



Getting Health Care
When You Are
Uninsured:
*A Survey of Uninsured Patients
at Two Hospitals in
Las Vegas, Nevada*

AUTHORS:

Dennis Andrulis, Ph.D., MPH

Research Professor

Department of Preventive Medicine & Community Health

State University of New York, Health Science Center at Brooklyn

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
the Progressive Leadership Alliance of Nevada (PLAN)*

December 2000

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.

For more information, please contact:

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 **Progressive Leadership Alliance of Nevada (PLAN)** is a statewide coalition that focuses on state legislative issues. Founded in 1994, the coalition has more than tripled in size to 42 member organizations. The coalition includes anti-poverty activists, children's advocates, disabled individuals, environmentalists, lesbians and gay men, people of color, women and labor unions (including health care workers).

For more information, please contact:

Bob Fulkerson, State Director
Progressive Leadership Alliance of Nevada (PLAN)
1101 Riverside Dr., Reno, NV 89503
Phone: 775-348-7557 Fax: 775-348-7707
e-mail: Planevada@aol.com

Paul Brown
Southern Nevada Director
1700 E. Desert Inn Road, Suite 113
Las Vegas, NV 89109
Phone: 702-791-1965 Fax: 702-791-1992
Email: Planvegas@aol.com

This report may be reproduced or quoted with appropriate credit.

•
•
•
•
•
•
•

TABLE OF CONTENTS

Executive Summary 5

Introduction 7

 Community Access Monitoring Survey Project 8

 About This Report 9

Lack of Insurance is Dangerous to Your Health..... 10

 Lack of Insurance and Access to Care10

 Lack of Insurance and Health Outcomes11

 Benefits of Improved Access to Health Care12

 The Health Care Market and Care for the Uninsured.....13

Community Context..... 15

Survey Methodology 17

Survey Findings..... 18

 Respondent Characteristics18

 Use of Health Services19

 Openness to the Uninsured and Satisfaction with Providers20

 Accessibility.....22

 Language Needs23

 Obtaining Prescription Medications24

 Concerns Over Payment for Health Care.....25

 Seeking Care in the Future26

Discussion 28

References..... 31

Appendix A: Table of Survey ResultsA-1

Appendix B: Surveyed Facilities by CAMS Sponsoring Organization and by Type B-1

Appendix C: Locations of CAMS Sponsoring Organizations and State Uninsurance Rates 1997-98 C-1

Appendix D: Survey Instrument..... D-1

Acknowledgements

•
•
•
•
•
•
•
•

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, Las Vegas, Nevada. The survey was conducted in the summer of 2000 and gathered information from 308 uninsured patients who obtained health care at the University Medical Center or Sunrise Hospital and 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

- ◆ UMC and Sunrise respondents were more likely than the average for All Urban and Suburban Hospitals (AUSHs) included in CAMS nationwide to report that, in their experience, their hospital had been open and accepting even if they were unable to pay for care. At the same time, only two of five respondents for each hospital said the facility had a reputation in the community for providing “a lot” of care to the uninsured.
- ◆ More than four-fifths of the respondents for both hospitals said they used the emergency room at least once in the past year. At the same time, the proportion of respondents who said they used the outpatient clinic was lower than the AUSH average.
- ◆ The majority of respondents for both hospitals said that they were satisfied with the care and service they received from staff. However, about one-fifth of the UMC respondents said that they

•
•
•
•
•
•
•
•

were dissatisfied with their encounters with several categories of staff.

- ◆ UMC respondents were twice as likely as Sunrise respondents to say that the waiting time to get an appointment was a problem for them at least sometimes, and their average reported waiting time was twice as long (8 days) as for Sunrise respondents (4 days). The average reported waiting times to see a provider on the day of an appointment were similar for both hospitals (46 minutes for UMC and 53 minutes for Sunrise).
- ◆ Among respondents who needed help with translations, the proportion reporting that interpreters were available for both hospitals was higher than the average for AUSHs, and over 90 percent said that their interpreter's ability was either "very good" or "fair." However, over one-third of respondents who needed help reported that an interpreter was either "not very available" or "unavailable."
- ◆ About three-fourths of the respondents for both hospitals said they paid for their medications out-of-pocket, while the proportion receiving medications free was significantly smaller for UMC (14%) and Sunrise (11%) respondents than the average for AUSHs (27%). Among respondents who said they needed help paying for their medications, the majority (between 67% and 81%) said they "never" received assistance from staff.
- ◆ Among those who said they needed help paying their medical bills, respondents for both hospitals were much more likely to say that staff "always" offered to find out if financial assistance was available than the average for AUSHs. Nevertheless, about half of the respondents who needed help said they "never" received any assistance.
- ◆ More than one of five respondents for both UMC and Sunrise said their past experiences paying for care would make them **not** seek care at the hospital again. The average for AUSHs was 13 percent. Moreover, for both facilities, about one-fifth or more of respondents who owed money to their hospital said that their indebtedness would deter them from seeking care there again.
- ◆ The majority of respondents for both hospitals stated that they would use their hospital again 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

•
•
•
•
•
•
•
•
•
•

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 research documenting the impact of lack of insurance on healthcare access and on health outcomes, describes the survey results at one CAMS site, Las Vegas, Nevada. The survey was conducted by the Progressive Leadership Alliance of Nevada (PLAN) in the summer of 2000, and gathered information from 308 uninsured individuals who received care at University Medical Center or Sunrise Hospital and Medical Center 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

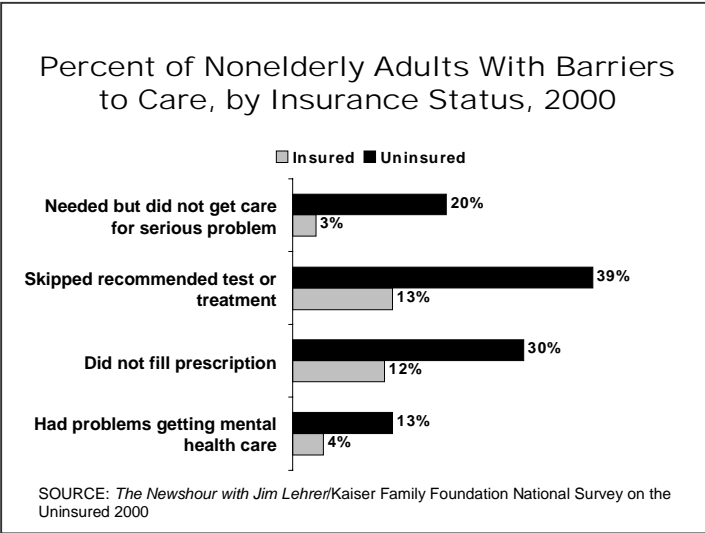
With great consistency, national research has demonstrated that insurance status affects the amount and type of care individuals receive. Lack of health insurance is related to both reduced access to care and to poorer health outcomes. In addition, many of the changes in the health care market over the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

•
•
•
•
•
•
•
•

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

•
•
•
•
•
•
•

- ◆ 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 Progressive Leadership Alliance of Nevada (PLAN).

Nevada is tied with New Mexico for the fourth highest rate of uninsured residents in the nation.³¹ In 1998, 21.2% of Nevada's population lacked health insurance,³² a figure that translates to more than 390,000 people. The majority of the uninsured lives in Clark County, which includes the city of Las Vegas. Clark County's population is booming, as is the number of its residents who lack health insurance. Between 1998 and 1999, the percentage of county residents without health insurance increased 6.8%, while the percentage of uninsured under age 18 increased by 7.7%. Currently more than 246,000 people in Clark County, including over 80,000 children, are uninsured.³³

One aspect of Clark County's population boom is a rapid increase in the number of Hispanic residents. During the 1990s, this population grew by 145% and now numbers over 300,000 people.³⁴ National studies have shown that Hispanics are at particularly high risk for being uninsured; according to a recent Commonwealth Fund report, the percentage of Hispanics under the age of 65 in the U.S. who are uninsured is nearly twice the rate of the general population.³⁵ Nationally, Hispanic children are more likely to be uninsured than children of other racial and ethnic groups. In Nevada, according to 1998 U.S. Census Bureau data, 30% of Hispanic children are uninsured, compared to 23.1% of children in the state overall.³⁶

While many Nevadans lack insurance, they face major health care problems. Nevada has the highest rate of teen pregnancy in the nation and ranks second from the top for teen tobacco use.³⁷ It also has the highest suicide rate in the nation.³⁸ Within Clark County, the president of the Southern Nevada Dental Society, Dwyte Brooks, has described dental care for poor children as "atrocious," and said that "If (children) are not covered by Medicaid or private insurance, they're probably not getting taken care of at all."³⁹ The County also has high levels of dust and carbon monoxide in its air, which can aggravate lung problems such as asthma.^{40,41}

Nevada and Clark County both have programs designed to help poor people access health care. At the state level, the Nevada Checkup program is a health care program for children from poor families. Statewide, 13,890 children are currently enrolled in the program, while it is estimated that about 21,000 children could qualify for free

•
•
•
•
•
•
•
•
•
•

care.⁴² However, in Clark County alone, there are an estimated 70,000 low-income children.⁴³

The Clark County Social Service Department runs the Medical Assistance to Indigent People Fund. Money for the fund comes from county property taxes, and the fund recently grew by nearly \$14 million due to major construction projects in the county. The fund is used to pay hospital bills up to \$25,000 for uninsured people, as well as to help underinsured people with their medical bills. In 1999, the fund paid out \$27.5 million and helped 5,333 people with their bills. The bulk of the money went to University Medical Center of Southern Nevada, which serves a disproportionate share of low-income patients.⁴⁴

Clark County has also recently been experiencing a crisis in emergency care, which is jeopardizing patient care and contributing to lower ambulance response times. Many hospitals have been forced to go on divert status, sending ambulances to other facilities because they lack available beds to care for more patients.^{45,46} Clogged emergency rooms may particularly affect care for the uninsured, because they often lack primary care providers and are forced to use emergency rooms for non-urgent care.

In an effort to better understand the needs and experiences of uninsured patients, PLAN surveyed people who had received care while they were uninsured at two hospitals in urban Clark County — University Medical Center (UMC) and Sunrise Hospital and Medical Center. Because of the rapid growth of the Hispanic population in Clark County and its high risk for being uninsured, PLAN focused its surveying activities on uninsured Hispanics who had used these facilities.

UMC is a large public hospital and the only true safety-net provider in Clark County. It provides the lion's share of the county's uncompensated care (55%), which exceeds the amount of uncompensated care provided by all other hospitals in the area combined.⁴⁷ It is a Level I Trauma Center and houses the only burn care facility in the state. Sunrise Hospital and Medical Center, which has 688 beds, is the largest hospital in Clark County. It has a Bone Marrow Transplant Unit, Renal Transplant Center and Sleep Disorder Center. Its Children's Hospital provides acute care in separate Level II and Level III Neonatal Intensive Care Units. It also recently opened an emergency room facility that is one of the largest in the state.⁴⁸ Sunrise is part of the HCA/Columbia chain of for-profit hospitals.

SURVEY METHODOLOGY

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. Most of the surveyors were bilingual and members of the community where they were surveying.

Surveys were conducted at locations close to either University Medical Center (UMC) or Sunrise Hospital. These included Family to Family, a resource center for low-income people; the main office of the Clark County Health District; and the Cambridge Community Center. All three organizations serve low-income working people, including a large number of Hispanics.

All surveys were conducted between May 21 and June 30, 2000. To be eligible to participate in the survey, respondents had to have received care at either UMC or Sunrise during the last year while they were uninsured. Surveys took an average of 20 minutes to complete. Upon completing the surveys, respondents received a \$10 grocery store gift certificate as a “thank you” for their time.

Surveyors sought to interview at least 150 people who had received care at each facility. At all locations where respondents were recruited, the majority of those eligible to participate had received care at UMC; for this reason, surveyors were able to complete the targeted number of surveys for UMC more quickly than for Sunrise Hospital. In total, 308 surveys were completed: 155 for respondents who had received care at UMC, of which 87 were completed in Spanish, and 153 for respondents who had received care at Sunrise Hospital, of which 86 were completed in Spanish.

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.

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.*

•
•
•
•
•
•
•
•

SURVEY FINDINGS

This section describes and compares the survey results for respondents who received care while uninsured at one of the two hospitals—University Medical Center (UMC) and Sunrise Hospital and Medical Center (Sunrise)—included in the CAMS project in Las Vegas. In addition, it compares these results 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 Las Vegas respondents, as well as aggregate results for AUSHs.

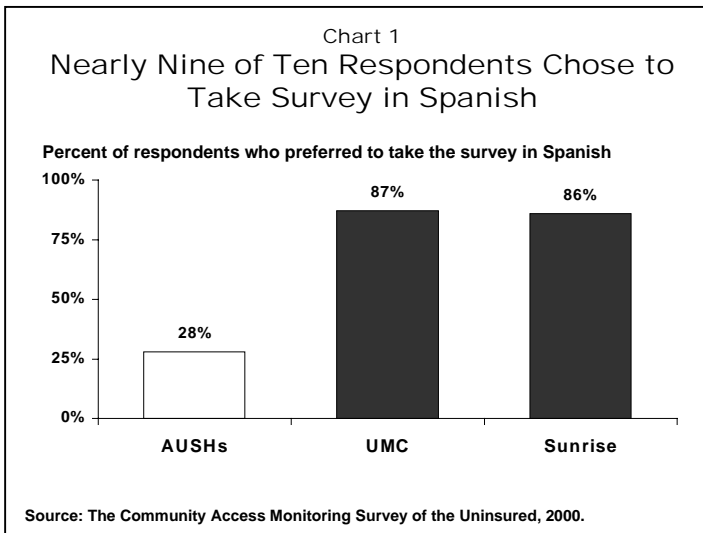
Note: For the purpose of analysis, all facilities included in the CAMS project were grouped by type (hospital or clinic), and by location (urban/suburban or rural.) These designations were determined by the organizations that sponsored the surveying. See Appendix B for a list of all facilities included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

RESPONDENT CHARACTERISTICS

The demographic characteristics of UMC and Sunrise respondents were similar, but both groups differed significantly from the AUSH average. Specifically, UMC and Sunrise respondents were more likely to be young and Hispanic than the AUSH average, and they were more likely to have taken the survey in Spanish.

A majority—over 90 percent—of UMC and Sunrise respondents were under 40 years of age, and about one-fourth of the respondents answered on behalf of a child. In contrast, the age distribution for AUSHs was more evenly spread across age groups.

In addition, 90 percent of UMC respondents and 86 percent of Sunrise respondents identified themselves as Hispanic, and most of the respondents chose to take the survey in Spanish. The average proportion of Hispanic respondents for AUSHs was 37 percent and the proportion taking the survey in Spanish was 28 percent. (Chart 1)



Finally, about seven of ten of the respondents for both facilities were women, slightly higher than the AUSH average of 60 percent.

USE OF HEALTH SERVICES

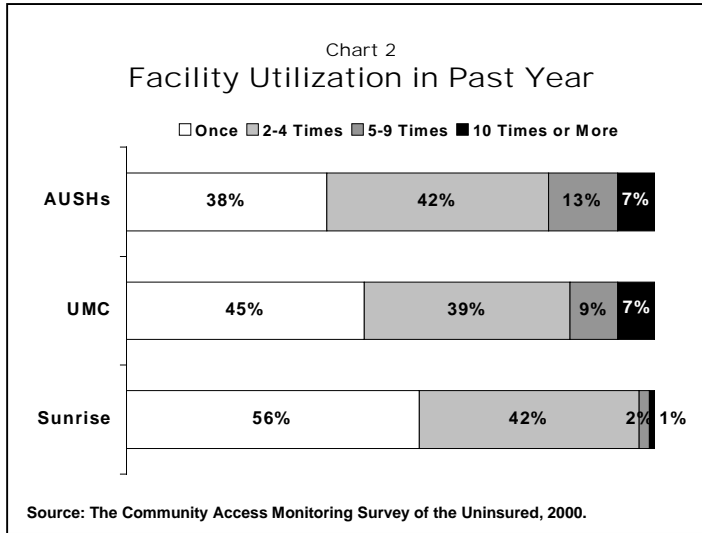
The overwhelming majority of the respondents for both hospitals used the emergency room at least once in the past year. About half used their hospital more than once.

Emergency room use: Respondents for both hospitals reported very high emergency room use: 84 percent of UMC respondents and 89 percent of Sunrise respondents used the emergency room at least once in the past year (ns), compared to 77 percent for AUSHs.

Inpatient hospitalization: Over one-half (53%) of UMC respondents and 45 percent of Sunrise respondents said that they had been admitted to the hospital at least once in the past year. These proportions were much higher than the AUSH average of 32 percent.

Outpatient clinic use: Use of the hospitals' outpatient clinics was much lower among UMC (35%) and Sunrise (28%) respondents than the AUSH average (45 percent).

Frequency of use: Sunrise respondents were a little more likely than UMC respondents to report that they had used the hospital only once in the past year. However, many respondents for both hospitals used their facility multiple times. Notably, one of six respondents for UMC used the facility five or more times in the past year. (Chart 2)

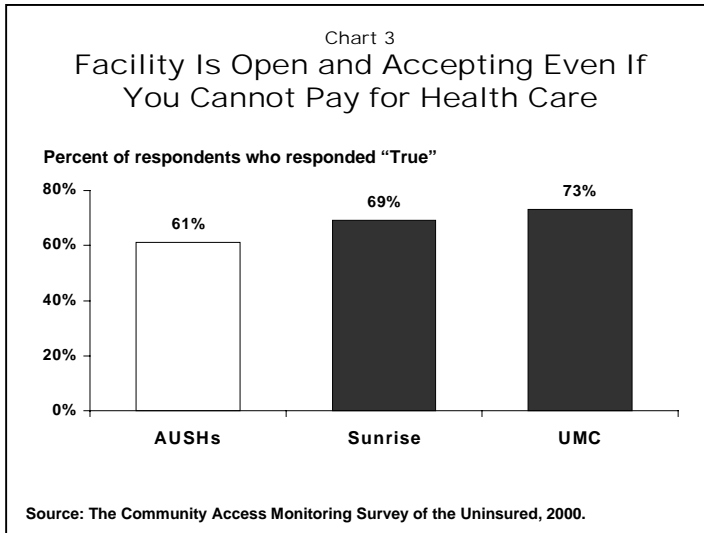


OPENNESS TO THE UNINSURED AND SATISFACTION WITH PROVIDERS

The majority of the respondents for UMC and Sunrise said their hospital had been open and accepting to them even if they were unable to pay. However, only two of five respondents reported that their hospital had a reputation in the community for providing “a lot of care” to the uninsured. Most respondents were satisfied with their interactions with staff, although UMC respondents were more likely to report being dissatisfied than either Sunrise respondents or the AUSH average.

“In the ER, they have it posted that if you don’t have insurance, you can still be admitted.”
Sunrise Respondent

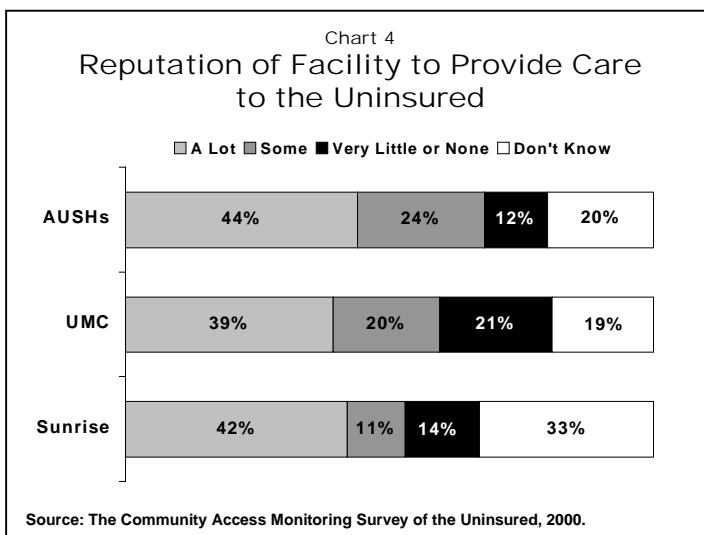
About seven of ten respondents for both facilities reported that their hospital had been “open and accepting” to them even if they were unable to pay for their care. (Chart 3)



Notably, however, 11 percent of UMC respondents said that the hospital did not provide them with care because they were unable to pay. In contrast, three percent of Sunrise respondents and three percent of AUSH respondents reported similar experiences.

About two of five respondents for both facilities said that their hospital had a reputation in the community for providing "a lot" of care to the uninsured. UMC respondents were slightly more likely to report that the hospital had a reputation for providing "very little or no care" than respondents for Sunrise or the average for AUSHs. Notably, between one-fifth and one-third of the respondents did not know the reputation of their facility. (Chart 4)

"They did not treat me well. They discriminate against you for not having insurance and for being Hispanic. You can see a change in their attitude when you say you don't have insurance."
UMC Respondent



•
•
•
•
•
•
•
•

Both UMC and Sunrise respondents were generally satisfied with their interactions with staff. For example, 94 percent of Sunrise respondents and 84 percent of UMC respondents said that they were “very satisfied” or “satisfied” with their doctors. In general, a larger proportion of Sunrise respondents were satisfied with the care and service they received from staff than UMC respondents; however, except for the ratings for nurses and physician assistants, these differences were not statistically different.

“Sunrise Hospital is very clean, but I would like to see more bilingual people there and also treat the people who don’t speak English or don’t have any kind of insurance with respect.”

Sunrise Respondent

However, between 17 and 21 percent of the UMC respondents stated that they were dissatisfied with the care they received from physician assistants, billing clerks, nurses, and receptionists, and 16 percent of Sunrise respondents said they were dissatisfied with the service they received from billing clerks.

ACCESSIBILITY

Overall, less than one-third of the respondents for either hospital reported that their facility’s hours, location, and convenience to public transportation had been a problem for them. However, more than two in five respondents for both hospitals found the waiting time to see a provider a problem. In general, UMC respondents were a little more likely to report that they had problems with access than Sunrise respondents.

“I don’t have a problem with their children’s emergency, trauma center, or pediatrics. I just won’t go for care for myself.”

UMC Respondent

Ninety percent or more of the respondents for both facilities said that their hospital’s hours, including emergency room hours, were “never a problem” for them. However, one-third of the UMC respondents and 12 percent of the Sunrise respondents said that the location of their hospital was a problem for them at least sometimes.

One-fifth (22%) of UMC respondents reported that convenience to public transportation was a problem for them at least sometimes, compared with 11 percent of Sunrise respondents. The average reported travel time for both respondent groups was about the same (23-24 minutes).

“The only problem has been that I had to wait in the emergency room between three to four hours.”

UMC Respondent

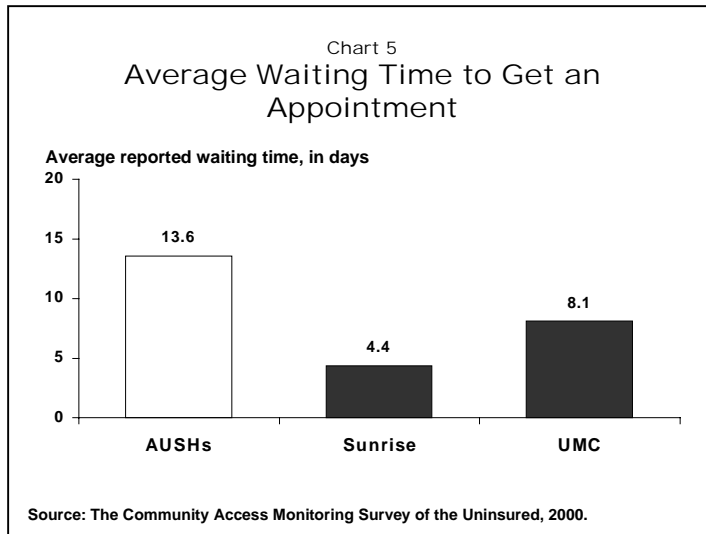
Sunrise and UMC respondents were just as likely to find the waiting time on the day of an appointment to be a problem at least sometimes (41% and 47%, respectively). Indeed, the average reported waiting times were about the same for the two respondent groups: 53 minutes for Sunrise respondents and 46 minutes for UMC respondents.

“It’s supposed to be an emergency room and I had to wait four or five hours. My son was dying of a fever to a point of shock.”

Sunrise Respondent

The reported waiting time to get an appointment was significantly different between the two respondent groups. Thirteen percent of Sunrise respondents found the waiting time to be a problem,

compared with 29 percent of UMC respondents. Indeed, the average reported time for UMC respondents was twice as long as for Sunrise respondents. However, both respondent groups had shorter waiting times than the average for AUSHs. (Chart 5)



LANGUAGE NEEDS

Many UMC and Sunrise respondents stated that they needed help with translations, but more than one-third of these respondents said interpreters were not readily available.

One-half of the UMC respondents (49%) and 38 percent of Sunrise respondents said they needed help with translations. In comparison, the average for AUSHs was 17 percent. Among the respondents who needed help, 35 percent of UMC and 40 percent of Sunrise respondents said that interpreters were “not very available” or were “unavailable” (AUSH average 55%).

Nevertheless, over 90 percent of the respondents for both facilities who said they needed help reported that the ability of the interpreters was either “very good” or “fair.” In addition, UMC and Sunrise respondents were more likely than the average for AUSHs to receive written information in their native language (72% and 56% vs. 42%, respectively).

“There is a sign that said to bring your own interpreter.”
UMC Respondent

“They treat you well, but they don’t have the necessary bilingual personnel.”
Sunrise Respondent

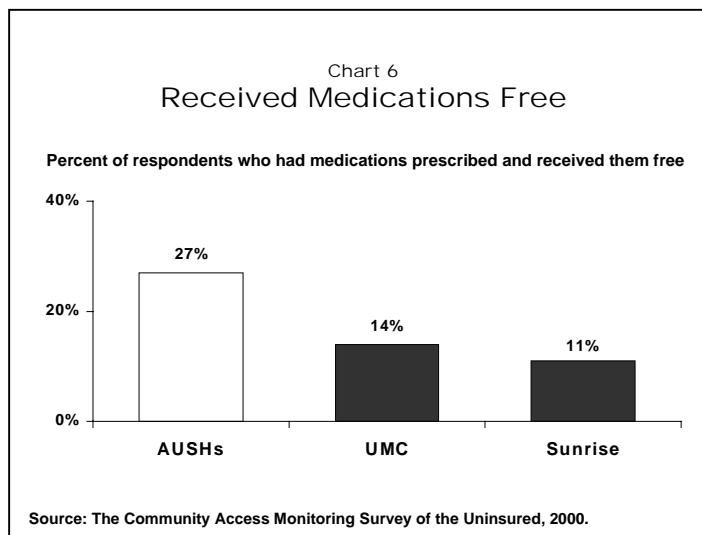
“I always take someone because they never have an interpreter.”
Sunrise Respondent

•
•
•
•
•
•
•
•
•
•

OBTAINING PRESCRIPTION MEDICATIONS

A majority of respondents for both UMC and Sunrise reported that paying for their medications was very difficult. Indeed, 12 percent of Sunrise respondents who received prescriptions were unable to fill any of them due to cost. Among respondents who said they needed help paying for their medications, nearly half of the respondents for both hospitals said staff “never” offered help.

More than two-thirds of each respondent group had medications prescribed. Among those who received prescriptions, less than one of six respondents for either group received their medications free. In comparison, the average for AUSHs was 27 percent. (Chart 6)



“I couldn’t buy the medication because it was too expensive.”
Sunrise Respondent

Nearly three of four respondents for both hospitals who had medications prescribed said they used a drug store and paid out-of-pocket, compared with an average of 57 percent for AUSHs. Moreover, 12 percent of Sunrise respondents reported that they were unable to fill *any* of their prescriptions due to cost.

Sixty-four percent of respondents for UMC and 72% for Sunrise said that paying for their medications was “very difficult,” while the average for AUSHs was 40 percent. Sixty-seven percent of UMC respondents and 45 percent of Sunrise respondents said they needed help paying for their medications, while the average for AUSHs was 47 percent. Notably, among the respondents who said they needed help, nearly half of the respondents for both hospitals said staff “never” offered help (ns) (UMC: 46%, Sunrise: 45%).

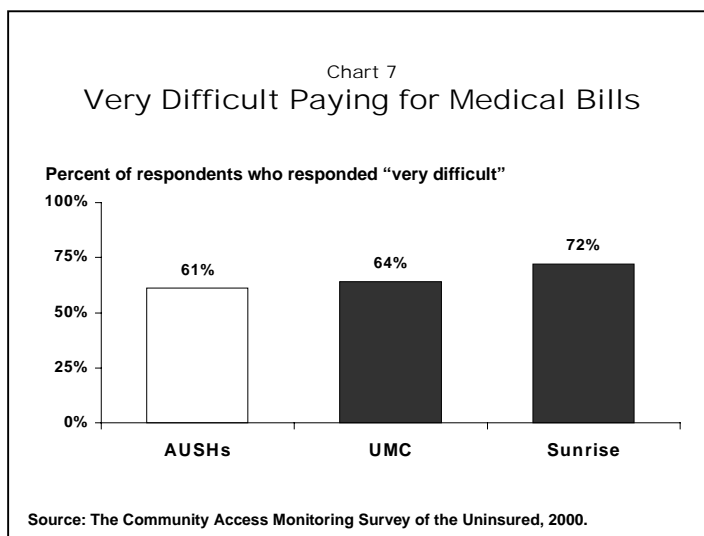


The proportion of respondents who understood the instructions for using their medications was relatively high: 80 percent at UMC and 89 percent at Sunrise. However, 17 percent of UMC respondents and seven percent of Sunrise respondents said they did not receive or did not understand their instructions (ns).

CONCERNS OVER PAYMENT FOR HEALTH CARE

The majority of respondents for both hospitals said it was “very difficult” to pay for their medical care, although UMC respondents were more likely than Sunrise respondents to say they needed help paying their bills. Among those who needed help, at both facilities only about half said they received help even sometimes.

Sunrise respondents were more likely to find paying for their medical bills “very difficult” than UMC respondents or the average for AUSHs. (Chart 7)



Nevertheless, Sunrise respondents were much less likely than UMC respondents or the average for AUSHs to say that they needed help paying for their medical bills (45% vs. 67% and 65%, respectively). Among the respondents who needed help, only about half of the respondents for both hospitals said that staff offered help even sometimes, while 50 percent of UMC respondents and 54 percent of Sunrise respondents said staff “never” offered assistance. About one-third of UMC and Sunrise respondents said they were “always” offered help, compared to an average for AUSHs of 19 percent.

“I told them I couldn’t pay but they still sent me a bill and called me. They said that they would not turn anyone away but they hassled you if you can’t pay.”
Sunrise Respondent

“It’s a very good hospital, but the medical cost was high and it was hard to pay.”
Sunrise Respondent

•
•
•
•
•
•
•
•

Among those respondents who did receive help, the most commonly reported form of assistance was a monthly billing plan, followed by referral to charitable organizations and a reduction in the bill. These proportions did not differ significantly from the AUSH averages.

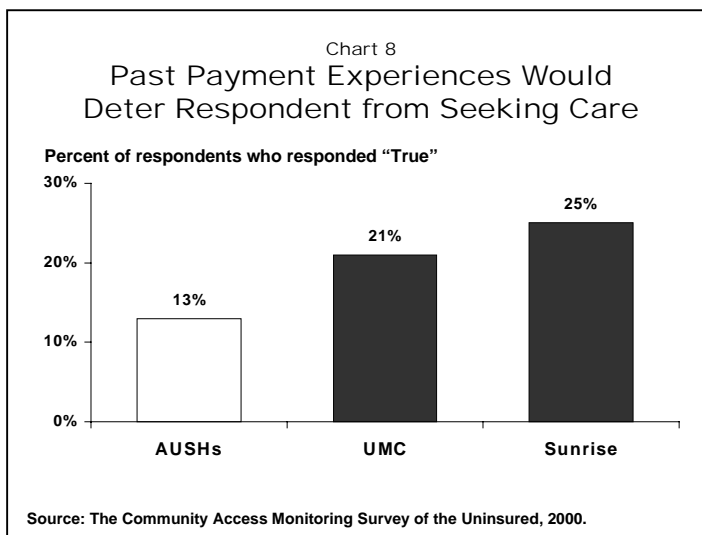
SEEKING CARE IN THE FUTURE

More than one-fifth of the respondents for both hospitals said their past experiences paying their bills would deter them from seeking care at the hospital again, and more than half said they owed money to the hospital. The majority of both respondent groups said that they would use the facility again if they had health insurance.

"I don't think they will treat me there again because I have not paid my bill."
Sunrise Respondent

When respondents were asked how their past experiences paying for care at their hospital would affect their likelihood of seeking care there in the future, about one-fourth of the respondents said that they would not seek care again. The average for AUSHs was much lower. (Chart 8)

"They didn't explain if I could return for treatment before paying my bill."
UMC Respondent



In addition, 14 percent of UMC and 11 percent of Sunrise respondents said their experiences paying for care would cause them to use a different facility in the future. Still, about one-half of respondents stated that their past bill paying experience would make no difference on whether they sought care at the hospital in the future, and about one-fifth said that it would make it easier to seek care.

UMC respondents were much more likely to owe money to the hospital than Sunrise respondents (70% vs. 52%, respectively). The average for AUSHs was 61 percent. About one of five or more of these



respondents said their indebtedness would deter them from seeking care at the hospital again.

Finally, Sunrise respondents (86%) were much more likely to say that they would use their hospital again if they were insured than respondents for either UMC (72%) or the average for AUSHs (77%).

•
•
•
•
•
•
•

DISCUSSION

This section discusses some of the perceived strengths of University Medical Center (UMC) and Sunrise Hospital and Medical Center (Sunrise) suggested by the survey results. In addition, it highlights issues that might warrant further discussion.

Openness to the Uninsured: UMC and Sunrise respondents were more likely than the average for All Urban and Suburban Hospitals (AUSHs) included in CAMS nationwide to report that, in their experience, their hospital had been open and accepting even if they were unable to pay for care.

At the same time, only two of five respondents for each hospital said the facility had a reputation in the community for providing “a lot” of care to the uninsured. In addition, 21 percent of UMC respondents and 14 percent of Sunrise respondents said their respective facility had a reputation for providing “very little or no care” to the uninsured. Notably, between one-fifth and one-third of the respondents said that they did not know the reputation of the facility.

Use of Facility: More than four-fifths of the respondents for both hospitals said they used the emergency room at least once in the past year. At the same time, the proportion of respondents who said they used the outpatient clinic was lower than the AUSH average. Many respondents for both hospitals said they had used their facility more than once in the last year, and one of six UMC respondents used it five or more times.

Satisfaction with Staff: The majority of respondents for both hospitals said that they were satisfied with the care and service they received from staff. However, about one-fifth of the UMC respondents said that they were dissatisfied with the care received from receptionists/admitting clerks, nurses, physician assistants, and billing clerks.

Accessibility Measures: The vast majority of the respondents for both hospitals reported that their hospital’s hours and emergency room hours were never a problem for them. While one-fifth of UMC respondents stated that convenience to public transportation was a problem for them at least sometimes, and one-third said the location of the facility was a problem for them at least sometimes, the average reported travel time for UMC and Sunrise respondents was about the same (23-24 minutes).



UMC respondents were twice as likely as Sunrise respondents to say that the waiting time to get an appointment was a problem for them at least sometimes. Indeed, the average reported waiting time for an appointment was twice as long for UMC respondents (8 days) as for Sunrise respondents (4 days). However, the average number of days for both hospitals was less than the average for AUSHs (14 days).

Sunrise and UMC respondents were just as likely to report that the waiting time on the day of an appointment was a problem for them at least sometimes. The average reported waiting times were similar for the hospitals (46 minutes and 53 minutes, respectively).

Language Assistance: Among respondents who needed help with translations, the proportion reporting that interpreters were available was higher than the average for AUSHs. In addition, over 90 percent said that their interpreter's ability was either "very good" or "fair." However, over one-third of respondents who needed help reported that an interpreter was either "not very available" or "unavailable." Increasing the availability of interpreters might contribute to improvements in other areas, such as compliance with instructions for using medication and even satisfaction with providers.

Obtaining Medications: Both UMC and Sunrise respondents were less likely to find paying for medications "very difficult" or to need help paying for their medications than the average for AUSHs. In fact, about three-fourths of the respondents for both hospitals said they paid for their medications out-of-pocket, while the proportion receiving medications free was significantly smaller for UMC (14%) and Sunrise (11%) respondents than the average for AUSHs (27%). Nevertheless, among the respondents who did need help paying for their medications, the majority (between 67% and 81%) said they "never" received assistance from staff.

In addition, one of six respondents for UMC said they were not given instructions for their medications or that they did not understand the instructions provided.

Paying for Medical Care: Sunrise respondents were more likely than UMC respondents to say that paying their medical bills was "very difficult." However, Sunrise respondents were *less* likely to report that they needed help paying their bills. Among those who said they needed help, respondents for both hospitals were much more likely to say that staff "always" offered to find out if financial assistance was available than the averages for AUSHs. Nevertheless, about half of the respondents who said they needed help paying their medical bills reported that they "never" received any help.

•
•
•
•
•
•
•
•

Seeking Care in the Future: More than one of five respondents for both UMC and Sunrise said their past experiences paying for care would make them **not** seek care at the hospital again. The average for AUSHs was 13 percent. Moreover, for both facilities, about one-fifth or more of respondents who owed money to their hospital said that their indebtedness would deter them from seeking care there again. However, the majority of respondents for both hospitals stated that they would use their hospital again 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.



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*.

•
•
•
•
•
•
•
•

-
- 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 R.E. Schmid , “Nevada among worst in nation for health insurance coverage,” *Las Vegas Review-Journal*, October 4, 1999.
- ³² U.S. Census Bureau, *Health Insurance Coverage: 1998 - State Uninsured Rates*, Washington D.C..
- ³³ C.L.Popoff, B. Fadali, and D.H. Judson *Nevada-Specific Estimates of the Uninsured: Preliminary Report*, Decision Analytics, Inc., October, 2000.
- ³⁴ G. Armas, “Nevada grew fastest in the ‘90s,” *Las Vegas Review-Journal*, August 30, 2000.
- ³⁵ K. Quinn, *Working without Benefits: The Health Insurance Crisis Confronting Hispanic Americans*, Commonwealth Fund, March 2000.
- ³⁶ *Uninsured Children by Age, Race, and Hispanic Origin: 1998*, U.S. Census Bureau, 1998.
- ³⁷ L.K. Bach, “School survey finds increase in teen sex,” *Las Vegas Review-Journal*, February 1, 2000
- ³⁸ G. Puit, “Suicide drop fails to hearten experts,” *Las Vegas Review-Journal*, February 4, 2000.
- ³⁹ M. Weissenstein, “Valley’s poor children in dental care crisis,” *Las Vegas Review-Journal*, February 6, 2000.
- ⁴⁰ J.L. Smith, “(Commentary) Take a deep breath: LV rates among the clean air elite,” *Las Vegas Review-Journal*, June 28, 2000.
- ⁴¹ K. Rogers, “County air likely to make serious air pollution list,” *Las Vegas Review-Journal*, August 17, 2000.
- ⁴² E. Vogel, “Officials seek ways to provide free health care to more Nevada children,” *Las Vegas Review-Journal*, June 7, 2000.
- ⁴³ M. Weissenstein, *op cit*.
- ⁴⁴ B. Tugan, “Valley’s growth gives medical fund shot in the arm,” *Las Vegas Sun*, June, 12, 2000.
- ⁴⁵ J. Babula, “Hospitals work to solve emergency room crisis,” *Las Vegas Review-Journal*, August 24, 2000.
- ⁴⁶ J. Babula, “Emergency Rooms: Experts pose changes for LV hospitals,” *Las Vegas Review-Journal*, September 21, 2000.
- ⁴⁷ C.J. Waddoups, *Employer Sponsored Health Insurance and Uncompensated Care: The Role of the University Medical Center in Clark County*, University of Nevada, Las Vegas, January 1999.
- ⁴⁸ “Local news briefs for November 1, 2000, Sunrise Hospital and Medical Center,” *Las Vegas Sun*, November 1, 2000.

