



Getting Health Care  
When You Are  
Uninsured:  
*A Survey of Uninsured Patients  
at Earl K. Long Medical Center  
in Baton Rouge, Louisiana*

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

*This report was produced in collaboration with Dr. Holley Galland,  
Dept. of Family Medicine, Louisiana State University Health Sciences Center.*

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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 in developing and sustaining 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](mailto:info@accessproject.org)  
Web site: [www.accessproject.org](http://www.accessproject.org)

The **Department of Family Medicine** is affiliated with both the Louisiana State University (LSU) Health Sciences Center in New Orleans, the state medical school, and the LSU Healthcare Services Division, which administers the state public hospital system, including the Earl K. Long Medical Center, the state run public hospital in Baton Rouge. As part of its responsibilities at the Earl K. Long Medical Center, the Department of Family Medicine runs a Family Practice clinic and oversees the urgent care center and two community outreach clinics. It also provides medical staff and supervision for Baton Rouge's school based health clinics, which provide comprehensive, primary health services to students in eight public schools. For more information, contact:

Dr. Holley Galland  
5825 Airline Highway  
Baton Rouge, La. 70805  
Phone: 225-358-1215  
Fax: 225-358-1211  
E-mail: [hgalla@lsuhsc.edu](mailto:hgalla@lsuhsc.edu)

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**Acknowledgements**

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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 at one site in Baton Rouge, Louisiana. The survey was conducted in the summer of 2000 and gathered information from 201 uninsured patients who obtained health care at the Earl K. Long Medical Center 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.

### KEY FINDINGS

- ◆ The overwhelming majority of Earl K. Long Medical Center (EKLMC) respondents said that in their *experience*, the facility had been open and accepting to them even if they could not pay for care, and that it had a *reputation* in the community for providing a lot of care to the uninsured.
- ◆ Respondents were generally satisfied with their interactions with receptionists, nurses, physician assistants, and doctors. However, only one-third of the respondents reported that they were “always” treated with respect, compared to 61 percent of respondents for All Urban and Suburban Hospitals (AUSHs) included in CAMS nationwide.
- ◆ Over 90 percent of the respondents reported that the facility’s hours and location were “never a problem.”

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- ◆ The average reported waiting time to get an appointment was over five weeks, markedly longer than the average for AUSHs, which was about two weeks. In addition, the average reported waiting time on the day of the appointment was over an hour and a half, much longer than the average for AUSHs.
- ◆ While EKLMC respondents were less likely than the AUSH average to report that they found paying for medications “very difficult,” they were also less likely to receive their medications free and more likely to pay for them out-of-pocket. About one-third of EKLMC respondents said that they needed help paying for their prescriptions; of these respondents, about two-thirds said staff never offered to find out if assistance was available.
- ◆ While EKLMC respondents were less likely than the AUSH average to report that they needed help to pay their medical bills, among those respondents who said they needed help, more than two-thirds reported that staff “never” offered help.
- ◆ Most of the respondents said that their past experiences paying for care at EKLMC either would make it easier for them to seek care there in the future or would make no difference.
- ◆ Fewer than two out of five respondents (39%) said they would use EKLMC if they had health insurance. This compares with 77 percent of AUSH respondents.



## INTRODUCTION

In 1998, 44 million people in the United States were uninsured, representing a 38% increase in the number of uninsured since 1987.<sup>1</sup> While this number fell slightly between 1998 and 1999, according to current estimates 43 million people are still without health insurance.<sup>2</sup> 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.<sup>3</sup> 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."<sup>4</sup>

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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 Baton Rouge, Louisiana. The survey was conducted by the Department of Family Medicine, Louisiana State University Health Sciences Center in the summer of 2000, and gathered information from uninsured individuals who received care at the Earl K. Long Medical Center in Baton Rouge in the previous year. Along with providing the results of the survey for this facility, 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 Summer 2001.



## LACK OF INSURANCE IS DANGEROUS TO YOUR HEALTH

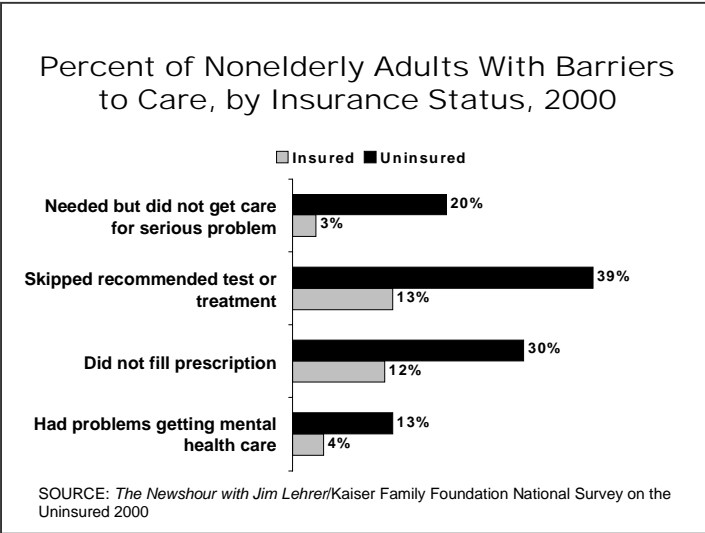
With great consistency, national research has demonstrated that insurance status affects the amount and type of care individuals receive. Lack of health insurance is related to both reduced access to care and to poorer health outcomes. In addition, many of the changes in the health care market over the 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;<sup>5</sup>
- ◆ 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;<sup>6</sup>
- ◆ 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;<sup>7</sup>
- ◆ Among persons with severe mental illnesses, the uninsured were less likely to access needed health care than those covered by insurance;<sup>8</sup>
- ◆ Uninsured adolescents were twice as likely as insured adolescents not to have had a doctor's visit in the past year;<sup>9</sup>
- ◆ Lack of insurance was related to substandard care, such as using fewer procedures and having shorter inpatient stays.<sup>10,11</sup>

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.<sup>12</sup>



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;<sup>13</sup>
- ◆ 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;<sup>14</sup>
- ◆ The uninsured were more likely to be hospitalized for conditions that could have been avoided, such as pneumonia and uncontrolled diabetes.<sup>15</sup>
- ◆ Patients without insurance were more likely to die in the hospital,<sup>16</sup> 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;<sup>17</sup> while those with breast cancer had lower survival rates;<sup>18</sup>
- ◆ Young adults without insurance had higher mortality rates because they were unable to obtain needed care.<sup>19</sup>

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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.<sup>20</sup> 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.<sup>21</sup> 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.<sup>22</sup>

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.<sup>23</sup> 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.<sup>24</sup> 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.<sup>25</sup>



## 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.<sup>26</sup> 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.<sup>27</sup>
- ◆ Physicians involved with managed care plans and those who practice in areas with high managed care penetration tend to provide less charity care.<sup>28</sup>

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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.<sup>29</sup>

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?"<sup>30</sup>



## COMMUNITY CONTEXT

**Note:** Information in this section was provided by the Department of Family Medicine, Louisiana State University Health Sciences Center.

The state of Louisiana faces major healthcare challenges. Nationally, the state ranks first in lack of access to primary medical care;<sup>31</sup> second in both poverty<sup>32</sup> and age-adjusted death rates from all causes (582.9 per 100,000 compared to a U.S. rate of 478.1 per 100,000);<sup>33</sup> third in the percentage of residents without health insurance (22.5%);<sup>34</sup> and in 1998 last in healthcare indicators based on 17 criteria, including disease rates, access to health care, and other mortality and death rates.<sup>35</sup>

Louisiana has a tradition of state-run public hospitals. These hospitals serve as a health care safety net for the uninsured and as a training site for the state's health care providers. In 1997, the Health Care Services Division (HCSD) of the Louisiana State University Health Sciences Center assumed responsibility for operating the state's nine public hospitals. The mission of the public hospitals is to provide high quality medical care regardless of income, maintain facility environments conducive to medical education, operate efficiently, and work cooperatively with other health care programs, providers and groups at the state and community level. Since 1994, funding for the public hospital system, when indexed for inflation, has decreased in real dollars by 9.8 percent.<sup>36</sup>

Earl K. Long Medical Center (EKLMC) in Baton Rouge is one of the nine public hospitals run by HCSD. It has been in operation for 30 years and serves a nine-parish (county) catchment area of approximately 100,000 people. It has 257 licensed beds, of which 108 are currently staffed.<sup>37</sup> While the statewide uninsurance rate in 1999 was 22.5 percent, over 60 percent of the patients using EKLMC had no health insurance.<sup>38</sup>

The focus of LSUHSC-HCSD is to provide effective service delivery both in hospitals and in the community. EKLMC has a busy Emergency Department and also provides outpatient services. In the last fiscal year (July 1999 to June 2000), the hospital had approximately 9,000 admissions, almost 50,000 emergency room visits, over 25,000 urgent care clinic visits, and over 125,000 outpatient visits.<sup>39</sup> The Department of Family Medicine, which runs a Family Practice clinic, recently received the additional tasks of overseeing the hospital's urgent care center and two community outreach clinics.

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The CAMS project in Baton Rouge was initiated by the Department of Family Medicine and administered by Literacy Works, an adult literacy agency. It surveyed patients who had received services at EKLMC or one of its associated clinics in the past year while uninsured. The Department of Family Medicine undertook the survey to provide information to the hospital community advisory board; to facilitate the evaluation, planning, and coordination of outpatient services provided at both the community clinics and the EKLMC campus; and to help articulate the needs of the uninsured consumers as part of larger community efforts to meet the healthcare challenges faced by this population.

## SURVEY METHODOLOGY

The survey was administered by Literacy Works, an adult literacy agency. Three surveyors who had experience conducting personal interviews, as well as involvement in the underserved neighborhoods from which respondents were recruited, conducted the survey interviews. The three 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.

Surveys were conducted in June and July of 2000. To identify respondents, surveyors focused on city neighborhoods that were likely to have large numbers of uninsured people—those where median income levels were low, dropout rates were high, and a large number of social services agencies were present or provided services. Surveyors conducted surveys at churches, community centers, adult literacy agencies, homeless shelters, small businesses, and in people’s homes. To be eligible to participate, respondents had to have received care at EKLMC within the previous year while they were uninsured. The surveys took an average of 15 minutes to complete. Patients who qualified and completed the survey received \$10.

Surveys were completed for 201 respondents. 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 Nanette Goodman, a health policy consultant.

Because the respondents were not randomly selected from the population of uninsured patients using the hospital, the survey responses cannot be generalized to the entire population; they reflect the experiences only of those patients surveyed.

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## SURVEY FINDINGS

This section describes the survey results for respondents who received care at Earl K. Long Medical Center (EKLMC) while uninsured and compares them with averages for All Urban and Suburban Hospitals (AUSHs) 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 Earl K. Long Medical Center, as well as for the aggregate results for all similar facilities 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

**Almost all respondents were African American. Respondents varied in age.**

Ninety-seven percent of the EKLMC respondents identified themselves as African-American. In comparison, the AUSH average was 46 percent. All EKLMC respondents took the survey in English.

Respondents varied in age, but one of five (22%) answered on behalf of a child, compared with 15 percent of AUSH respondents.

Sixty percent of the respondents were women, the same as the average for AUSHs.

### USE OF HEALTH SERVICES

**EKLMC respondents were less likely to use the emergency room and more likely to use an outpatient clinic than respondents for AUSHs overall. They were also more likely than the AUSH average to have used the facility more than once in the past year.**

More than three-fifths (65%) of the EKLMC respondents reported that they used the emergency room at least once in the past year, and 86 percent said that they used the outpatient clinic at least once. Emergency room use among EKLMC respondents was lower than the AUSH average (77%), while use of the outpatient clinic was substantially higher than average (45%).



Three of five (63%) respondents for EKLMC reported that they used the facility between two and four times in the past year, and an additional 22 percent reported using the facility between five and nine times. Only 9 percent of EKLMC respondents said they used the hospital only once, much lower than the AUSH average of 38 percent.

One of five (19%) respondents for EKLMC said they went to the facility to treat a chronic problem. This figure was much lower than the average for AUSHs (32%).

#### OPENNESS TO THE UNINSURED AND SATISFACTION WITH PROVIDERS

**According to most respondents, EKLMC had been open and accepting of them even though they were unable to pay. Similarly, most reported that the facility has a reputation in the community for providing a lot of care to those who are uninsured. Although most respondents said they were satisfied with their interactions with providers, only one-third felt that they had always been treated with respect by staff.**

When EKLMC respondents were asked whether they thought the hospital had been open and accepting to them even if they were unable to pay for their care, 94 percent reported that the facility had been open to them. In comparison, the average for AUSHs was 61 percent.

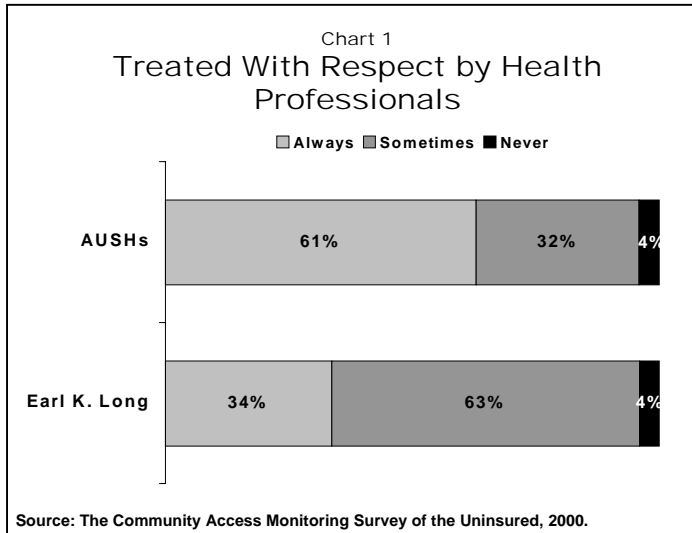
Respondents were also asked what reputation the facility had in the community for providing care to the uninsured. Nearly all—95 percent—said that the hospital provided “a lot” of care; this compared with 44 percent of respondents for AUSHs.

In contrast to AUSHs generally, few respondents reported that they were dissatisfied with their interactions with nurses, physicians, physician assistants, social workers, billing clerks and pharmacists. Notably however, only one-third (34%) of the respondents stated that they were “always” treated with respect by staff. The average for AUSHs was 61 percent. (Chart 1)

*“I didn't think they would take me in the hospital because I am homeless and don't have money, so they know they won't get their money. If I get sick I don't have a choice but to go to Long.”*  
EKLMC Respondent

*“I know when you don't have insurance, you can only use Earl K. Long, so you have to put up with the attitude and service.”*  
EKLMC Respondent

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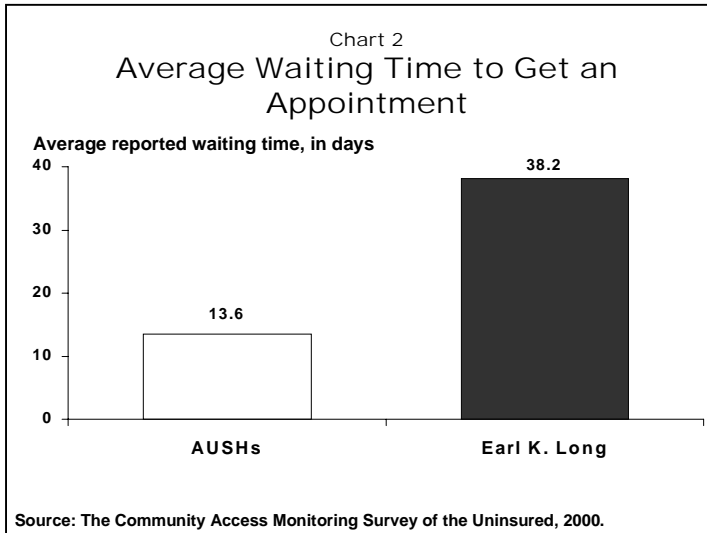


#### ACCESSIBILITY

**Most respondents said the hours and location of the hospital were never a problem for them, but many found that the waiting times to get an appointment and to see a provider on the day of the appointment were sometimes or often problems.**

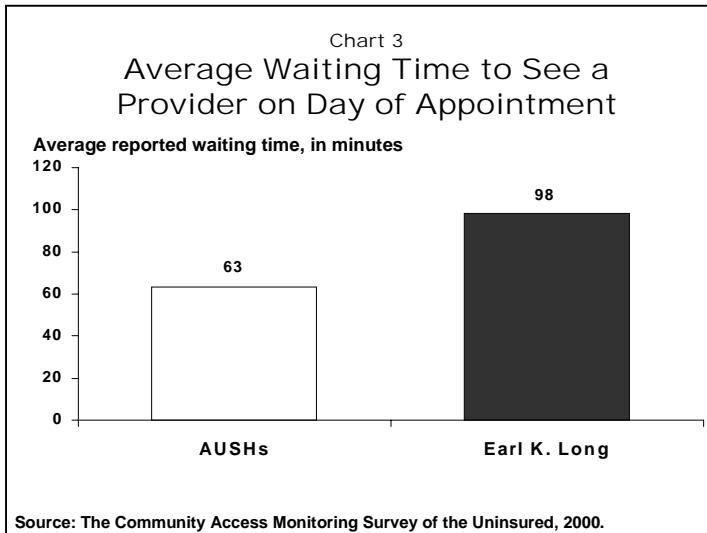
Nearly all of the respondents—98 percent—said that the hours of operation at the facility and the emergency room were “never a problem.” These proportions were higher than the averages for AUSHs. In addition, nine of ten respondents reported that the facility’s location was “never a problem.” Only ten percent said that the location was a problem even “sometimes,” compared with an average of 29 percent for AUSHs. The average reported travel time for EKLMC respondents was about 17 minutes, five minutes shorter than the AUSH average.

However, 75 percent of the respondents reported that the waiting time to get an appointment was a problem at least sometimes, much higher than the 36 percent average for AUSHs. This was reflected in the average reported waiting time to get an appointment—38 days for EKLMC respondents compared to an average of about 14 days for AUSHs. (Chart 2)



Most EKLMC respondents—84 percent—also said that the waiting time to see a provider on the day of the appointment was a problem at least sometimes. The average reported waiting time was over an hour and a half—35 minutes longer than the average for AUSHs (63 minutes). (Chart 3)

*“There are a lot of people, so it takes a long time.”*  
EKLMC Respondent



Less than five percent of the EKLMC respondents reported problems accessing public transportation or getting transportation assistance, when needed.

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## OBTAINING PRESCRIPTION MEDICATIONS

**Most respondents received prescriptions for medications. Few said they received their medications free; most reported paying for them out-of-pocket at a drug store. Nine percent said they were unable to obtain some or all of their medications because of cost.**

Nine of ten (89%) respondents reported that they received prescriptions for medications. The average for AUSHs was 74 percent.

Of those who had medications prescribed, six percent reported that they received their medications free, much lower than the 27 percent average for AUSHs. Eighty percent said they obtained their medications at a drug store and paid out-of-pocket. This figure was much higher than the average for AUSHs (57%). Nine percent of respondents said they were unable to receive some or all of their medications because of cost. The AUSH average was 17 percent.

About three of ten (28%) respondents for EKLMC reported that paying for their medications was “very difficult.” In comparison, the average for AUSHs was 40 percent. EKLMC respondents were also less likely than the average for AUSHs to report that they needed help paying for their medications (34% vs. 47%, respectively).

Among the respondents who said they needed financial assistance to pay for their medications, about two-thirds (65%) reported that staff “never” asked them if help was needed. The average for AUSHs was nearly the same (64%).

## CONCERNS OVER PAYMENT FOR HEALTH CARE

**EKLMC respondents were less likely than average to report that paying their medical bills was “very difficult” or that they needed financial assistance to pay them.**

EKLMC respondents were much less likely than the average for AUSHs to report that paying their medical bills was “very difficult” (20% vs. 61%, respectively). Twenty-eight percent of the respondents for EKLMC stated that they needed financial assistance to pay their bills, much lower than the 65 percent average for AUSHs.

Among the EKLMC respondents who needed help with their medical bills, however, while some respondents commented that staff offered to find out if financial assistance was available, 71 percent said they were “never” offered assistance, such as reductions or waivers of their bills.

“It was free.”  
EKL Respondent

“I knew I was going to get a bill but, I also knew if I didn't have the money I didn't have to pay.”  
EKL Respondent



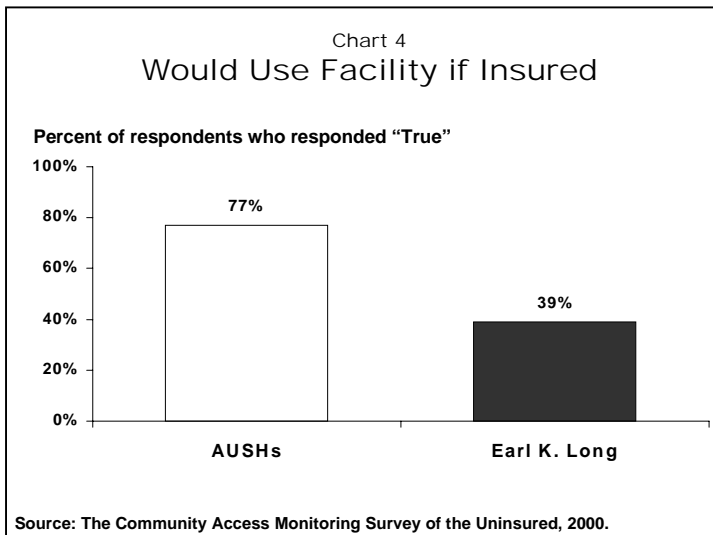
## SEEKING CARE IN THE FUTURE

**Few respondents said they would be deterred from using EKLMC because of their past payment experiences or because they had unpaid bills, but most respondents said they would not use the hospital if they were insured.**

When asked how their past experiences paying for care would affect their likelihood of seeking future care at EKLMC, 51 percent of EKLMC respondents said that it would make it easier for them to seek care and another 47 percent said it would make no difference. In comparison the averages for AUSHs were 17 percent and 60 percent, respectively. Only one of ten respondents for EKLMC (11%) reported that they were in debt to the facility, while the average for AUSHs was 61 percent. Among those who were in debt, ten percent said the debt would deter them from seeking care at the hospital again, a figure comparatively smaller than the average for AUSHs (28%).

Only two of five respondents for EKLMC (39%) said they would use the facility again if they had health insurance. The average for AUSHs was much higher (77%).

*"I will work hard at getting some health insurance so I don't have to use EKLMC again."*  
EKLMC Respondent



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## DISCUSSION

This section discusses some of the perceived strengths that are suggested by the survey results for Earl K. Long Medical Center (EKLMC). In addition, it highlights issues that may warrant further discussion.

### STRENGTHS

- ◆ Nearly all EKLMC respondents said that the facility had been open and accepting to them even if they could not pay, and that it had a reputation in the community for providing a lot of care to the uninsured.
- ◆ Respondents were generally satisfied with their interactions with receptionists, nurses, physician assistants, and doctors.
- ◆ Over 90 percent of the respondents reported that the facility's hours and location were "never a problem."
- ◆ Most of the respondents said that their past experiences paying for care would either make it easier for them to seek care at the hospital in the future or make no difference. EKLMC respondents were also much less likely to report being in debt to the hospital than respondents for AUSHs generally.

### ISSUES FOR FURTHER CONSIDERATION

- ◆ Only one-third of the respondents reported that they were "always" treated with respect by staff.
- ◆ The average reported waiting time to get an appointment at EKLMC was over five weeks, markedly longer than the average for AUSHs, which was about two weeks. In addition, the average reported waiting time to see a provider on the day of the appointment was over an hour and a half, much longer than the average for AUSHs, which was about an hour.
- ◆ While EKLMC respondents were less likely than the AUSH average to report that the found paying for medications "very difficult," only six percent said they received their medications free, lower than the AUSH average of 27 percent. Conversely, 80 percent said they paid for their medications out-of-pocket, higher than the AUSH average of 57 percent. About one-third of the respondents said that they needed help paying for their



prescriptions; of these respondents, about two-thirds said staff never offered to find out if assistance was available.

- ◆ While EKLMC respondents were less likely than the AUSH average to report that they needed help to pay their medical bills, among those respondents who said they needed help, more than two-thirds reported that staff “never” offered help.
- ◆ Fewer than two out of five respondents (39%) said they would use EKLMC if they had health insurance.

#### 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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