



Getting Health Care
When You Are
Uninsured:
*A Survey of Uninsured
Patients at Two Clinics in
Chicago, Illinois*

AUTHORS:

Dennis Andrulis, Ph.D., MPH

Research Professor

Department of Preventive Medicine & Community Health

State University of New York, Health Science Center at Brooklyn

Nanette Goodman, MS

Health Policy Consultant

Christina An, MPH, MA

Research Instructor

Department of Preventive Medicine & Community Health

State University of New York, Health Science Center at Brooklyn

Carol Pryor, MPH, M.Ed.

Policy Analyst, The Access Project

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The Access Project is a national initiative supported by the Robert Wood Johnson Foundation and the Annie E. Casey Foundation. It works in partnership with the Heller Graduate School for Advanced Studies in Social Welfare at Brandeis University and the Collaborative for Community Health Development. It began its efforts in early 1998. The mission of The Access Project is to improve the health of our nation by assisting local communities develop and sustain efforts that improve healthcare access and promote universal coverage, with a focus on people who are without health insurance.

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

The Access Project
30 Winter Street, Suite 930
Boston, MA 02108
Phone: 617-654-9911 Fax: 617-654-9922
E-mail: info@accessproject.org Web site: www.accessproject.org

The Westside Health Authority (WHA) is a grassroots membership-based organization that seeks to “use the capacity of local people to improve the health and well being of Westside residents and to preserve existing health service institutions.” Founded in 1988 to respond to the closing of St. Anne’s Hospital, the tenth and largest hospital to close in Chicago, the WHA has since initiated a block-by-block, asset-based organizing strategy, networking neighbors with neighbors and with organizations, providers, businesses, schools, and parks. Its member organizations include 50 social service agencies, faith-based organizations, businesses, political entities, educational institutions, hospitals, health clinics, and community-based organizations. WHA’s accomplishments include the purchase of St. Anne’s hospital and use of the facility as a campus for ambulatory care and social services, the prevention of the sale of a community hospital, the creation of health internships for youth interested in health careers, and prevention of the closure of the R.M Gunnar Health Clinic by MacNeal Hospital.

Jacqueline Reed, MA
Executive Director
Westside Health Authority
5437 W. Division Street
Chicago, IL 60651
E-mail: info@healthauthority.org

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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 in Chicago, Illinois. The survey was conducted in the summer of 2000 and gathered information from 300 uninsured patients who obtained health care at the Austin Cook County Health Center or at Circle Family Care/R.M Gunnar 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.

The survey responses indicate that on most indicators of access and satisfaction, respondents for Austin Cook County Health Center (Austin) and CFC/Gunnar Clinic (CFC/Gunnar) fared as well as or better than respondents for All Urban and Suburban Clinics (AUSCs) included in the CAMS project nationwide.

- ◆ Ninety-five percent or more of the respondents for both facilities reported that, in their experience, their clinic had been open and accepting to them even if they were unable to pay for their care. In addition, four of five respondents for both clinics reported that their clinic has a reputation for providing a lot of care to the uninsured.
- ◆ The majority of respondents for both clinics (over 96%) rated their interactions with receptionists, nurses, and doctors very highly, and nearly all of the respondents for both clinics (over 95%) stated that staff “always” treated them with respect. Notably, however,

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one of five Austin respondents (21%) reported dissatisfaction with the care and service they received from pharmacists.

- ◆ The majority of respondents for both facilities reported that they used their clinic more than once in the past year; 22 percent of Austin respondents said they used their clinic ten times or more.
- ◆ Relatively few respondents for either clinic reported that their clinic's hours or location were a problem. In addition, the average reported waiting times to see a provider on the day of an appointment were shorter for both respondent groups than the AUSC average. However, the average reported waiting time to obtain an appointment for Austin respondents was 17 days, much longer than the waiting time reported by either CFC/Gunnar respondents (11 days) or the AUSC average (9 days).
- ◆ Two-thirds or more of the respondents for both clinics who needed to fill prescriptions received their medications free, while 96 percent or more stated that they understood their instructions for using their medications.
- ◆ CFC/Gunnar respondents were much more likely than Austin respondents or the AUSC average to report that paying for their medications and their medical care was "very difficult." In addition, about half of the CFC/Gunnar respondent said that they needed financial assistance to help pay their medical bills, compared with only 17 percent of Austin respondents. However, among Gunnar respondents who said they needed help, over 90 percent reported that staff offered help at least sometimes.
- ◆ Very few respondents for either facility reported that they were in debt to their clinic.
- ◆ Nearly all the respondent for both clinics said that they would use their facility again even if they had health 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 in Chicago, Illinois. The survey was conducted by Westside Health Authority in the summer of 2000, and gathered information from 300 uninsured individuals who received care at Austin Cook County Health Center or at Circle Family Care/R.M Gunnar Clinic 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

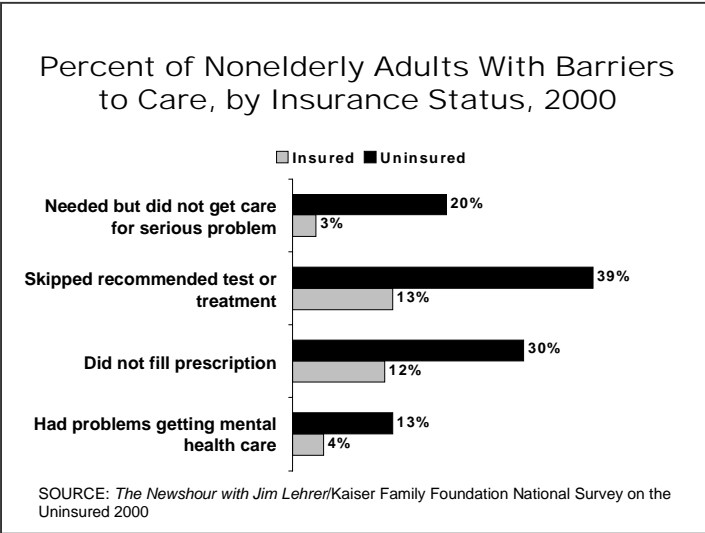
With great consistency, national research has demonstrated that insurance status affects the amount and type of care individuals receive. Lack of health insurance is related to both reduced access to care and to poorer health outcomes. In addition, many of the changes in the health care market over the 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
- ◆ Physicians involved with managed care plans and those who practice in areas with high managed care penetration tend to provide less charity care.²⁸

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- ◆ 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 Westside Health Authority.

The Westside Health Authority serves the predominantly African-American and economically distressed Chicago neighborhoods of Austin, East and West Garfield Park, and North Lawndale. The combined population of the three contiguous neighborhoods is approximately 230,000 residents, 87 percent of whom are African-American, 9 percent Latino, and 4 percent White. An estimated 34 percent of residents live below the poverty line, and approximately 27 percent receive Transitional Aid to Needy Families (TANF), greatly exceeding the 13.2 percent rate for the City of Chicago. A little less than half of the residents have a high school diploma. The unemployment rate is approximately 18%, more than twice the seven percent rate for the City of Chicago.³¹

The community's health indicators demonstrate acute and chronic health problems. Residents suffer from disproportionate rates of asthma, heart disease, low-birth weight babies, AIDS, syphilis, gonorrhea, tuberculosis, street violence, violent crimes, domestic violence, and lead poisoning.³²

Twenty-four percent of Westside residents have no health insurance, compared to 16% of residents of the Chicago metropolitan area.³³ It is common for residents to rely on expensive and episodic emergency room care due to lack of primary care facilities, an inability to pay for care, and limited knowledge about preventive health practices. In addition, three hospitals have recently closed on Chicago's West side: St. Anne's Hospital, located in the center of Austin, which employed 400 workers, and Mary Thompson Hospital and Walter Memorial Hospital, located in nearby communities.

For the CAMS project, Westside Health Authority surveyed patients who had received services during the last year while uninsured at any of the following facilities:

The Austin Cook County Health Center is a public satellite clinic of Cook County Hospital. The clinic handles approximately 1,000 visits each month: 60 percent of its patients are uninsured, 35 percent are on Medicare or Medicaid, and 5 percent are privately insured. Fifty percent of the patients are aged 18-65, the majority of whom are between 45-60. In addition, 20 percent are aged 18 years or younger, and 30 percent are over age 65. Cook County Hospital and its clinics

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are funded by county tax dollars and provide both medical care and medications free of charge to indigent patients.

Circle Family Care (CFC) is a private federally qualified health center (FQHC) that serves the North Austin community. CFC has several sites; this project surveyed patients who received services at two of these sites.

The first site, the central parent site, is located at 4909 West Division. This health center handles approximately 1,300 patient visits each month. Twenty-three percent of the patient population is uninsured. Most of the clinic's clients are adults of all ages, many of whom have chronic diseases.³⁴

The second site, Circle Family Care's **R.M. Gunnar Clinic**, is located in South Austin, a high crime, poor area of Austin. The clinic provides 400 patient visits each month: 15 percent of its patients are uninsured, 30 percent are covered by Medicaid, 20 percent are covered by Medicare, and the remaining 55 percent are covered by private insurance.³⁵ The clinic was originally established by MacNeal Hospital, which provided up to \$400,000 annually in subsidies.³⁶ After the sale of MacNeal, the Chicago Department of Health subsidized the clinic's rent to care for patients with sexually-transmitted diseases (STDs) under the auspices of Circle Family Care (CFC). The clinic also provides primary care services.

All of the clinics emphasize preventive health care and have a good community reputation. In 1994-96, Westside Health Authority established relationships with neighborhood clinics, including Austin Cook County Health Center, Circle Family Care, and the R.M. Gunnar Clinic, as part of its involvement in the Opening Doors: Reducing Socio-Cultural Barriers to Health Care project supported by the Robert Wood Johnson Foundation. As part of this project, the clinics worked actively with Westside Health Authority to identify and eliminate or reduce barriers to care.

SURVEY METHODOLOGY

The survey was administered by seven community surveyors, all of whom were community residents and four of whom were unemployed or retired. The surveyors attended a full-day training session in survey administration, which was conducted by trainers from the Health Training Innovations Program of The Medical Foundation in Boston, Massachusetts. In addition, Westside Health Authority provided eight hours of pre and post-training.

To be eligible to participate, respondents had to have received care during the previous year while uninsured at Austin Cook County Health Center or at Circle Family Care/R.M Gunnar Clinic. Participants were recruited and the interviews conducted at the health clinics. Staff alerted patients about the project and provided contact information, and surveyors conducted the interviews with eligible individuals willing to participate in private rooms or other private areas. Surveyors worked days, evenings and weekends when the clinics were open. All respondents who qualified and completed the survey received a five dollar cash incentive.

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 policy consultant.

In total, 300 surveys were completed, 150 for each clinic. 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 targeted facilities. *The results reflect the experiences only of those surveyed.*

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SURVEY FINDINGS

This section describes the survey results for respondents who received care at Austin Cook County Health Center (Austin) or at Circle Family Care/R.M Gunnar Clinic (CFC/Gunnar) while uninsured. It also compares their results with averages for All Urban and Suburban Clinics (AUSCs) included in the CAMS project nationwide. All comparisons are statistically significant unless otherwise indicated (ns = non-significant). See Appendix A for a table of the results for the two Chicago clinics, as well as for the aggregate results for AUSCs included in CAMS .

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

Nine of ten respondents for both facilities identified themselves as African-American. Austin respondents tended to be slightly older than CFC/Gunnar respondents.

Respondents varied by age, but only seven percent of each respondent group answered on behalf of a child. Austin respondents tended to be slightly older than either CFC/Gunnar respondents or the average for AUSCs.

About nine of ten respondents for both respondent groups identified themselves as African-American, compared to a 44 percent average for AUSCs.

All respondents took the survey in English.

USE OF HEALTH SERVICES

Respondents for both Austin and CFC/Gunnar were more likely than the AUSC average to have visited their clinic for a chronic condition and to have used it more than once in the past year.

Between 84 and 89 percent of the respondents for both facilities reported that they used their respective clinic more than once in the past year. In fact, one of five (22%) respondents for Austin stated that they had used their clinic *ten* times or more in the past year. This



compared to one in ten (11%) of CFC/Gunnar respondents and 13 percent of respondents for AUSCs.

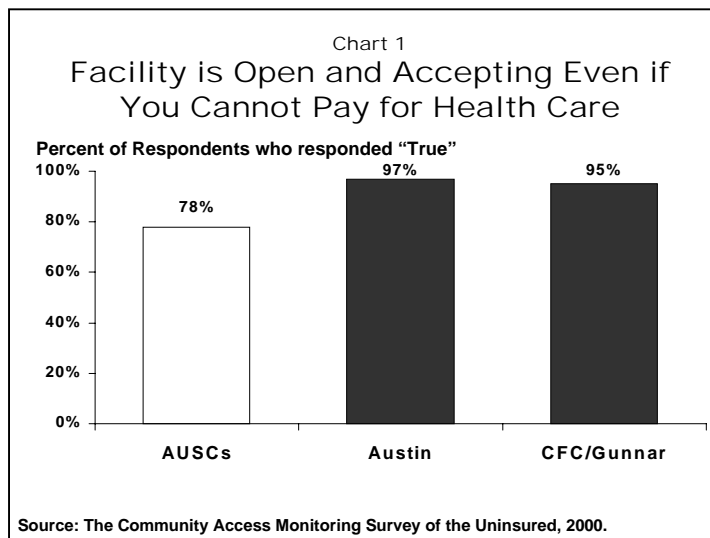
More than half of the respondents for both facilities said that they used their respective facility to treat a chronic problem (Austin 51% and CFC/Gunnar 54%). The average for AUSCs was 38 percent.

OPENNESS TO THE UNINSURED AND SATISFACTION WITH PROVIDERS

Most Austin and CDF/Gunnar respondents said their clinic was “open and accepting” even if they were not able to pay for their care, and that it had a reputation for providing “a lot” of care to the uninsured.

The overwhelming majority of both respondent groups—95 percent or more—stated that, in their experience, their clinic had been “open and accepting” even if they were unable to pay for their care. In comparison, the average for AUSCs was 78 percent. (Chart 1)

“They are very nice about people not being able to pay. They treat you anyway.”
CFC/Gunnar Respondent



Respondents were also asked what kind of reputation their facility had in the community for providing care to the uninsured. More than 80 percent of respondents for Austin and CFC/Gunnar reported that their clinic had a reputation for providing “a lot” of care to the uninsured. The average for AUSCs was 62 percent.

Nearly all of the respondents (over 96%) reported that they were either “very satisfied” or “satisfied” with the care and service they received from receptionists, nurses, and doctors.

“[I was] treated with excellent care. The doctor stayed with me even when it was time for him to go.”
Austin Respondent

Less than eight percent of the respondents for both facilities rated their interactions with physician assistants, social workers, or billing

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“The pharmacy gives other patient’s medicine to you. Also if there are a lot of medications, they only give you half and say they are out of the prescriptions. They need attitude adjustment classes.”
Austin Respondent

clerks as unsatisfactory. Notably, however, 21 percent of the Austin respondents said that they were dissatisfied with the care and service they received from pharmacists, while only 3 to 4 percent of respondents for CFC/Gunnar or for AUSCs reported dissatisfaction with pharmacists.

Nearly all respondents for both clinics (95%-96%) stated that they are “always” treated with respect. The average for AUSCs was 84 percent.

“Pharmacy is unconcerned and gives you the wrong medication a lot of times. Every time I get a prescription they fill it wrong, and I have to go see administration.”
Austin Respondent

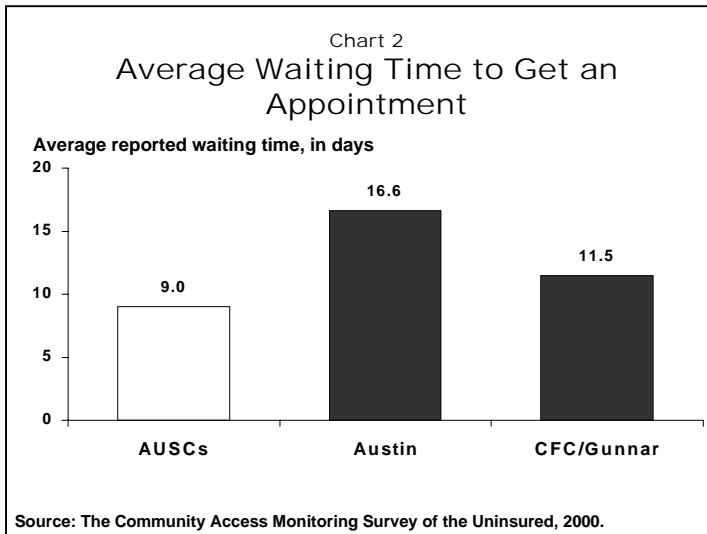
ACCESSIBILITY

Respondents generally reported that Austin and CFC/Gunnar were accessible in terms of hours of operation and location. Austin respondents were more likely than CFC/Gunnar respondents or the AUSC average to report that the waiting time to get an appointment was a problem. Fewer respondents considered the waiting time on the day of the appointment to be a problem.

Thirteen percent of Austin respondents and 19 percent of CFC/Gunnar respondents reported that the hours at the facility were a problem for them at least sometimes. This proportion was smaller than the AUSC average of 24 percent. In addition, over 90 percent of both respondent groups stated that the location of their clinic was “never a problem.”

“It takes some time to schedule appointments, that’s about it.”
Austin Respondent

One-half of the Austin respondents said that the waiting time to get an appointment was a problem at least sometimes. In comparison, the proportion of respondents who reported problems getting an appointment for CFC/Gunnar and AUSCs was smaller (33% and 39%, respectively). The reported waiting times to get an appointment reflected these ratings: the average reported waiting time for Austin respondents was 17 days, compared to 11 days for CFC/Gunnar respondents and 9 days for AUSCs. (Chart 2)



Both Austin and CFC/Gunnar respondents were less likely to report that the waiting time on the day of an appointment was a problem than the average for AUSCs. That is, while 60 percent of Austin respondents and 70 percent of CFC/Gunnar respondents stated that the waiting time on the day of an appointment was “never a problem,” the average for AUSCs was 46 percent. The average reported waiting times were also correspondingly shorter: Austin 37 minutes, CFC/Gunnar 31 minutes, and AUSCs 47 minutes.

When respondents were asked whether convenience to public transportation or assistance with transportation were issues for them, less than ten percent responded that they were problems even sometimes.

OBTAINING PRESCRIPTION MEDICATIONS

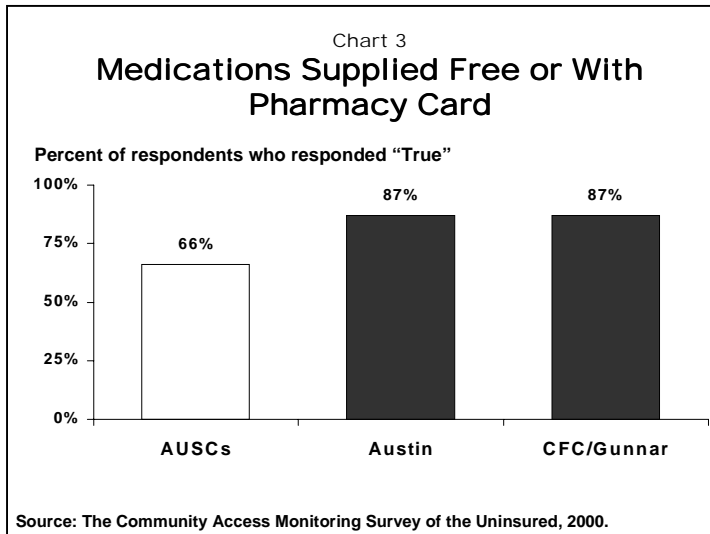
The majority of the respondents for both clinics reported that they had medications prescribed. Among these respondents, two-thirds or more said they received their medications free.

Four of five (81%) respondents for Austin and 69 percent for CFC/Gunnar reported that they received prescriptions for medications. The average for AUSCs was 70 percent.

Among those who received prescriptions, 66 percent of Austin respondents and 81 percent of CFC/Gunnar respondents reported that they received their medications free. The average for AUSCs was 56 percent. In addition, 21 percent of Austin respondents and 6 percent of CFC/Gunnar respondents said they used a pharmacy card. (Chart 3)

“It’s free, you just go to Cook County Hospital and pick it up.”
Austin Respondent

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Nearly all of the respondents for both facilities (96% or more) said that they understood the instructions for using their medications.

Two of five (39%) respondents for CFC/Gunnar and 11 percent for Austin reported that paying for their medications was "very difficult." The average for AUSCs was 27 percent. In addition, one of five respondents for Austin (22%) and 43 percent for CFC/Gunnar reported that they needed help paying for their medications. The average for AUSCs was 36 percent. Among the respondents who needed financial assistance, 25 percent of Austin respondents and 13 percent of CFC/Gunnar respondents said that staff "never" offered any help. Ten percent of CFC/Gunnar respondents and 7 percent of Austin respondents said they were unable to get some of their medications due to cost.

CONCERNS OVER PAYMENT FOR HEALTH CARE

Austin respondents were more likely than the AUSC average to report that paying for their medical care was "easy," while CFC Gunnar respondents were more likely to report that it was "very difficult" to pay for medical care. However, among those who said they needed help to pay for their care, Gunnar respondents were more likely to report that staff "always" offered help.

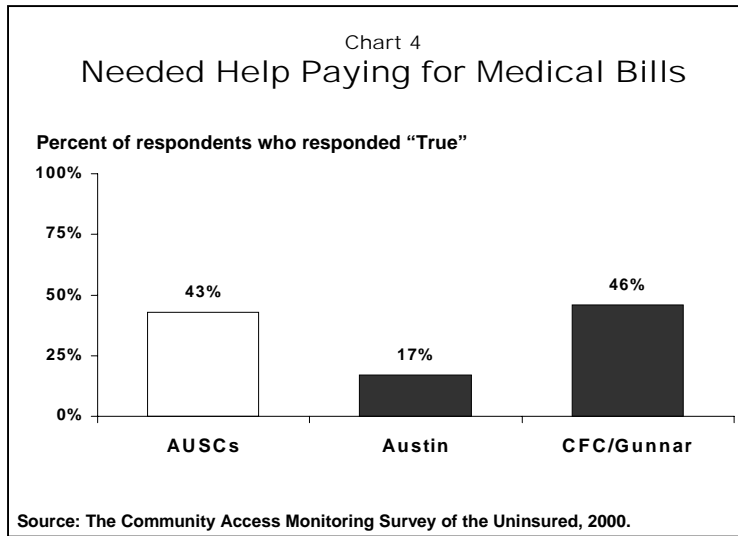
CFC/Gunnar respondents were much more likely than either Austin respondents or the average for AUSCs to report that paying for their medical care was "very" difficult (49% vs. 17% and 33%, respectively). Three-fourths (75%) of Austin respondents reported that it was "easy

"Medical care is free."
Austin Respondent



to pay” for medical care, compared to 40 percent of CFC/Gunnar respondents and 34 percent of all AUSC respondents.

About half of the CFC/Gunnar respondents (46%) stated that they needed financial assistance to pay for their medical bills. In comparison, only 17 percent of Austin respondents reported that they needed help, while the average for AUSCs was 43 percent. (Chart 4)



Among the Gunnar respondents who needed financial assistance, the majority (over 90%) reported that staff offered help at least sometimes, compared to about two-thirds of both Austin respondents and respondents for all AUSCs. Of the respondents who received help, waiving the bill was the most common form of assistance (Austin 53%, CFC/Gunnar 40%, AUSC average 26%).

“They do work with a sliding scale. I don’t think they could be any fairer than that.”
CFC/Gunnar Respondent

SEEKING CARE IN THE FUTURE

Two-thirds of the respondents for both clinics reported that their past experiences paying for care would make it easier to seek care at their clinic in the future. In addition almost all respondents said they would use the facility even if they had health insurance

Respondents were asked how their past experiences paying bills at their clinic would affect their likelihood of seeking care there in the future. Two-thirds of the respondents for both facilities stated that their past experiences would make it easier for them to seek care. The average for AUSCs was 53 percent.

“I just hope they stay here, because they are good for the community. There are no other free clinics in the community.”
Austin Respondent

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Very few respondents (Austin 3% and CFC/Gunnar 6%) reported that they owed money to their clinic. These proportions were much lower than the AUSC average of 20 percent.

"I've been coming here for five years. I won't go anywhere else."
CFC/Gunnar respondent

The overwhelming majority of respondents for both clinics—Austin 97 percent and CFC/Gunnar 98 percent—stated that they would use their clinic again even if they had health insurance. The average for AUSCs was 82 percent.

DISCUSSION

The survey responses indicate that on most indicators of access and satisfaction, respondents for Austin Cook County Health Center (Austin) and CFC/Gunnar Clinic (CFC/Gunnar) fared as well as or better than respondents for All Urban and Suburban Clinics (AUSCs) included in the CAMS project nationwide. The two notable exceptions were that CFC/Gunnar respondents were more likely than either Austin respondents or the average for AUSCs to report difficulty paying for their medical care and prescriptions, while Austin respondents reported a longer average time to get an appointment than either CFC/Gunnar respondents or the AUSC average.

COMMON STRENGTHS

- ◆ Ninety-five percent or more of the respondents for both facilities reported that, in their experience, their clinic had been open and accepting to them even if they were unable to pay for their care. In addition, four of five respondents for both clinics reported that their clinic has a reputation for providing a lot of care to the uninsured.
- ◆ The majority of respondents for both clinics (over 96%) rated their interactions with receptionists, nurses, and doctors very highly. Nearly all of the respondents for both clinics (over 95%) stated that staff “always” treated them with respect.
- ◆ Relatively few respondents for either clinic reported that their clinic’s hours or location were a problem. In addition, the average reported waiting times to see a provider on the day of an appointment were shorter for both respondent groups than the AUSC average.
- ◆ Two-thirds or more of the respondents for both clinics who needed to fill prescriptions received their medications free, while 96 percent or more stated that they understood their instructions for using medication.
- ◆ Very few respondents reported that they were in debt to their clinic.
- ◆ Nearly all the respondent for both clinics said that they would use their facility again even if they had health insurance.



REFERENCES

- ¹ Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers, *America's Health Care Safety Net: Intact but Endangered*, Institute of Medicine, National Academy Press, Washington D.C., 2000.
- ² U.S. Census Bureau, *Health Insurance Historical Tables*, Washington D.C., 2000.
- ³ Harvard/Robert Wood Johnson Foundation Report on Public Attitudes Towards Access to Health, 1999, cited in "RWJF Steps Up Insurance Coverage Initiatives," *Advances: The Robert Wood Johnson Foundation Quarterly Newsletter*, 1 (2000): 2.
- ⁴ G. Melnick, cited in "Hospitals' Uncompensated Care Expenses Not Keeping Pace with Per Capita Spending," *Health Care Financing & Organization News & Progress*, The Alpha Center, Washington D.C., March 2000: 6.
- ⁵ K. Donelan, R. Blendon, J. Benson, R. Leitman, and H. Taylor, "All Payer, Single Payer, Managed Care, No Payer: Patients' Perspectives in Three Nations," *Health Affairs* (Millwood), 15 (1996): 254-265.
- ⁶ Health Desk, *National Survey on the Uninsured, 2000*, Newshour with Jim Lehrer/Kaiser Family Foundation, Menlo Park, April 2000.
- ⁷ B. Spillman, "The Impact of Being Uninsured on Utilization of Basic Health Care Services," *Inquiry*, 29 (1992): 457-466.
- ⁸ D.D. McAlpine and D. Mechanic, "Utilization of Specialty Mental Health Care Among Persons with Severe Mental Illness: The Roles of Demographics, Need, Insurance, and Risk," *Health Serv Res*, 35(1 Pt 2) (2000): 277-92.
- ⁹ P.W. Newacheck, C. Brindis, C.U. Cart, K. Marchi, and C.E. Irwin, "Adolescent Health Insurance Coverage: Recent Changes and Access to Care," *Pediatrics*, 104 (1999): 195-202.
- ¹⁰ H. Burstein, S. Lipsitz, and T. Brennan, "Socioeconomic Status and Risk for Substandard Medical Care," *JAMA*, 268 (1992): 2383-2387.
- ¹¹ J. Weissman, and A. Epstein, "Case Mix and Resource Utilization by Uninsured Hospital Patients in the Boston Metropolitan Area," *JAMA*, 261 (1989): 3572-3576.
- ¹² Kaiser Commission on Medicaid and the Uninsured, *Uninsured Facts*, The Henry J. Kaiser Family Foundation, May 2000.
- ¹³ National Academy on Aging, "One in Four: Child Poverty in America," *The Public Policy and Aging Report*, 1997, 8.
- ¹⁴ Kaiser Family Foundation, *The Uninsured and Their Access to Health Care*, May 2000.
- ¹⁵ Kaiser Commission on Medicaid and the Uninsured, *op cit*.

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- ¹⁶ J. Hadley, E. Steinberg, and J. Feder, "Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use, and Outcome," *JAMA*, 265 (1991): 374-379.
- ¹⁷ J.M. Ferrante, E.C. Gonzalez, R.G. Roetzheim, N. Pal, L. Woodward, "Clinical and Demographic Predictors of Late-Stage Cervical Cancer," *Arch Fam Med* 9(5): (2000): 439-45.
- ¹⁸ J. Ayanian, B. Kohler, T. Abe, and A. Epstein, "The Relation Between Health Insurance Coverage and Clinical Outcomes Among Women with Breast Cancer," *New England Journal of Medicine*, 329: (1993): 326-331.
- ¹⁹ P. Franks, C. Clancy, and M. Gold, "Health Insurance and Mortality: Evidence from a National Cohort," *JAMA*, 270 (1993): 737-741.
- ²⁰ J.D. Kasper, T.A. Giovannini, and C. Hoffman, "Gaining and Losing Health Insurance: Strengthening the Evidence for Effects on Access to Care and Health Outcomes," *Med Care Res Rev*, 57(3): (2000): 298-318; discussion 319-25.
- ²¹ B. Saver and N. Peterfreund, "Insurance, Income and Access to Ambulatory Care in King County, Washington," *American Journal of Public Health*, 83 (1993): 1583-1588.
- ²² H. Bograd, D. Ritzwoller, N. Calonge, K. Shields, and M. Hanrahan, "Extending Health Maintenance Organizations to the Uninsured: A Controlled Measure of Health Care Utilization," *JAMA*, 277 (1997): 1067-1072.
- ²³ "Update: Trends in AIDS Incidence—United States, 1996," *Morbidity and Mortality Weekly Report*, 46 (1997): 861-867.
- ²⁴ B.L. Devaney, M.R. Ellwood, and J.M. Love, "Programs that Mitigate the Effects of Poverty on Children," *Future Child*, 7(2): (1997) 88-112.
- ²⁵ B.R. Clarridge, B.J. Larson, and K.M. Newman, "Reaching Children of the Uninsured and Underinsured in Two Rural Wisconsin Counties: Findings from a Pilot Project," *Journal of Rural Health*, 9(1): (1993), 40-49.
- ²⁶ See for example Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers, *op cit*.
- ²⁷ P. Cunningham, "Pressures on Safety Net Access: The Level of Managed Care Penetration and Uninsurance Rate in a Community," *Health Services Research*, 34 (1998): 255-270.
- ²⁸ P. Cunningham, et al, "Managed Care and Physicians' Provision of Charity Care," *JAMA*, 281 (1997): 1087-1092.
- ²⁹ G. Melnick, *op cit*.
- ³⁰ D. Andrulis and M. Gusmano, *Public-Private Community Initiative and Partnership in Designing and Financing Health Care for the Uninsured*, New York Academy of Medicine, 2000.
- ³¹ U.S. Census, 1990.



³² City of Chicago, Department of Public Health, *Epidemiology Report 1994-96*.

³³ R. Seifert and K. Sokol, *The Uninsured in Illinois and Chicago: Close to 2 Million Face Barriers to Health Care*, The Access Project, Boston, 1999.

³⁴ Len Sharber, CEO, Circle Family Care, March 1, 2000.

³⁵ Dr. Peter Mayock, Co-Medical Director, R.M. Gunnar Clinic, February 28, 2000.

³⁶ *Ibid.*

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