



Getting Health Care  
When You Are  
Uninsured:  
*A Survey of Uninsured Patients  
at North Central Bronx Hospital  
in The Bronx, New York*

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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.

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The **Northwest Bronx Community and Clergy Coalition (NWBCCC)** and the **Commission on the Public's Health System (CPHS)** work together on the Coalition to Save North Central Bronx Hospital.

NWBCCC is a people power organization that unites ten grassroots neighborhood associations in the Northwest section of the Bronx. It is a membership organization of low income and working class residents. NWBCCC, a multi-issue organization, brings together people of different races, classes, and religions to identify common problems and desired solutions. Community residents drive every stage of planning and implementation through regular attendance at neighborhood planning meetings and actions.

CPHS is a citywide community-based health advocacy membership organization formed in 1991 to fight the privatization of the public hospitals and support the strengthening of the public health and hospital system. It has taken a leadership role in stopping city government from dismantling public hospitals, as well as in pressing for improvement in funding and access to health care services. CPHS has many uninsured residents among its members.

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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 in one community, The Bronx, New York. The survey was conducted in the summer of 2000 and gathered information from 154 uninsured patients who obtained health care at the North Central Bronx Hospital 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

- ◆ *Facility Use:* Survey responses indicated heavy use of the hospital. Nearly nine of ten respondents said they used the facility more than once in the past year, three out of four said that they used the emergency room at least once in the past year, and 80 percent used the outpatient clinic. Over half of the respondents reported that they sought care at the hospital to treat a chronic problem such as asthma or diabetes.
- ◆ *Openness to the Uninsured:* Two-thirds of the respondents said that the facility had been open and accepting to them even if they were unable to pay for their care. While only two of five respondents (44%) said that the hospital had a reputation in the community for providing “a lot” of care to the uninsured, few (7%) said that it provided “little or no” care.

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- ◆ *Satisfaction with Staff:* The majority of respondents reported that they were either “very satisfied” or “satisfied” with the care and service they received from North Central staff. However, 22 percent of respondents said they were dissatisfied with their interactions with pharmacists.
- ◆ *Accessibility:* Most respondents did not report problems with the hospital’s hours, location, or convenience to public transportation. Waiting times, however, were a problem for many respondents. The average reported waiting time to get an appointment at the hospital was four days longer than the average for All Urban and Suburban Hospitals (AUSHs) included in the CAMS project nationally, while the average waiting time to see a provider on the day of an appointment (71 minutes) was 8 minutes longer than the average.
- ◆ *Obtaining Medications:* More than half (54%) of the respondents said they needed help paying for their medications. Of these respondents, the majority said that staff offered help at least sometimes, although 45 percent said staff never offered help. This figure, however, was lower than the AUSH average (64%). In addition, North Central respondents were more likely to receive medications free (38%) than the average for AUSHs (27%).
- ◆ *Paying for Medical Care:* Half of the respondents found paying for their medical bills very difficult. Nearly three of four respondents (73%) who needed help with their medical bills stated that staff offered them help at least sometimes, much higher than the AUSH average of 44 percent.
- ◆ *Seeking Care in the Future:* Half of the respondents reported that they owed money to the hospital; by comparison, the AUSH average was 61 percent. About three in ten of those who had debts stated this debt would deter them from seeking care in the future. The majority of respondents—over 80 percent—would use the hospital again even if they had health insurance.



## INTRODUCTION

In 1998, 44 million people in the United States were uninsured, representing a 38% increase in the number of uninsured since 1987.<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, in order to assist them in improving access to care for this population.

#### 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, The Bronx, New York. The survey was conducted by The Northwest Bronx Community and Clergy Coalition (NWBCCC) and the Commission on the Public's Health System (CPHS) in the summer of 2000, and gathered information from uninsured individuals who received care at North Central Bronx Hospital 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 Spring 2001.



## LACK OF INSURANCE IS DANGEROUS TO YOUR HEALTH

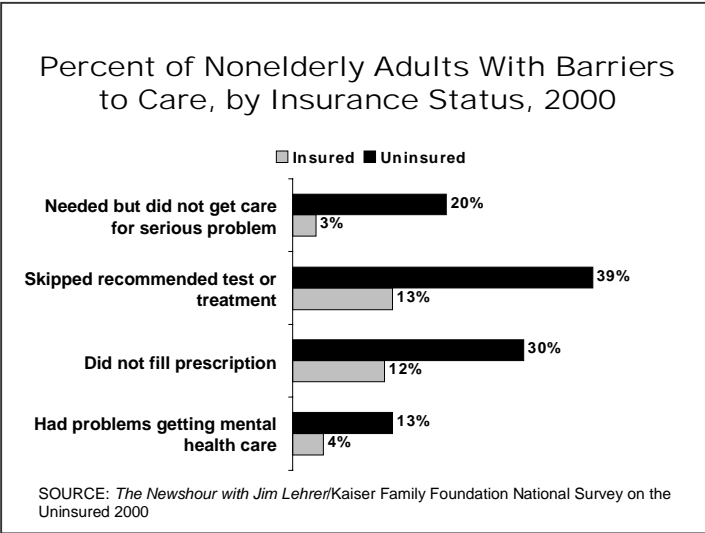
With great consistency, national research has demonstrated that insurance status affects the amount and type of care individuals receive. Lack of health insurance is related to both reduced access to care and to poorer health outcomes. In addition, many of the changes in the health care market over the 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;<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 Northwest Bronx Community and Clergy Coalition (NWBCCC) and the Commission on the Public's Health System (CPHS).

Lack of health insurance is a serious problem in New York City; 28 percent of the city's residents under the age of 65, or 1.8 million people, are uninsured. A recent report from the Mayor's Office estimated that of the 1.8 million uninsured, 1.5 million are low-income, and of these, 800,000 have incomes below the poverty level. The report also estimated that 525,000 children and adults eligible for current programs are not enrolled.<sup>31</sup> In addition, the city has a large immigrant population, which includes groups that have historically had high rates of uninsurance. About 50% of new births in New York City in 1997 and 1998 were to mothers born in other countries.<sup>32</sup>

The Northwest Bronx, with a population of approximately 350,000, is very diverse. In addition to long-standing residents, the community is home to many newer immigrant populations, including people from Korea, Albania, Cambodia, Vietnam, and Bangladesh. Much of the community is low-income or working class. Data show that 29 percent of the residents of the Bronx have no health insurance, while a large number are members of low-income families that are covered by or eligible for Medicaid or the Child Health Plus program.<sup>33</sup> The population of the Bronx also includes disproportionately high numbers of Latinos, African-Americans, and people from the Caribbean, all groups with traditionally high rates of uninsurance. The Bronx has the highest percentage of Latino residents in the city (46% vs. 27% citywide), and the second highest percentage of African-American and Caribbean residents (33% vs. 26% citywide).<sup>34</sup>

The public community hospital in the area is North Central Bronx Hospital (NCB). The hospital, which is run by the New York City Health and Hospitals Corporation (HHC), has about 250 inpatient beds and offers basic primary and secondary services. HHC-run facilities have a stated mission to serve everyone regardless of ability to pay, and in 1998, over 20% of NCB's discharges (2,263 people) were uninsured.<sup>35</sup>

NCB is part of a public healthcare network, the North Bronx Network, which is run by HHC. In 1998, the network closed 30 children's inpatient beds and 25 inpatient rehabilitation beds at NCB. The director of this network, Joseph Orlando, said that the pediatric and rehabilitation beds at NCB were underutilized. The hospital also

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capped medical beds at 60 for about a year because of a lack of doctors to service them. In addition, the North Bronx Network discontinued inpatient and outpatient asthma services for children at NCB.<sup>36</sup> The loss of pediatric asthma services is of special concern because of the area's high rate of pediatric asthma<sup>37</sup>. The community fears this problem will be exacerbated by the building of a chemical water filtration plant nearby.

The cutback in services, along with newspaper stories, caused many community residents to worry that NCB might close.<sup>38</sup> NCB was built next door to, and on the land of, a private non-profit hospital, Montefiore Medical Center (MMC), and the community feared that MMC might want to buy back the land and building from the city.<sup>39</sup> Adding to these concerns were the Mayor's desire to privatize health care in New York City; he had recently made an unsuccessful attempt to lease Coney Island Hospital, a public hospital in Brooklyn, to a private, for-profit company.<sup>40,41,42</sup>

These concerns led to the formation of the Coalition to Save NCB, which is coordinated by NWBCCC with the help of CPHS. The coalition includes local community organizations, unions, health advocacy groups, health professionals, local elected officials, and residents concerned about access to health services. In 1999, the Coalition organized protests, rallies, community meetings, and testified at legislative meetings. By the end of 1999, the Mayor and HHC had retreated from efforts to close NCB, and some of the outpatient services were restored.<sup>43</sup>

The NWBCCC and CPHS surveyed patients who had received care during the last year while uninsured at NCB. These organizations undertook the CAMS project to better understand the needs, situations, and experiences of the uninsured at neighborhood facilities and to identify any issues affecting the ability of the uninsured in the community to obtain quality care.

## SURVEY METHODOLOGY

Northwest Bronx Community and Clergy Coalition (NWBCCC) and Commission on the Public's Health System (CPHS) staff, along with six paid NWBCCC members and community residents, conducted the surveys. 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.

Survey respondents were identified in a variety of ways, including at NWBCCC tenant and other planning meetings, as well as through tables set up both outside of and within the hospital and an article published in the local newspaper. Many churches that are members of the NWBCCC placed announcements in their Sunday bulletins, made announcements at Sunday services, and allowed surveyors to set up tables in their facilities. Other community organizations and elected officials spread the word that the Coalition to Save North Central Bronx was looking for uninsured people to interview for the project.

All surveys were conducted between May 29 and July 14, 2000. To be eligible to participate, respondents had to have received care at North Central Bronx Hospital during the previous year while they were uninsured. In total, 154 surveys were completed.

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.*

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## SURVEY FINDINGS

This section describes the survey results for respondents who received care while uninsured at North Central Bronx Hospital (North Central) and compares them with averages for All Urban and Suburban Hospitals (AUSHs) included in the CAMS project nationwide. All comparisons were statistically significant unless otherwise indicated (ns = non-significant).

See Appendix A for a table of the results for North Central 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

#### **Respondents were ethnically diverse and varied in age.**

Two of five respondents (41%) identified themselves as Hispanic and 38 percent said they were Black. Only four percent of the respondents identified themselves as white. Nine of ten (92%) respondents took the survey in English, a proportion much higher than the AUSH average (72%). Seventeen percent of respondents identified themselves as Other, also higher than the AUSH average of seven percent.

Respondents varied in age, but 12 percent of the respondents answered on behalf of a child.

### USE OF HEALTH SERVICES

**The majority of respondents for North Central said that they used the emergency room at least once in the past year, and 80 percent used the outpatient clinic. Nearly 90 percent of the respondents said they used the hospital more than once.**

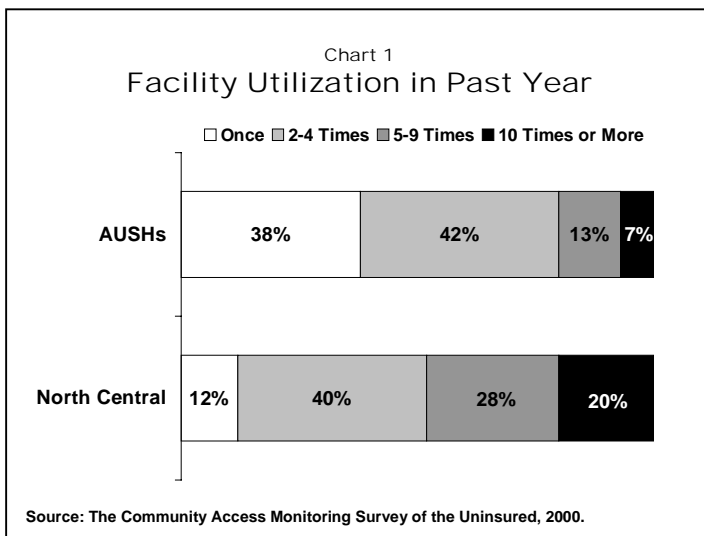
*Emergency room use:* Three-fourths (76%) of the respondents reported that they used the emergency room at least once in the past year, which was similar to the average for AUSHs (77%).

“Because it was a public hospital and I do not have a private doctor, I used their emergency room services because my throat was closing.”  
North Central Bronx  
Respondent

*Outpatient clinic use:* North Central respondents were much more likely to report use of the hospital’s outpatient clinic (80%) than the AUSH average (45%).

*Inpatient hospitalization:* A little more than one-third (36%) of the respondents for North Central said they had been admitted to the hospital at least once in the past year. The AUSH average was similar (32%).

*Frequency of facility use:* North Central respondents were much more likely to report that they used the facility more than once in the past year than the average for AUSHs. Indeed, nearly half of the respondents reported that they used the facility five times or more in the past year, while the average for AUSHs was 20 percent. (Chart 1)



North Central respondents were also more likely than the AUSH average to report that they sought care to treat a chronic health problem, such as asthma or diabetes (54% vs. 32%, respectively).

OPENNESS TO THE UNINSURED AND SATISFACTION WITH PROVIDERS

**The majority of North Central respondents said the facility had been open and accepting to them even if they were unable to pay for care. Slightly less than half said that it has a reputation in the community for providing a lot of care to the uninsured, but few said it provides little or no care. In addition, the majority of respondents said they were satisfied with their interactions with staff.**

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*“It is well known for helping poor people.”*  
North Central Respondent

More than two-thirds of the respondents for North Central (68%) reported that the hospital, in their experience, had been “open and accepting” to them even if they were not able to pay for their care. This proportion was similar to the AUSH average of 61 percent.

*“They are good because they don’t turn you away.”*  
North Central Respondent

More than two of five (44%) respondents said the hospital had a reputation in the community for providing “a lot” of care to those who cannot pay and another 25 percent reported that it had a reputation for providing “some” care. These proportions were identical to the AUSH averages. Only seven percent of respondents said the hospital provides “very little or no” care to the uninsured.

*“I was treated very well and I was given information on how to apply for financial assistance and get insurance. They treated me like they care personally for me.”*  
North Central Respondent

Over 85 percent of the respondents reported that they were either “very satisfied” or “satisfied” with their interactions with receptionists, nurses, physician assistants, and doctors. Notably, however, 22 percent of North Central respondents stated that their encounters with pharmacists were unsatisfactory.

*“[The pharmacy] opens at 9 am but doesn’t serve people until 9:30 or 10. They need to open earlier. They need more pharmacist assistance—they have four windows, but only two are open.”*  
North Central Respondent

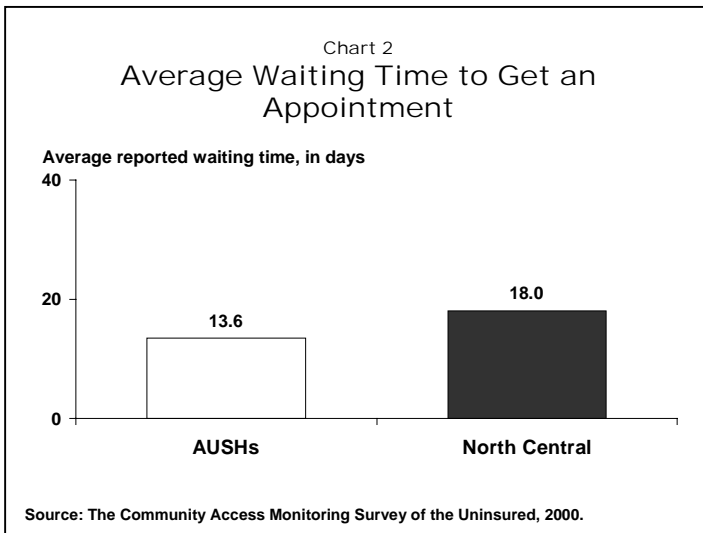
#### ACCESSIBILITY

**Overall, most respondents reported that they never had a problem related to accessibility indicators such as facility hours. However, nearly half of the respondents said that waiting time was a problem.**

The majority (79%) of North Central respondents reported that the facility’s hours were never a problem for them. In addition, two-thirds of the respondents stated that the location of the hospital was never a problem. Indeed, the average travel time (23 minutes) was only about one minute longer than the AUSH average. Seventy-one percent of the respondents also stated that convenience to public transportation was not an issue for them. However, between 16 and 30 percent of respondents did say that these access indicators were a problem for them at least sometimes.

*“It took me 3 months to get an appointment with the neurologists.”*  
North Central Respondent

Nearly half (47%) of all respondents for North Central reported that the waiting time to get an appointment was a problem for them at least sometimes. The average waiting time to get an appointment was 18 days for North Central respondents, while the average waiting time for AUSHs was about four days shorter. (Chart 2)



In addition, nearly three of five (57%) respondents for North Central stated that the waiting time to see a provider on the day of an appointment was a problem for them at least sometimes. The average reported waiting time on the day of the appointment was 71 minutes for North Central respondents, about 8 minutes longer than the AUSH average (ns).

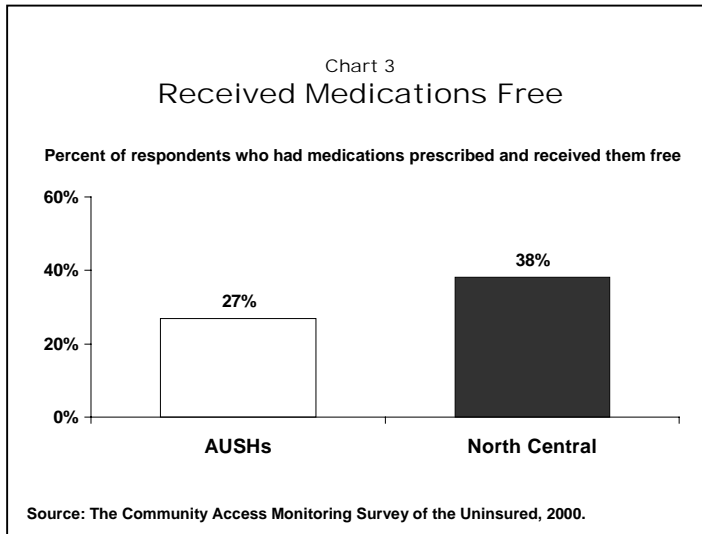
*“They don’t really cater to working people. They need after work hours. I had to take time off to go to the hospital. It takes too long to get an appointment with a doctor. Waiting time is excessive at the clinic and pharmacy.”*  
North Central Respondent

#### OBTAINING PRESCRIPTION MEDICATIONS

**Many North Central respondents reported that paying for their medications was difficult and that they needed help paying for them. Among the respondents who needed help, nearly half said that staff never asked them if help was needed.**

Four of five (81%) North Central respondents had medications prescribed. Among these respondents, nearly two of five received their medications free, and 45 percent reported that they went to a drug store and paid for the medications out-of-pocket. (Chart 3)

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More than two of five respondents (45%) for North Central reported that paying for their medications was “very difficult.” In addition, 54 percent said they needed help paying for their medications. While the majority of respondents reported that they received assistance at least sometimes, 45 percent said staff never asked them if help was needed. This proportion, however, was lower than the AUSH average of 64 percent.

#### CONCERNS OVER PAYMENT FOR HEALTH CARE

*“They give you help when you do not make that much money. You pay less.”*

North Central Respondent

**Many respondents stated that they had difficulty and needed help paying for their medical care. Among the North Central respondents who needed help, most were offered help at least sometimes.**

*“I have the fee scale. They adjust the cost according to income.”*

North Central Respondent

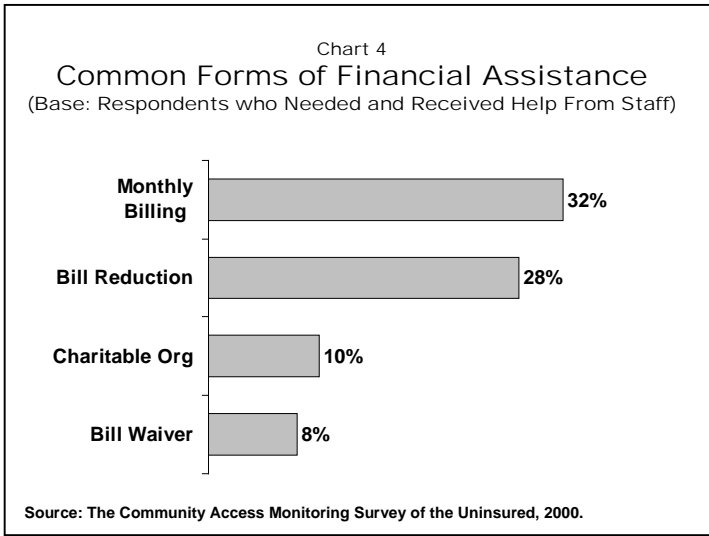
Half (49%) of the respondents reported that paying for their medical bills was “very difficult” for them. However, North Central respondents were much less likely to find paying for medical bills very difficult than the average for AUSHs (49% vs. 61%, respectively).

*“It would be good if the hospital more aggressively informed people of payment options and help available to them. Most people do not know about sliding scale and community Medicaid assistance. They need to have a table in the lobby with payment options. They need to cater more to the working poor.”*

North Central Respondent

Two-thirds (67%) of the respondents said they needed help to pay for their medical bills, a proportion similar to the AUSH average. Among those who needed assistance, North Central respondents were much more likely to be offered assistance at least sometimes than the average for AUSHs (73% vs. 44%, respectively). Thus, while 28 percent of North Central respondents said they were *never* offered assistance, the average for AUSHs was 56 percent. The most common forms of assistance were monthly billing plans and reductions of the bill. Notably, however, 40 percent of respondents said they received “other” types of assistance. (Chart 4)

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*"I think North Central has a lot of potential to be a good hospital. They have to focus on who actually lives in the community and that not everyone can pay the bills."*  
North Central Respondent

#### SEEKING CARE IN THE FUTURE

**One of ten respondents said they would not seek care at the hospital again or would use another facility due to their previous experiences paying bills at the facility. Half of the respondents reported that they were in debt to the hospital. The overwhelming majority of respondents said they would use the facility again if they were insured.**

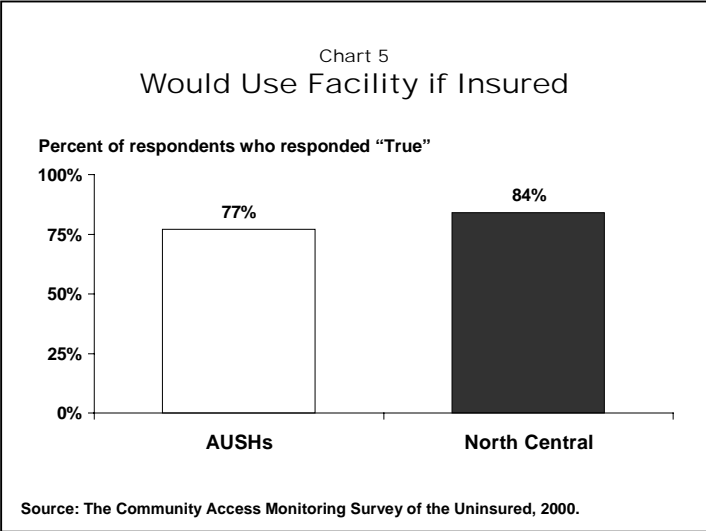
One of ten respondents for North Central said their past experiences paying bills at the hospital would make them not seek care again in the future. Ten percent of the respondents also said these experiences would make them use a different facility.

About half (49%) of the North Central respondents reported that they were in debt to the hospital, less than the AUSH average of 61 percent. Among those who owed the hospital money, 28 percent reported that the indebtedness would deter them from seeking care again at the hospital. This was identical to the average for AUSHs.

The majority of respondents—84 percent—said they would use the facility in the future even if they had health insurance, a proportion higher than the AUSH average. (Chart 5)

*"If I had insurance through a job I would still come here if I could."*  
North Central Respondent

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## DISCUSSION

This section discusses some of the perceived strengths and issues for further consideration suggested by the survey results for North Central Bronx Hospital.

- ◆ *Facility Use:* Responses indicated heavy use of the hospital. The overwhelming majority of respondents—88 percent—reported that they used the facility more than once in the past year. Three out of four said that they used the emergency room at least once in the past year, and 80 percent used the outpatient clinic. Over half of the respondents reported that they sought care at the hospital to treat a chronic problem such as asthma or diabetes.
- ◆ *Openness to the Uninsured:* Two-thirds of the respondents said that the facility had been open and accepting to them even if they were unable to pay for their care. However, only two of five respondents (44%) said that the hospital had a reputation in the community for providing “a lot” of care to the uninsured. At the same time, few (7%) said the hospital provided “little or no” care for the uninsured.
- ◆ *Satisfaction with Staff:* The majority of respondents reported that they were either “very satisfied” or “satisfied” with the care and service they received from North Central staff. However, 22 percent of respondents said they were dissatisfied with their interactions with pharmacists.
- ◆ *Accessibility:* Most respondents did not report problems with the hospital’s hours, location, or convenience to public transportation. Waiting times, however, were a problem for many respondents. The average reported waiting time to get an appointment at the hospital was four days longer than the average for All Urban and Suburban Hospitals (AUSHs) included in the CAMS project nationally, while the average waiting time to see a provider on the day of an appointment (71 minutes) was 8 minutes longer than the average (ns).
- ◆ *Obtaining Medications:* More than half (54%) of the respondents said they needed help paying for their medications. Of these respondents, the majority said that staff offered help at least sometimes, although 45 percent said staff never offered help. This figure, however, was lower than the AUSH average (64%). In addition, North Central respondents were more likely to receive medications free (38%) than the average for AUSHs (27%).

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- ◆ *Paying for Medical Care:* Half of the respondents found paying for their medical bills very difficult. Nearly three of four respondents (73%) who needed help with their medical bills stated that staff offered them help at least sometimes, much higher than the AUSH average of 44 percent.
- ◆ *Seeking Care in the Future:* One of ten respondents reported that their past experiences paying bills at the hospital would deter them from seeking care there again and 10 percent said that these experiences would make them use a different facility in the future. In addition, half of the respondents reported that they owed money to the hospital; by comparison, the AUSH average was 61 percent. About three in ten of those who had debts stated this debt would deter them from seeking care in the future. The majority of respondents—over 80 percent—would use the hospital again even 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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