Getting Health Care When You Are Uninsured:

A Survey of Uninsured Patients at Two Hospitals in Lincoln County, Oregon

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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 **Oregon Health Action Campaign (OHAC),** which was founded in 1985, is now a coalition of 101 member organizations representing over 450,000 Oregonians and 2,700 individual members. Its mission is to empower the consumer voice in the development of quality, responsive health systems that allow all people to access the health care they need, when they need it, from providers of their choice at an affordable cost. The Oregon Health Access Project (OHAP) is OHAC's research and education arm, a 501(c)(3) organization that provides and solicits the consumer-oriented information necessary for effective consumer participation in the health reform discussion at the local, state, and national level. Over the last 14 years OHAC/OHAP has been the major voice for the interests of traditionally disenfranchised constituencies through its local and statewide organizing, policy analysis, and public education.

Project Equality, an OHAP project, is a consumer-driven, chapter-based, statewide organization. It works to ensure that Medicaid enrollees have access to the quality care to which they are entitled, delivered in a timely and respectful manner. The Lincoln County chapter of Project Equality has long been concerned about access and quality issues for the many uninsured in Lincoln County and the impact of the proposed and recent changes in hospital management in the County on the provision of care to the uninsured. Project Equality undertook the CAMS survey to identify barriers that the uninsured and underserved may experience when they access health care at the local hospitals, a critical component of the safety net in Lincoln County.

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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, Lincoln County, Oregon. The survey was conducted in the summer of 2000 and gathered information from 305 uninsured patients who obtained health care at North Lincoln hospital or Pacific Communities 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.

- ♦ The overwhelming majority of North Lincoln and Pacific respondents reported using the emergency room at least once in the past year.
- ♦ Compared with the average for All Rural Hospitals (ARHs) included in the CAMS project nationwide, North Lincoln and Pacific respondents were much less likely to report that their hospital had been "open and accepting" to them even if they could not pay for their care, or that their hospital had a reputation in the community for providing "a lot" of care to the uninsured. Nearly a quarter to a third of respondents reported that their facility had a reputation for providing "very little or no care."
- ♦ While North Lincoln respondents were more likely to report that they were satisfied with their providers than Pacific respondents, respondents for both hospitals were more likely to report that they were dissatisfied with the care and service they received from staff

than the average for ARHs. Less than a third of the respondents for either hospital said that they were “always” treated with respect, compared to about two-thirds of respondents for ARHs.

- The average waiting times reported by Pacific respondents both to get an appointment and to see a provider on the day of an appointment were considerably longer than those reported by North Lincoln respondents or the ARH averages.
- More than half of the respondents for both hospitals reported that convenience to public transportation was a problem at least sometimes.
- More than half of the respondents for both hospitals said that paying for their medications was “very difficult,” and that they needed help to pay for them. Among respondents who said they needed help, more than 9 in 10 said that staff had “never” offered to find out if assistance was available. In addition, among respondents who received prescriptions, about one of five for each hospital said they did not fill any of them due to cost.
- About three-quarters of the respondents for both hospitals reported that they found paying their medical bills “very difficult,” and that they needed help to pay them. However, among respondents who said they needed help, 80 percent or more said staff “never” offered help. This compared to an ARH average of 48 percent.
- One of six or more respondents for both facilities reported that their past experiences paying bills would deter them from seeking care again at their hospital. About two-thirds of the respondents said they were in debt to their hospital, and about 40 percent of these respondents stated that their indebtedness would deter them from seeking care there in the future.
- The majority of respondents—over 80 percent—said they would use their hospital again if they had health insurance. However, a number of respondents commented that they would use the hospital if insured because there was nowhere else they could go.

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 general research documenting the impact of lack of insurance on healthcare access and on health outcomes, describes the survey results at one CAMS site, Lincoln County, Oregon. The survey was conducted in the summer of 2000 by the Lincoln County chapter of Project Equality, an initiative affiliated with the Oregon Health Action Campaign (OHAC). It gathered information from uninsured individuals who received care in the previous year at either North Lincoln Hospital in Lincoln City or Pacific Communities Hospital in Newport. 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

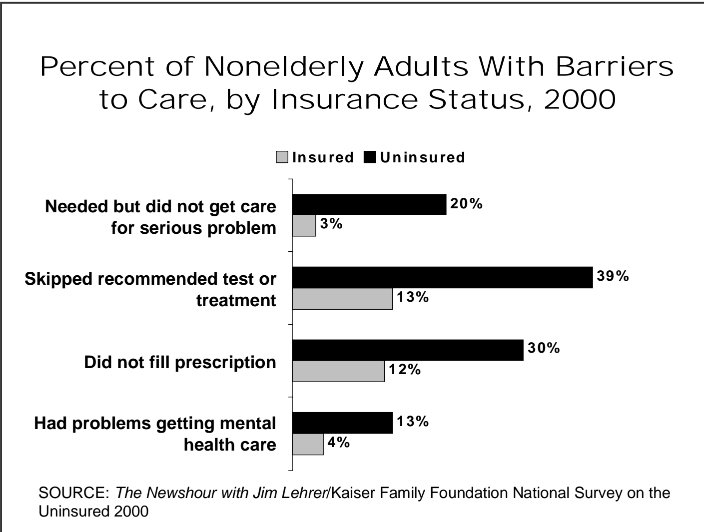
With great consistency, national research has demonstrated that insurance status affects the amount and type of care individuals receive. Lack of health insurance is related to both reduced access to care and to poorer health outcomes. In addition, many of the changes in the health care market over the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

Lincoln County is a rural county located on the central Oregon coast. In 1999, Lincoln County had 45,587 residents.[31] Like many rural communities, Lincoln County has a disproportionate number of elderly residents–20 percent of its residents are elderly, compared to a statewide average of 13.8 percent. The largest non-white populations in the county are American Indians and Hispanics, each of whom represents 2.4 percent of the county's population. The Hispanic population is growing by 10 percent a year.

Lincoln County has significantly higher uninsurance and poverty rates than the statewide averages. According to the Office of Oregon Health Plan Policy and Research, at 18 percent, the county's uninsurance rate is the second highest in the state. The county's 1997 unemployment rate was 8.7 percent, compared to a statewide average of 5.8 percent. In 1999, the median family income in Lincoln County was $36,200, compared to a statewide average of $45,100, while 14.6 percent of its residents had incomes below the federal poverty level, compared to 12 percent statewide. It is estimated that 16 percent of children in the region live in poverty.[32]

Lincoln County ranks first in the state in the proportion of its total employment that is comprised of visitor industry jobs—35 percent of all jobs in the County are tourist-related. Visitor industry jobs tend to be low income and are often part time or seasonal; quite often these jobs do not provide benefits such as health insurance.

According to the Lincoln County Health and Human Services Department, Lincoln County "has health problems and unfavorable ratings for cancer and stroke mortality and morbidity; prenatal care; Sexually Transmitted Diseases; and environmental illnesses–food born illnesses and tuberculosis, illicit drug use among youth and tobacco use among youth and adults."[33] At 10 percent, the percentage of the county's population receiving inadequate prenatal care is double the statewide average, while 15 percent of Lincoln County births were to teen mothers, compared to 13 percent statewide. In addition, 30 percent of Lincoln County residents use tobacco in some form, compared to a 25 percent statewide average; this includes 29 percent of pregnant women, compared to a statewide average of 18 percent. Rates of domestic violence are also higher in the county than in the state as a whole. Lincoln County has a child abuse rate of 2.7 percent

compared to a statewide average of 1.2 percent. Thirteen percent of women in a five-county region that included Lincoln County experienced physical abuse at least once in 1998.[34]

The county has two hospitals, both of which are classified as Type B Rural Hospitals. **North Lincoln Hospital** is located in Lincoln City. In 1998, it had 30 staffed beds and 1,348 admissions.[35] **Pacific Communities Hospital** is located in Newport. In 1998, it had 42 staffed beds and 1,824 admissions.[36]

In March of 2000, Samaritan Health Services took over management of North Lincoln Hospital. Since then, the Hospital has established a community advisory Board and invited OHAC and a Progressive Options Board member to serve on the Board. (Progressive Options is an independent living center.)

Project Equality, a consumer-driven, chapter-based statewide initiative of the research and education arm of OHAC, works to ensure that Medicaid enrollees have access to the care to which they are entitled, delivered in a timely and respectful manner. The Lincoln County chapter of Project Equality was concerned about the impact of the changes in hospital management in the county on the provision of care to the uninsured. For this reason, it undertook the CAMS project to identify barriers that the uninsured and underserved may experience when they access health care at the local hospitals. For the CAMS project, Project Equality surveyed patients who had received care during the previous year while uninsured at either North Lincoln Hospital or Pacific Communities Hospital.

SURVEY METHODOLOGY

Surveys were conducted by the Lincoln County chapter of Project Equality, in collaboration with Progressive Options, an independent living center, and Centro de Ayuda, a Latino service center with offices in North and South Lincoln County. Surveyors were recruited from among Project Equality members, as well as through contacts in other community organizations, such as Headstart, Centro De Ayudo, and Progressive Options. Twenty surveyors were recruited--ten in North Lincoln and ten in South Lincoln. Each surveyor was paid 10 dollars for each completed survey.

Prior to conducting interviews, all surveyors attended a full-day training session in survey administration. The session was conducted by trainers from the Health Training Innovations Program of The Medical Foundation in Boston, Massachusetts.

Survey respondents included patients who had received care during the previous year while uninsured at either North Lincoln Hospital or Pacific Communities Hospital. To identify respondents, organizers advertised in the local paper and distributed flyers to clinics, social service agencies, foodbanks, and Headstart sites. In addition, the Service Employees International Union (SEIU) mailed flyers to 400 home health providers in Lincoln County. The survey interviews were conducted in community centers, people's homes, offices, coffee shops and the community college. As a thank you for volunteering their time, respondents who completed surveys received two free movie passes.

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.

Three hundred and five surveys were completed, 150 for respondents who received care at North Lincoln Hospital, and 155 for those who received care at Pacific Communities Hospital. 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—North Lincoln Hospital (North Lincoln) and Pacific Communities Hospital (Pacific)—included in the CAMS project in Oregon. In addition, it compares these results with averages for All Rural Hospitals (ARHs) 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 both Oregon hospitals, as well as the aggregate results for all rural hospitals included in CAMS.)

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

Respondent Characteristics

The demographic characteristics of North Lincoln and Pacific respondents were similar. Respondents for both hospitals varied in age, and they were more likely to be white and to have taken the survey in English than the averages for ARHs.

Respondents for Pacific and North Lincoln varied in age. A small proportion (between 8% and 13%) of respondents for each group answered on behalf of a child.

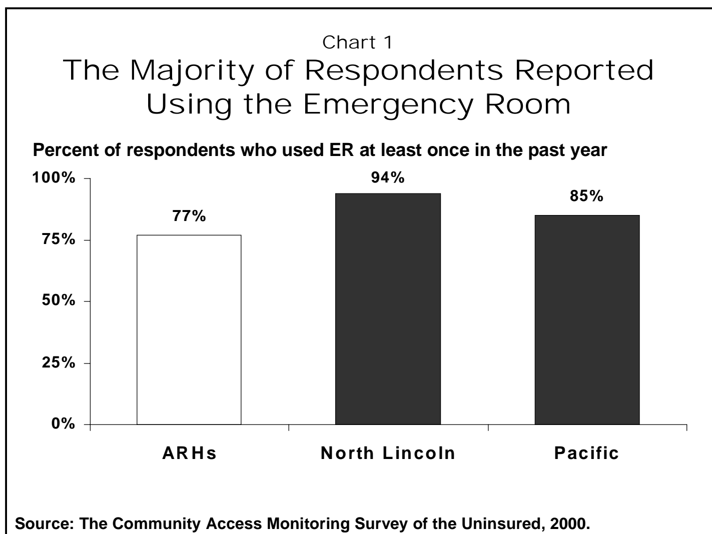
More than three-fourths of the respondents for both facilities were white, which was slightly higher than the average for ARHs (72%). In addition, 5 percent of North Lincoln and 9 percent of Pacific respondents were Hispanic.

Nearly all the respondents took the survey in English. Very few respondents (3% for North Lincoln and 7% for Pacific) took the survey in Spanish. The average for ARHs was one 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. In addition, more than two of five respondents reported that they used the facility more than once in the past year.

Emergency room use: Both respondent groups reported very high emergency room use. For both hospitals, more than four out of five respondents reported that they used the emergency room at least once in the past year. This proportion was much higher than the average for ARHs. (Chart 1)



Outpatient clinic use: Nearly one-half (49%) of the North Lincoln respondents and 38 percent of the Pacific respondents reported having used an outpatient clinic in the past year. The average for ARHs was 54 percent.

Inpatient hospital use: North Lincoln respondents were more than three times as likely to report that they had been admitted to the hospital as Pacific respondents (42% vs. 14%, respectively). The average for ARHs was 22 percent.

Frequency of use: Fifty-seven percent of North Lincoln respondents and 52 percent of Pacific respondents reported that they used their hospital once in the past year, while only six percent of North Lincoln and eight percent of Pacific respondents reported using their hospital five or more times. These proportions did not differ significantly from the ARH averages.

"I only went because I thought I was dying."
North Lincoln Respondent

"I don't go there unless I have to."
Pacific Respondent

Less than a third of the respondents for either facility reported that they went to the hospital to treat a chronic problem such as asthma (North Lincoln 29%, Pacific 25%). In comparison, the ARH average was 34 percent.

Openness to the Uninsured and Satisfaction with Providers

Respondents for North Lincoln and Pacific were much less likely than the average for ARHs to state that their facility had been open and accepting to them even if they were unable to pay for their care, or that it has a reputation in the community for providing a lot of care to the uninsured. Staff satisfaction ratings for both respondents groups were modest.

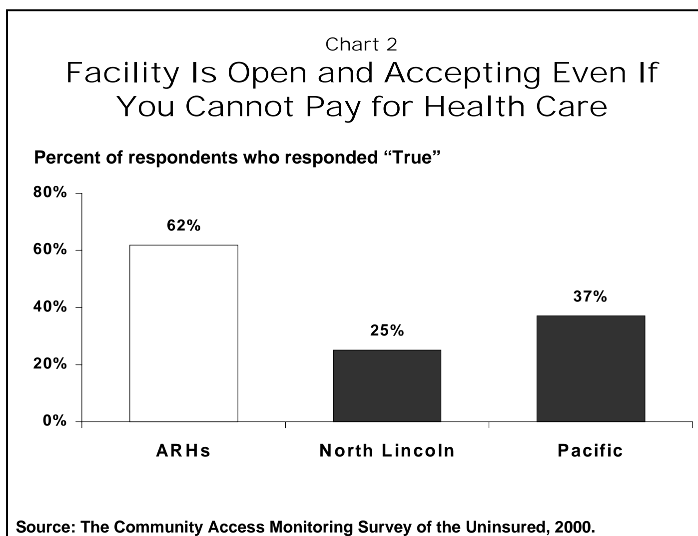
Thirty-seven percent of Pacific respondents and 25 percent of North Lincoln respondents reported that their hospital was open and accepting to them even if they were unable to pay for their care. These proportions were much lower than the 62 percent average for ARHs. (Chart 2)

"They offer care, but the quality suffers if you don't have an insurance card."
Pacific Respondent

"They do what they have to and then send you on your way."
North Lincoln Respondent

"They provide care because they have to. They seem bothered by it."
Pacific Respondent

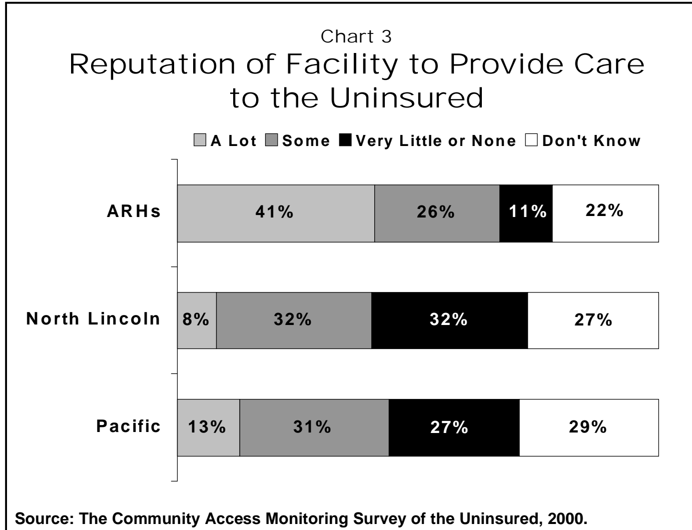
"They really don't know what it's like to be old and in pain."
North Lincoln Respondent



Notably, nearly half (47%) of North Lincoln respondents and one-third (34%) of Pacific respondents reported that, in their experience, the hospital had "reluctantly" provided care.

Only eight percent of North Lincoln respondents and 13 percent of Pacific respondents reported that their hospital had a reputation in the community for providing "a lot" of care to the uninsured. The average for ARHs was three to five times higher. Furthermore, about three of ten respondents for both facilities reported that their hospital has a reputation in the community for providing "very little or no care"

to the uninsured, a proportion three times higher than the ARH average. (Chart 3)



Source: The Community Access Monitoring Survey of the Uninsured, 2000.

"No hospital in this county is very compassionate about treating financially handicapped people."
North Lincoln Respondent

"They make you feel bad on top of already feeling bad."
Pacific Respondent

Overall, North Lincoln respondents were more likely than Pacific respondents to report that they were satisfied with their interactions with staff, but both groups were more likely to be dissatisfied with their interactions than the averages for ARHs.

For example, more than 80 percent of respondents in both groups reported that they were either "very satisfied" or "satisfied" with the care and service they received from receptionists and nurses. However, compared with the average for ARHs, North Lincoln and Pacific respondents were also twice as likely to report that they were dissatisfied with receptionists and nurses. In addition, about three of ten respondents (North Lincoln 28%, Pacific 33%) reported that they were dissatisfied with the care they received from their doctors. In comparison the average for ARHs was 12 percent. Finally, one-third of the respondents for North Lincoln and Pacific reported that they were dissatisfied with the service they received from billing clerks, while the average for ARHs was 15 percent.

"The receptionist was very rude and not culturally sensitive. I was trying my best to speak the little English that I know. She did not understand me and got upset."
Pacific Respondent

"The doctors were rude and so were the nurses. They want to hurry you in and out of the hospital."
North Lincoln Respondent

Less than a third of the respondents for either North Lincoln or Pacific reported that they were "always" treated with respect by staff, while the average for ARHs was 62 percent. The majority (57% for North Lincoln, 50% for Pacific) reported that they were "sometimes" treated with respect by staff.

"They make you feel quite inhuman, no compassion, as if I should apologize for making them get up and do their job."
Pacific Respondent

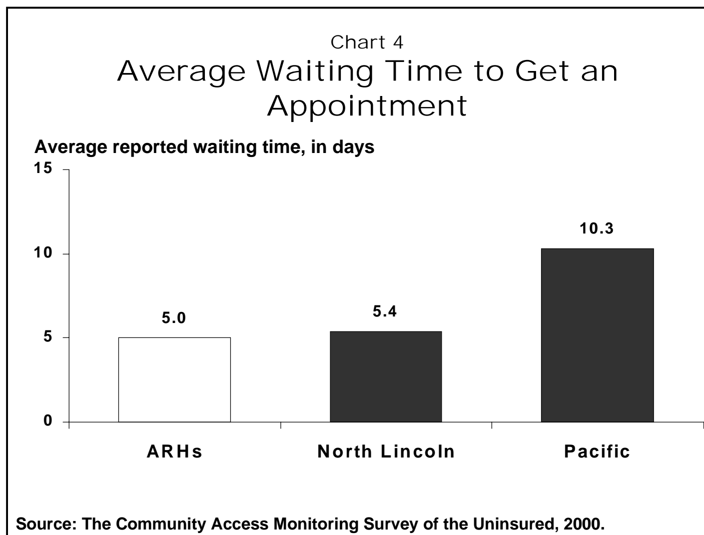
ACCESSIBILITY

On nearly all access indicators, about half or more of the respondents for each hospital reported that they experienced problems at least sometimes. Generally, North Lincoln respondents were more likely to report problems than Pacific respondents, but both respondents groups were more likely to report problems than the averages for ARHs.

One of five (21%) North Lincoln respondents reported that they found the hospital's hours a problem at least sometimes, compared to 13 percent of Pacific respondents and an average of 8 percent for ARHs.

More than two of five (44%) respondents for North Lincoln and 36 percent for Pacific said that the location of their hospital was a problem at least sometimes. These proportions were much higher than the ARH average of 21 percent. Notably, however, the average reported travel time for both respondent groups was 18-19 minutes, only a few minutes longer than the ARH average.

More than half (57%) of the North Lincoln respondents and 42 percent of Pacific respondents reported that the waiting time to get an appointment was a problem at least sometimes. The average for ARHs was 26 percent. Notably, the average waiting time to get an appointment reported by Pacific respondents was twice as long as the time reported by North Lincoln respondents or the average for ARHs. (Chart 4)



Respondents for North Lincoln and Pacific were just as likely (North Lincoln 57%, Pacific 51% (ns)) to state that the waiting time to see a provider on the day of an appointment was a problem for them at least sometimes. Notably, the average reported waiting time for Pacific respondents was 50 percent longer than the time reported by North Lincoln respondents. The average waiting time was about 45 minutes for Pacific respondents, compared with about 26 minutes for North Lincoln respondents and an ARH average of 36 minutes.

"I was having chest pains and I still had to wait over a hour and a half. I found out I did have a heart attack."
Pacific Respondent

A substantial number of respondents for both facilities found convenience to public transportation and assistance with transportation to be problems at least sometimes. Specifically, convenience to public transportation was rated a problem at least "sometimes" by about 70 percent of North Lincoln and 53 percent of Pacific respondents (ARH average: 20%). More than half (56%) of the respondents for North Lincoln and 41 percent of Pacific respondents reported that getting transportation assistance when needed was a problem frequently or sometimes (ARH average: 20%).

"There is no transportation if you don't have a car."
North Lincoln Respondent

"I had to take public transit, which doesn't run after 6pm and on weekends. I had to call an ambulance for a severe nose bleed."
Pacific Respondent

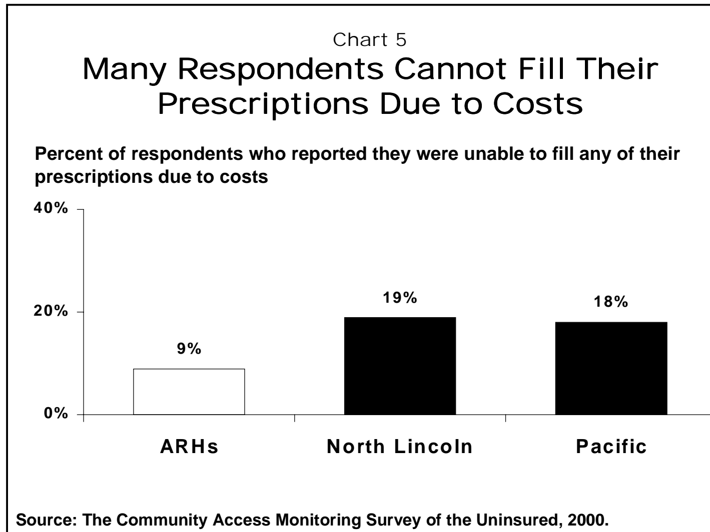
Obtaining Prescription Medications

The majority of the respondents for both groups stated that paying for their medications was very difficult and that they needed financial help to pay for them. Among the respondents who needed help, over 90 percent reported that staff never offered to find out if help was available. Nearly one of five respondents for both facilities said that they were unable to fill all of their prescriptions due to costs.

Seventy-four percent of North Lincoln and 72 percent of Pacific respondents had medications prescribed. Among these respondents some received their medications free (North Lincoln 39% and Pacific 27%), and about half reported that they went to a drug store and paid for the medications out-of-pocket. Yet, about one of five respondents for North Lincoln and Pacific said that they did not fill any of their prescriptions due to cost. (Chart 5)

"They will write a prescription. But then what's the use if you can't afford it."
Pacific Respondent

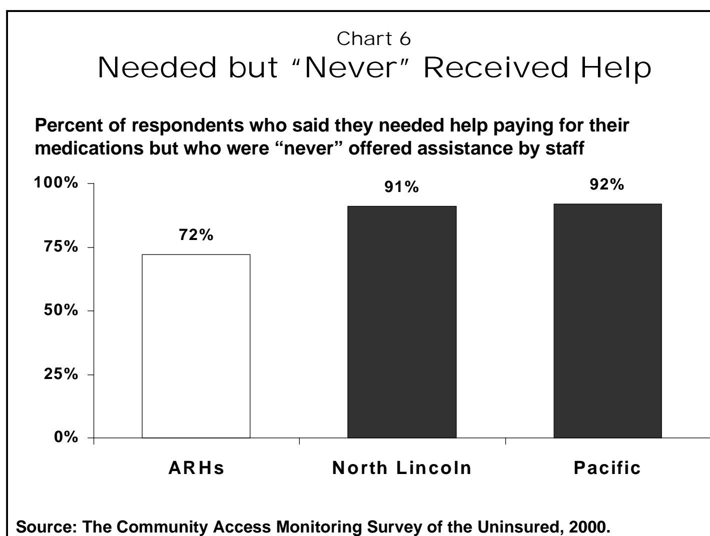
"I needed more medicine. They only gave me enough for one day."
North Lincoln Respondent



More than half of the respondents (North Lincoln 59% and Pacific 53%) reported that paying for their medications was "very difficult." Correspondingly, nearly three of five respondents (58% for North Lincoln and 59% for Pacific) said they needed help to pay for them. While a few respondents said they received help, more than 90 percent said they were "*never"* offered any form of assistance by staff. In comparison, the ARH average was 72 percent. (Chart 6)

"Sometimes when I pay for my meds, I can't afford to eat."
North Lincoln Respondent

"Most of the time, I can't afford to buy my own meds. So I go without."
Pacific Respondent



Five percent of North Lincoln respondents and four percent of Pacific respondents reported that they were not provided with instructions for taking their medications. Another six percent of Pacific respondents reported that they did not understand the instructions they received.

Concerns Over Payment for Health Care

The majority of the respondents reported that it was very difficult for them to pay their medical bills and that they needed help paying for them. However, more than four-fifths of the respondents who needed help said that staff never offered to find out if financial assistance was available.

Most of the respondents for both hospitals—73 percent for North Lincoln and 79 percent for Pacific—reported that paying their medical bills was "very difficult," although only the rate for Pacific was significantly higher than the average for ARHs (79% vs. 69%, respectively).

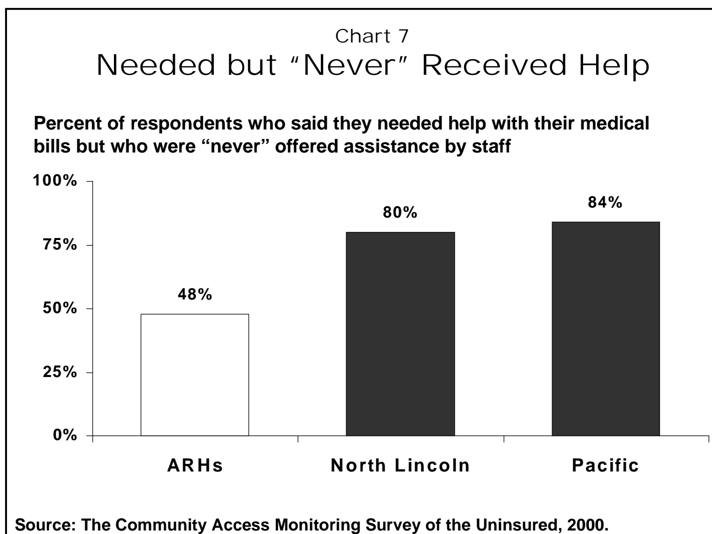
Three out of four respondents for each facility said they needed help to pay their medical bills. Among those who needed assistance, about one of five respondents reported that they were offered financial assistance at least sometimes. However, the vast majority of North Lincoln and Pacific respondents said they were "*never*" offered assistance. In comparison, the ARH average was much lower. (Chart 7)

"I needed help, but none was there. They told me I didn't qualify for anything."
North Lincoln Respondent

"I didn't know. They make you feel it's your problem. I didn't know if I should ask for help."
Pacific Respondent

"Because of the two surgeries, it was very expensive. My father claimed medical bankruptcy."
North Lincoln Respondent

"I was forced to sign a promissory note. I felt it was necessary so my daughter could get treatment. I've been served papers for collection."
Pacific Respondent

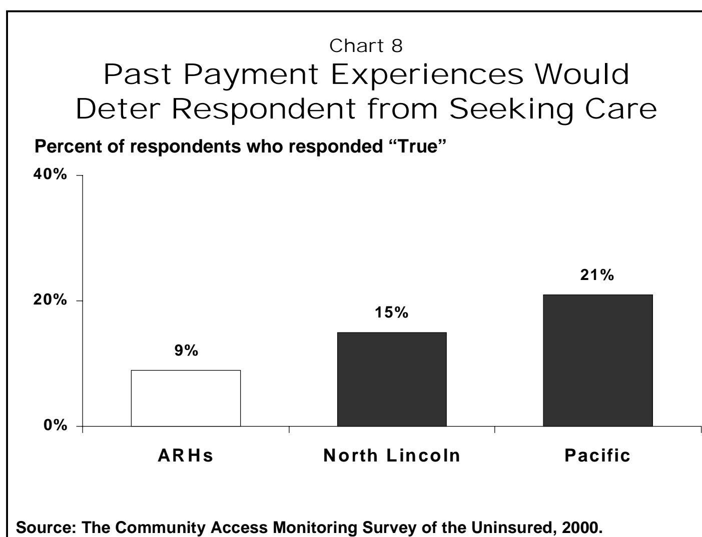


Seeking Care in the Future

Between 15 and 21 percent of the respondents stated that their past experiences paying medical bills at their hospital would deter them from seeking care there in the future. About two-thirds of the respondents for both facilities said that they owed money to their hospital, of whom about 40 percent said the indebtedness would deter them from seeking care there again. The majority of the respondents for both facilities said they would use their hospital again if they had health insurance.

"We wait until it's critical before we seek care, because of the cost."
Pacific Respondent

One of five respondents (21%) for Pacific and 15 percent for North Lincoln reported that their past experiences paying bills at their hospital would make them not seek care there in the future. (Chart 8) Another 11 to 13 percent of the respondents said that their experiences would make them use a different facility. The ARH averages were slightly lower (9% and 6%, respectively).



"I use it only because there is nowhere else to go."
North Lincoln Respondent

Two-thirds of the respondents reported that they were in debt to the hospital (66% for North Lincoln and 64% for Pacific). Among those who were in debt, about two of five respondents for each hospital reported that the debt would deter them from seeking care there again. The ARH average was significantly lower (29%).

"There is no other choice for treatment. What should I do? Drive to the Valley?"
Pacific Respondent

The majority of respondents—82 percent for Pacific and 86 percent for North Lincoln—said they would use the facility in the future if they had health insurance. In comparison, the average for ARHs was 90 percent. However, several respondents commented that they would use the hospital because there was nowhere else for them to go.

DISCUSSION

This section summarizes the findings of the CAMS project in Oregon for North Lincoln Hospital (North Lincoln) and Pacific Communities Hospital (Pacific), and highlights issues that might warrant further discussion.

- The overwhelming majority of North Lincoln and Pacific respondents reported using the emergency room at least once in the past year.
- Compared with the average for All Rural Hospitals (ARHs) included in the CAMS project nationwide, North Lincoln and Pacific respondents were much less likely to report that their hospital had been "open and accepting" to them even if they could not pay for their care. In addition, only about one-tenth of the respondents said that their hospital had a reputation in the community for providing "a lot" of care to the uninsured, while nearly a quarter to a third reported that their facility had a reputation for providing "very little or no care."
- While North Lincoln respondents were more likely to report that they were satisfied with their providers than Pacific respondents, respondents for both hospitals were more likely to report that they were dissatisfied with the care and service they received from staff than the average for ARHs. Up to a third of the respondents reported that they were dissatisfied or very dissatisfied with their interactions with billing clerks, and doctors. Less than a third of the respondents for either hospital said that they were "always" treated with respect, compared to about two-thirds of respondents for ARHs.
- More than half of respondents for both hospitals said that the waiting time to see a provider on the day of the appointment was a problem at least sometimes. More than half of North Lincoln respondents and 42 percent of Pacific respondents said that the waiting time to get an appointment was a problem at least sometimes. However, the average waiting times reported by Pacific respondents were considerably longer than those reported by North Lincoln respondents or the ARH averages.
- More than half of the respondents for both hospitals reported that convenience to public transportation was a problem at least sometimes.

- More than half of the respondents for both hospitals said that paying for their medications was “very difficult,” and that they needed help to pay for them. Among respondents who said they needed help, more than 9 in 10 said that staff had “never” offered to find out if assistance was available. In addition, among respondents who received prescriptions, about one of five for each hospital said they did not fill any of them due to cost.
- About three-quarters of the respondents for both hospitals reported that they found paying their medical bills “very difficult,” and that they needed help to pay them. However, among respondents who said they needed help, 80 percent or more said staff “never” offered help. This compared to an ARH average of 48 percent.
- One of six or more respondents for both facilities reported that their past experiences paying bills would deter them from seeking care again at their hospital. About two-thirds of the respondents said they were in debt to their hospital, and about 40 percent of these respondents stated that their indebtedness would deter them from seeking care there in the future.
- The majority of respondents—over 80 percent—said they would use their hospital again if they had health insurance. However, a number of respondents commented that they would use the hospital if insured because there was nowhere else they could go.

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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