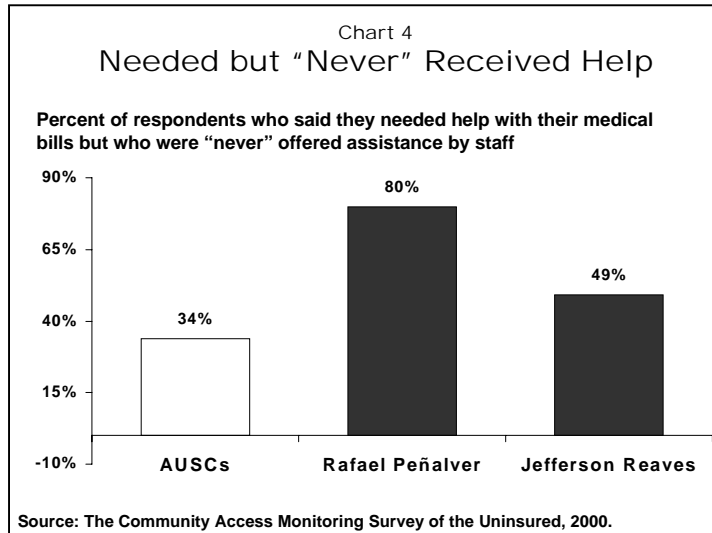
CONCERNS OVER PAYMENT FOR HEALTH CARE

Over two-fifths of the respondents reported that paying for the medical care was very difficult and more than half reported that they needed assistance. Among those who needed help, four out of five Peñalver respondents and half of JRC respondents said they were never offered assistance.

Over two-fifths of respondents (Peñalver 47% and JRC 43%) reported that paying for their medical bills was "very difficult." The average for AUSCs was 33 percent.

More than one-half of the respondents for both facilities (Peñalver 51% and JRC 57%) reported that they needed help paying for their

medical bills. Among those who needed assistance, JRC respondents were more likely than Peñalver respondents to be offered help at least “sometimes” (51% vs. 20%, respectively). Nevertheless, 49 percent of JRC respondents and 80 percent of Peñalver respondents who needed help said they were “never” offered assistance by staff. The average for all AUSCs was 34 percent. (Chart 4)



Among the respondents who were offered help, at both facilities, the most common forms of assistance offered were monthly billing plans and reductions in their bills. Notably, while an average of 26 percent of respondents for AUSCs reported that they their bills were waived, less than ten percent of the respondents for either clinic reported receiving waivers.

SEEKING CARE IN THE FUTURE

More Peñalver respondents said their past experiences paying for care at their clinic would deter them from using the facility again than JRC respondents or the average for AUSC respondents.

“If they advertised about sliding scale fees, then I would not have been scared to come back for future medical care.”
 JRC respondent

More than half (55%) of the JRC respondents reported that their past bill paying experiences would make no difference in whether they sought care at the facility again while 38 percent reported that the experience would make it easier. In comparison, 24 percent of the Peñalver respondents reported that their experience paying bills would make no difference, while 55 percent reported that it would make it easier to seek care. However, one of six respondents—17 percent—for Peñalver reported that their past experiences paying their bills would make them not seek care at the clinic again. This



was higher than the proportion of JRC respondents (5%) or the average for AUSCs (4%) who shared the same opinion.

One out of four respondents reported that they owed money to their clinic (23% of Peñalver and 27% of JRC respondents). Among those who owed money, three of ten (31%) respondents for Peñalver and 18 percent of respondents for JRC said the debt would make them not seek care there again in the future (AUSC average: 23%).

The majority of respondents—81 percent for JRC and 73 percent for Peñalver—said they would use the facility in the future if they had health insurance. The average for AUSCs was 82 percent.

“When I get my insurance I will continue coming here because at this clinic they speak Spanish.”
Peñalver respondent

“If I had insurance, I would not come back. I hate to wait for a long time.”
Peñalver respondent

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DISCUSSION

This section discusses some of the perceived strengths of the Rafael A. Peñalver Clinic and Jefferson Reeves Health Center suggested by the survey results, as well as issues that might warrant further discussion.

DR. RAFAEL A. PEÑALVER CLINIC

STRENGTHS

- ◆ Virtually all Peñalver respondents took the survey in Spanish but most found that language was not a barrier to access. Most respondents said that written information was available in their language and that, if interpreters were needed, they were available and their ability was good.
- ◆ Peñalver respondents were more likely to say that they were either very satisfied or satisfied with their interactions with physicians, physician assistants and social workers than the average for All Urban and Suburban Clinics (AUSCs) included in the CAMS project nationally.
- ◆ Three quarters of Peñalver respondents said they would use the clinic even if they had health insurance.

ISSUES FOR FURTHER CONSIDERATION

- ◆ Only 46 percent of Peñalver respondents reported that in their experience, the facility had been open and accepting to them even if they could not pay. In comparison the average for AUSCs was 61 percent.
- ◆ Compared with the average responses for AUSCs, Peñalver respondents were less likely to report that the clinic has a reputation in the community for providing a lot of care to the uninsured.
- ◆ Peñalver respondents reported that it took an average of nearly four weeks to get an appointment, three times longer than the average waiting period reported by respondents for AUSCs.
- ◆ Peñalver respondents reported that the waiting time to see a provider on the day of the appointment averaged over an hour and a half—twice the average for AUSCs.
- ◆ More than half the Peñalver respondents reported that they needed financial assistance to pay their medical bills. Eighty percent of these respondents reported that staff never offered help.

- ◆ Among those who were given prescriptions, very few received their prescriptions free, while nearly three-fourths of the respondents purchased their medications at a pharmacy. Forty-six percent of respondents reported that they needed help paying for their medications, but most of these respondents said they were never offered that help.
- ◆ One-fourth of the Peñalver respondents reported that the amount and the way that they had to pay for their medical care would make them either not seek care or seek care at another facility in the future.
- ◆ One-third of those who were in debt to the clinic said the debt would deter them from seeking care there in the future.

JEFFERSON REEVES HEALTH CENTER

STRENGTHS

- ◆ Most Jefferson Reeves Health Center (JRC) respondents reported that the clinic's hours were not a problem for them.
- ◆ Four out of five JRC respondents said they would use the clinic even if they had health insurance.

ISSUES FOR FURTHER CONSIDERATION

- ◆ Only half of JRC respondents reported that in their experience, the facility had been open and accepting to them even if they could not pay. In comparison the average for AUSCs was 61 percent.
- ◆ Compared with the average responses for AUSCs, JRC respondents were less likely to report that the clinic has a reputation in the community for providing care to the uninsured. Only one-third believed that the facility provides "a lot" of care for those who cannot pay.
- ◆ While two-thirds of JRC respondents reported that they were always treated with respect, one-third reported that they were only sometimes treated with respect.
- ◆ JRC respondents were more likely than the average AUSC respondent to be dissatisfied with their interactions with providers and staff, including physicians, nurses, physician assistants, pharmacists, billing clerks and receptionists.
- ◆ Many JRC respondents saw the location of the clinic and its convenience to public transportation as a problem.

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- ◆ JRC respondents reported that it took an average of almost 12 days to get an appointment—three days longer than the average waiting period for respondents for AUSCs.
- ◆ JRC respondents considered the waiting time to see a provider on the day of the appointment as a problem more often than the average for AUSCs.
- ◆ More than half of the JRC respondents who reported needing financial assistance to pay their medical bills said they were never offered help by staff.
- ◆ Among those who received prescriptions, more than half of the JRC respondents purchased their medications at a pharmacy. Very few respondents reported that their medications were provided free although one-third reported using a pharmacy card.

CONCLUSION

This report provides information on a topic that has not often been investigated, the experiences of the uninsured when they access health care at their local health facilities. Given the large numbers of uninsured in our country, it is a topic of increasing importance.

Because the survey was not based on a random sample, the results are more suggestive than definitive. Notwithstanding its limitations, however, the authors expect that the results will be useful in suggesting issues and questions that would benefit from further discussion and investigation as communities attempt to ensure and improve access to care for their uninsured residents.



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