

ACCESS TO HEALTH CARE

ACCESS TO HEALTH CARE SUMMARY

- ❖ There are 35 general acute care hospitals, 17 of which are not-for-profit, and 19 community clinics.
- ❖ *No health care coverage* means those individuals or families who have absolutely no form of health insurance. *Underinsured* refers to individuals and families who have government-assisted health coverage or partial coverage.
- ❖ Just over 83% of Orange County residents have health care coverage, with 21.6% of those indicating they had more than one source of coverage.
- ❖ Three out of four (75%) Orange County adults with health coverage have employer based coverage.
- ❖ **Nearly 17% (335,000)** of Orange County adults aged 18 and older are *without any* type of health care coverage.
- ❖ **Just over 12%** of adults have health care coverage through Medicare (7.8%) and Medi-Cal (4.6%) and could be considered underinsured.
- ❖ It is estimated that approximately 30,000 seniors (12%) aged 65 and older are without health coverage.
- ❖ **Almost 52%** of those without any health care coverage are from the Latino/Hispanic and Vietnamese populations. This figure represents almost 150,000 or 1 out of 4 adults within these subpopulations.
- ❖ **Almost 13% (89,840)** of children in Orange County are *without any* health coverage.
- ❖ **57%** of all children without any health care coverage are Latino/Hispanic; more than 1 in 5 (over **50,000**) Latino/Hispanic children are without coverage.
- ❖ **Close to 21.5%** of the overall Latino/Hispanic child population lacks health care coverage.
- ❖ **Just over 8%** of Vietnamese children have no sources of health care coverage.
- ❖ **More than 7%** of white children are without any health care coverage.
- ❖ Programs such as Medi-Cal and the Orange County Medical Services for Indigents (MSI) have regulations and eligibility requirements that dictate who can be covered and, what services may be available to that client. For this reason alone, an individual or family with this type of health coverage may be considered to be underinsured.
- ❖ Medi-Cal/CalOPTIMA recipients represent only 4.5% of survey respondents. It should be noted that not all Medi-Cal recipients receive the same level of benefits or have equal access to health care.
- ❖ During 1997, the Medi-Cal/CalOPTIMA program's average enrollment was 9.6% of the total population of Orange County. Income level data from the OCHNA survey indicate 16.8% of respondents had annual household incomes below \$20,000, and 4.4% reported annual household incomes less than \$10,000. This finding would suggest more residents might, in fact, qualify for Medi-Cal coverage than are currently enrolled.
- ❖ The degree to which all types of health care services are used is dependent on a number of environmental, social, and economic factors that exist within a community.

- ❖ The OCHNA data indicate that of those who had not seen a doctor in the last year, men tend to visit health care providers less often than women. Among men, 24% reported no visits and 15% of women reported no visits. Similarly, 11% of men had 7 or more visits and 16% of women had 7 or more visits.
- ❖ Older adults tend to visit health care providers more often than their younger counterparts. There is a significant difference of 10% between the proportion of young adults aged 18 to 34 reporting no visits to the proportion of older adults aged 65 and over reporting no visits. Similarly, there is a significant difference of 6% between the proportion of adults aged 35 to 54 reporting no visits to the proportion of adults aged 55 to 64 reporting no visits.
- ❖ Among the racial groups, Latino/Hispanic adults are least likely to have visited a health care provider in the year previous to the survey.
- ❖ Barriers to health care access include lack of knowledge of where and how to access health care services, lack of knowledge of how the health care system is set up and how it operates, language, transportation, inflexible office hours, child care issues, and the belief that only those with money will receive quality care.

The following are focus group comments regarding access and barriers to health care services in Orange County.

Providers in the behavioral health focus groups had the following to say about coverage for behavioral/mental health and substance abuse:

Some policies, some coverage is very good, and I have no difficulties getting referrals for clients that come in. Others are very restricted. I think the ones that are the most frustrating for me are the ones that just basically don't have the benefit to cover... the type of problem we're dealing with. And I see that most frequently with chemical dependency. That's an issue. And there is no benefit for that type of coverage. It's very difficult because I think the community it's pretty limited in what we can offer, and it's a very unstructured type of resource that's out there. So chemical dependency needs a lot of structure, at least initially, for successful (treatment), I think. So that's a real tough one for me to deal with.

The irony for me is that...the federal government has many, many state legislatures that mandated parity for mental health coverage, but totally obviated chemical dependency treatment.

Yes. (1:13)

I would say at least 30% of people that I see (have a substance abuse issue). Now ...some of those people have good coverage. To add to the frustration, I think that people that typically don't have that coverage in their policy also have the least amount of financial resources. And so we're talking about the lower part of the economic scale, and then you're trying to come up with something to give them some resources is really a tough one. (1:14)

Beyond these issues within the system, participants in the providers group noted coverage is not consistent, which presents issues of continuity between systems.

I do think part of the fragmentation that people have is if their insurance and health care coverage is always tied to your job and then they move, lose their job, quit, take another job, their health care changes. They can't stay with the same provider. There's no continuity. ...It's a real problem. There is no continuity for people.

Providers for children noted transportation, education, and scheduling difficulties as concerns in regard to access to care for children.

...But still, you know, a lot of parents don't bring the kids for different reasons. Some of them they don't have transportation, or ...they don't know...even though we've been in clinics around Santa Ana and all that. But a lot of people ...still...don't know that we have a clinic here. (1:22)

...When we have parents come in, or families come in, 'I never knew about these services'. 'I never knew they were available' and, you know, they've been there for years. And so its is really an education issue. It's getting the word out. (1:6)

...And our farthest southwest school is eight miles from the clinic and we have families walking with their kids to get to the clinic, to get their immunizations. (1:11)

...You'll see them come into the emergency room when it's not quite an emergent situation, only because they can't get an appointment with their doctor, or they don't have a clinic that they can go to, or they can't...just get in to see the pediatrician, so they bring them to the emergency room... (1:6)

Providers of services to children also commented on the need for a holistic, noncategorical approach to care.

...A one stop place where families can come in and access a variety of services so they don't have to drive all over town to get the dental care, to get the health care, to get the counseling, to get the parenting class that they need...and if it can't be in one center, then close in proximity so that transportation isn't an issue. (1:26)

One teen participating in a child and teen focus group voiced his/her opinion about health care coverage for kids.

...And...at least have coverage for the kids because...you know, the adults, I can see them saying, okay, we're not going to cover you because you're an adult. You should go out and get a job, but I think they should have cull coverage for kids. (2:22)

Providers in the immigrant focus group talked about barriers to care such as a lack of understanding and fear of the health system here in the United States.

...In my experience, the perception on health care is [that it is] inaccessible...They are afraid to go in and receive services because they will get charged an enormous amount of money...In my experience, coming from Mexico, if you are sick, you go to the emergency room anytime. You don't get charged. And when you come to this county, you have to learn the new rules. So if I feel very sick and I go to the emergency room, and then the bill comes, and I get afraid, because I get a \$300 bill for nothing. (1:10)

There's definitely a fear factor there for the immigrants, in that, they come to this county to better themselves, both financially, economically, health care, yet the stigmatism...they have a fear...of being found out. (1:16)

Most of the time when you send a patient to Medi-Cal or for Healthy Families, they don't want to apply. (1:8)

Immigrants participating in the focus group cited language, trust, and a lack of respect as major barriers to care.

...There were times that you can not express your self well enough. I think that they should always have someone who can speak Spanish in case we need information or something like that... (2:20)

My daughter's pediatrician, he does cure her. I have doubt, however. I know that he knows what is wrong with my daughter but for some reason he doesn't want to tell me what it is... (2:14-15)

You've got maybe five minute with a provider, if you're lucky...A little time with the doctor, and you cannot build trust with that at that level. We're not an assertive community, and it isn't because we don't have any self-respect or self esteem. It's that we don't question physicians. We don't question priests. We don't question teachers. (1:18)

One mother in the maternal health focus group had the following comment about the struggle to access good prenatal care.

Well, I think that the first concern when one gets pregnant is to look for medical attention, right? Because I think, especially for us who are older, the difficulty is in the language. And so we always try to ask to get advice from other people, where should we go for care? How should we take care of ourselves...? (1:3)

Mothers in the pregnant teen focus group had a different set of concerns in regard to accessing care.

Some people may be scared to letting anybody know that they're pregnant so they won't go see the doctor at all.

...Or they don't want to let their mom know, so that's why they don't go to the doctor, if that's your insurance. (4:11)

The following statement from a provider in one of the maternal health focus groups, referring to communication between patient and doctor could be applied to all areas of access, not just prenatal care.

A lot of people, in general, are very intimidated when they go to the doctor about asking questions. Um, even if they follow all the tips about writing things down, you know. They get to the doctor's office and everybody's rushed because there are a lot of people in the waiting room, or they're embarrassed about what the problem is. And so things get missed because you can't ask every single thing at every doctor's visit. And if the patient doesn't ask or offer information, it gets missed. (1:15)

Another provider in the maternal health focus group expressed the following concern regarding prenatal care and the low income population:

...I mean, these people's priorities in the low income population is how they're going to get to the clinic, and domestic violence issues, and being in a safe environment, and, um, where they're going to eat their next meal and feed their children, those are the more pressing... (1:29)

One senior voiced the following frustration over the complications faced in accessing care.

For Medi-Cal, we have to join a health group. If we want to go to specialists, we have to go through primary care physicians...Before...I could go straight to my heart doctor. Now they give appointments after 14 or 10 days, must be through my primary care doctor. I have to ask for permission. Very inconvenient. (2:5)

Providers of care for the frail elderly also voiced concerns over transportation for seniors.

...If you want to talk about improving the health care of seniors in this county, you have to put dollars in organized transportation to get them to health care sources, period. (1:16)

...We need buses with hydraulic lifts. We need assistants on the bus to help people on and of, and we need flexible scheduling because it isn't easy for seniors to call up and make a date. (1:30)

Providers of services to the frail elderly were also disturbed by the lack of geriatric specialists.

...They ignore the fact that geriatrics is a special kind of primary care, just as pediatrics is, and just as gynecology is, very important...Hospitals and their physicians who treat older people, with no knowledge of the fact that they don't know an older man from an older woman. Have no idea how to treat a person whose cardiovascular system has changed, and medicate them properly. (1:19)

...They don't think of a 92 year old as being worth doing preventive health care, because they figure, why prevent anything, next week they'll be dead. We'll, maybe not. (1:40)

ACCESS, UTILIZATION, AND BARRIERS TO HEALTH CARE

Defining Terms

Clear and consistent use of terminology is necessary in order to understand the access, utilization, and barriers data as it relates to health care services in Orange County. The term *no health care coverage* refers to individuals and families who have absolutely no form of health care insurance, including but not limited to private (e.g., employer-based coverage, coverage provided under a parent or spouse's employer, COBRA employment health coverage, and individually purchased health plans), and/or government subsidized health insurance programs (e.g., Medi-Cal/CalOPTIMA, Medicare, Medical Services for Indigents). The term *underinsured* refers to individuals and families who may have government-assisted health care coverage or partial coverage (which may include any or all of the following: no dental, vision or mental health coverage and/or partial coverage).

Measuring Access to Health Care

The health care environment that currently exists in Orange County includes 19 community clinics and 35 general acute care hospitals, 17 of which are not-for-profit hospitals. There is no county hospital. In addition, the number of primary care and specialty care physicians are 20% and 16% higher, respectively, than the national average (A case Study: Health System Change in Orange County, Calif., Sept. 1997). The Orange County Medical Association estimates the following:

- ❖ 5,870 practicing physicians in Orange County (10/98)
- ❖ 64% (3,765) of practicing physicians are specialists (i.e., surgeons, dermatologists, radiologists, ophthalmologists, etc.)
- ❖ 36% (2,105) are primary care physicians.
- ❖ Among primary care physicians, nearly 13% (751) are in family practice.
- ❖ Just over 11% (669) practice internal medicine.
- ❖ Close to 7% (384) are in pediatrics.
- ❖ Just over 5% (301) practice in the OB/GYN sector.

Orange County Community Clinics

In 1997, there were 19 community clinics located in Orange County. Special populations targeted for their services include the homeless; agricultural, immigrant, and seasonal farm workers; HIV/AIDS patients; and substance abusers. The cities of Santa Ana, Anaheim, Huntington Beach, Irvine, Orange, and Fullerton which "...[contain] the County's most indigent, uneducated, [and] newly immigrated populations (West Med Health Foundation's *Orange County Health care Needs Report 1997*) are the sites for 13 of the 21 (as of 1999) licensed community based clinics that "...serve as a safety net for...those who are medically indigent and/or underserved" (Wulsin Report 1999). According to the Coalition of Orange County Community Clinics, 95% of community clinics' patients' annual family income is less than 200% of the federal poverty level.

While there appears to be adequate resources of physicians and hospitals, this does not necessarily mean there is equal access to health care services.

Characteristics of Patients in Community Clinics Orange County 1997

Clinic Sites 19
Patients 103,962
Encounters 298,740

	Patients	
	Number	Percent (%)
Sex		
Male	33,088	32
Female	70,874	68
Total	103,962	100
Race/Ethnicity		
Asian	10,023	10
Black	1,751	0.2
White	30,166	29
Hispanic	56,606	54
Other	5,416	05
Total	103,962	100
Age (years)		
Less than 1	3,639	4
1 to 4	9,454	9
5 to 12	9,971	10
13 to 19	11,497	11
20 to 34	351,47	34
35 to 44	16,916	16
45 to 64	14,782	14
65 and older	2,574	2
Total	103,962	100
Poverty Level		
Above 200%	5,182	05
200% or below	98,780	95
Total	103,962	100
Payers (in order of proportion of encounters)	Encounters	Percent
Self-pay	27,446	25.9
State (not Medi-Cal)	14,739	13.9
Medi-Cal	20,652	19.5
County(not funded by CHDP,MISP,EAPC)	719	.7
CHDP (Child Health Disability Prevention)	5,088	4.8
Private insurance	643	.6
MISP (Medical Indigent Service Program)	5,987	5.6
EAPC (Early Access to Primary Care)	7,103	6.7
Other (County)	8,830	8.3
Nonpay	13,658	12.9
Medicare	738	.7
Other pay	399	.4
Total	106,002	100

Health Care Coverage

One primary ingredient in measuring the *potential* access to health care services is the prevalence of health care coverage, or more accurately the lack of health care coverage. The Orange County Health Care Needs Assessment (OCHNA) project conducted a countywide random digital dialing telephone survey to determine the status of health and health needs of county residents. The nearly 5,000 survey respondents were asked a series of questions designed to determine whether they had *any* health care coverage, what type, and from what source. Azhar K. Qureshi, MD, DrPH, (Senior Research Scientist, St. Joseph Health System) provided an in-depth analysis of the population weighted data and determined the following:

First, the Good News

A little more than 83% of Orange County residents have health care coverage, with 21.6% of those indicating they had more than one source of coverage. Orange County has a higher rate (59.6%) of employer-based coverage than the State (58.2%) (Schauffler & Brown, *The State of Health Insurance in California*, 1998), with an additional 16.3% of residents having coverage through a family member's employer. Seventy five percent of Orange County adults, or 3 out of 4, with health coverage have employer-based coverage. Of those residents with health coverage, slightly more than 49.5% indicated having HMO based coverage. And finally, it is estimated that 88% of seniors aged 65 and older have health coverage.

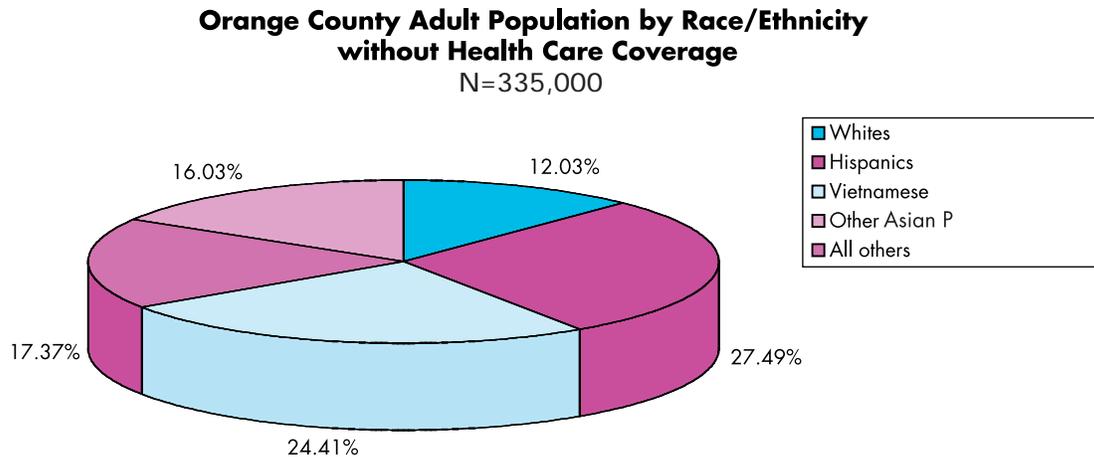
Sources of Health Coverage for Orange County Residents

Source of Insurance	Population Percentage (%)
	Estimated value
Self-employment	59.6
Spousal employment	16.3
Self-paid health plan	9.6
Medicare	7.8
Medi-Cal/CalOPTIMA	4.6
U. S. military	1.0
Indian Health Service	.07
Medical Services Indigents	.34
Unspecified source	.90

The Not-So-Good news

- ❖ **Nearly 17% (335,000)** of Orange County adults aged 18 and older are *without* any type of health care coverage.
- ❖ **Just over 12%** of adults have health care coverage through Medicare (7.8%) and Medi-Cal (4.6%) and could be considered underinsured.
- ❖ It is estimated approximately 30,000 (12%) seniors aged 65 and older are without health coverage.
- ❖ **Almost 52%** of those without any health care coverage are from the Latino/Hispanic and Vietnamese populations. This figure represents almost 150,000 or 1 out of 4 adults within these subpopulations.

The pie chart below illustrates the wide disparity in health care coverage among different ethnic groups in Orange County. Latino/Hispanic and Vietnamese adults are much more likely than their white counterparts to be *without* any source of health care coverage.

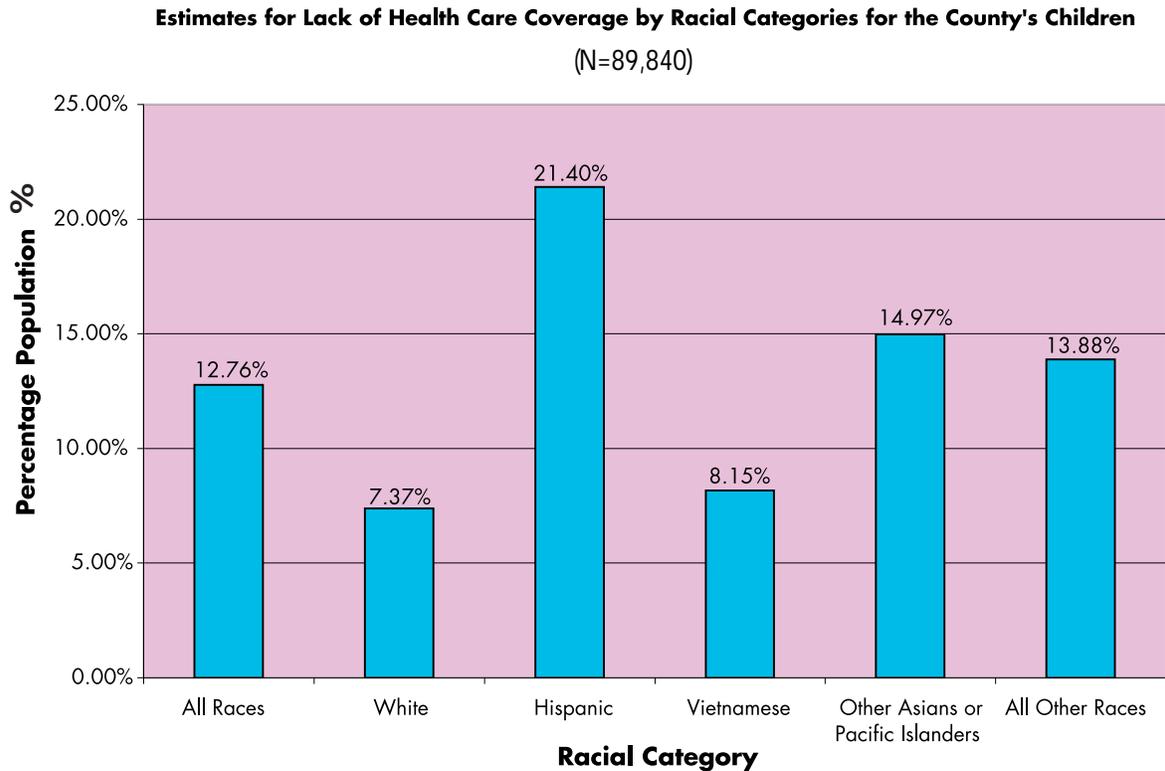


The black population represents approximately 1.8% of the total Orange County population: 36,559 adults and 12,678 children. It is important to note the survey sample size for the black population in Orange County was too small for statistical reliability; therefore, the estimates presented must be considered with caution. It is estimated 2,615 (10.6%) black adults and 357 (3.4%) black children are without any health care coverage.

Orange County Children:

- ✓ **Almost 13%** (89,840) of children in Orange County are without *any* health coverage.
- ✓ **57%** of all children without any health care coverage are Latino/Hispanic, which is more than 1 in 5, or over **50,000** children.
- ✓ **Close to 21.5%** of the overall Latino/Hispanic child population lacks health care coverage.
- ✓ **Just over 8%** of Vietnamese children have no sources of health care coverage.
- ✓ **More than 7%** of white children are without any health care coverage.

As the chart below indicates and similar to the adult population, non-white children are more likely to be without health coverage than their white counterparts. Latino/Hispanic children are most likely to be without health care coverage.



Medi-Cal/CalOPTIMA

In order to assess the continuum of care on which access is measured, there needs to be some understanding of what services government subsidized (public sector) health coverage provides and to whom those services are provided. Programs such as Medi-Cal and the Orange County Medical Services for Indigents (MSI) have regulations and eligibility requirements that dictate who can be covered and what services may be available to that client. For this reason alone, an individual or family with this type of health coverage may be considered to be underinsured. Payments for many covered services are generally considered to be below the actual cost of providing those services.

Medi-Cal/CalOPTIMA recipients represent only 4.5% of survey respondents. It should be noted that not all Medi-Cal recipients receive the same level of benefits or have equal access to health care. Medi-Cal recipients with undocumented or nonimmigrant alien status receive very limited services, generally restricted to prenatal care, labor and delivery, and emergency services.

Under CalOPTIMA, the Orange County's managed care program for Medi-Cal beneficiaries, residents who qualify for full medical coverage have access to preventive, on-going acute, and chronic medical services. This includes both inpatient and outpatient medical services and institutional long term care coverage. In spite of the global medical coverage provided under this program, it is not clear that all eligible residents are using the available services or even applying for coverage.

During 1997, the Medi-Cal/CalOPTIMA program's average enrollment was 263,256 recipients or 8% of the total population of Orange County. However, the percentage of Orange County residents living below the federal poverty level was estimated to be higher, at 12.6% (Medi-Cal Policy Institute: County-by County Data, 1998). The income level data from the OCHNA survey indicated 16.8% of respondents had annual household incomes below \$20,000, and 4.4 % of those reported annual household incomes of less than \$10,000. This finding would suggest more residents might, in fact, qualify for Medi-Cal coverage than are currently enrolled.

Orange County Medical Services for Indigents

An ongoing mandated program (Welfare and Institutions code 17000 et seq.) covering all Orange County, Medical Services for Indigents (MSI) plans, develops, implements, and monitors medical services for indigents. While this program does not include routine physical examinations, routine dental care, and routine eye examinations, MSI is designed to provide a coordinated, cost-effective system for the delivery of mandated health services necessary to protect life, prevent significant disability, and prevent serious deterioration of health for county-responsible patients. The program is generally designed to serve the working poor, who have a demonstrated medical need, are between 21 and 64 years of age, making less than 200 % of the federal poverty level, and have no other source of medical care coverage.

The County negotiates an annual contract with hospitals and providers, and pays out approximately \$43 million in state and county funds for delivery of contracted health services. MSI serves approximately 20,000 persons per year, and currently serves 1,600 patients with chronic illnesses requiring continuous management – diabetes, hypertension, and asthma. Qualifying for this program may be difficult for some Orange County residents because of eligibility criteria and administrative processes, and others may not even be aware the program exists.

Government subsidized health care coverage programs, as described above, and others such Healthy Families (a partially subsidized program that provides health, vision, and dental coverage to children aged 1 through 18 years), have financial eligibility requirements based on official federal poverty guidelines (FPG). According to the 1998 FPG, a family of 4 is living at 100% of the poverty level when earning an annual gross household income of \$16,450 (\$1,371 monthly gross). Eligibility requirements for many government subsidized programs, such as Medi-Cal and the new Healthy Families, are for those whose household incomes are at or below 200 % of the FPG. For a family of 4 this would mean a gross annual income of less than \$33,000.

**Orange County
MSI Population by Ethnicity by Sex
Fiscal Year 1995-1996**

	White	Percent
Male	5784	26.43
Female	4803	21.95
Total	10587	48.38
	Black	
Male	464	2.12
Female	291	1.33
Total	755	3.45
	Hispanic	
Male	2673	12.21
Female	2568	11.73
Total	5241	23.95
	Native American Aleut, Eskimo	
Male	41	0.19
Female	62	0.28
Total	103	0.47
	Asian Pacific Islander	
Male	1516	6.93
Female	2653	12.12
Total	4169	19.05
	Other Unknown	
Male	471	2.15
Female	558	2.55
Total	1029	4.7
	Total	
Male	10949	50.03
Female	10935	49.97
Total	21884	100.00

Utilization of Health Care Services

The degree to which all types of health care services are used is dependent on a number of environmental, social, and economic factors that exist within a community. Such factors include the availability and acceptability of the medical care services offered, the health care system's organizational structure, and whether access to health care is considered to be an individual or community responsibility. In addition, the characteristics of the population influence how and when access and utilization of health care services will be sought. The age, gender, and ethnicity along with the financial, educational, and occupational status will influence consumers' ability to cope with challenges and to demand resources to address their needs. In turn, the perceived need for health care services, and the subsequent use of those services, is greatly influenced by individual or community beliefs, attitudes, personal and cultural values, and knowledge of health and health services (Andersen, Ronald, M. and Davidson, Pamela L., *Measuring Access and Trends, Causes and Characteristics of Health Care Utilization*).

OCHNA data estimate 18.3% (372,000) of adults visited an emergency room during the last year. There was no difference in emergency room utilization between men and women. Note, the youngest (18-34) and the oldest age (over 65) groups consume more emergency services compared to the 2 other age groups (35-54 and 55-64). Overall, the youngest (18-34) used the emergency services most often. Among the racial groups, Vietnamese and other Asian or Pacific islanders (API) used emergency services substantially less than whites, Latino/Hispanics, and all other races.

Of all adults who visited an emergency room during the past 12 months, 42.1% were younger than 35 years. Similarly, of all adults who visited an emergency room during the past 12 months, 68.1% were white. Vietnamese and other API adults are less likely to use emergency services compared to their white and Hispanic counterparts. Asians and Pacific islanders (including Vietnamese) account for almost 11% of the County's adult population, yet they comprise only 6.9% of the total number of people who visited an emergency room during the past 12 months.

Number of Annual Visits to Health Care Providers

The total number of times adults visited a health care provider to receive health care (regardless of reason) during the past 12 months indicated almost 400,000 (1 in 5) adults did not visit any health care provider in the year previous to the survey. Another 20% of adults visited a health care provider only once in the year previous to the survey. At the other extreme, 278,000 (1 in 7) adults visited a health care provider 7 or more times in the year previous to the survey.

Annual Visits to Health Care Providers by Gender

The data indicate men tend to visit health care providers less often than women. Of the men, 24% had no visits while 15% of women had no visits, which is a significant difference of 9% between the 2 groups. Similarly, 11% of men had 7 or more visits and 16% of women had 7 or more visits, which is a significant difference of 5% between the 2 groups. Men outnumbered women by 73,000 in not visiting a health care provider in the year previous to the survey. In contrast, almost 49,000 more women than men visited a health care provider more than 6 times in the year previous to the survey.

Annual Visits to Health Care Providers by Age Categories

Older adults tend to visit health care providers more often than their younger counterparts. There is a significant difference of 10% between the proportion of young adults aged 18 to 34 with no visits to the proportion of older adults aged 65 and over with no visits. Similarly, there is a significant difference of 6% between the proportion of adults aged 35 to 54 with no visits to the proportion of adults aged 55 to 64 with no visits.

The following comes from an analysis of the population totals for the number of times adult residents visited a health care provider to receive health care (regardless of reason) during the past 12 months. With regard to the almost 100,000 *most frequent visitors* (13 or more times per year), more than 44% belong to the youngest age group, 18 to 34 years (5.63%). It is noteworthy that, even though older adults (4.58%) are

more likely to visit a doctor, of the people 18 to 34 years who see the doctor they tend to be the most frequent users.

Annual Visits to Health Care Providers by Racial Categories

Among the racial groups, Latino/Hispanic adults are least likely to have visited a health care provider in the year previous to the survey. For example, there is a statistically significant difference of 10% between the proportion of Latino/Hispanic adults reporting no visits to a health care provider to the proportion of white adults reporting no visits. In contrast, white adults are most likely to have visited a health care provider in the year previous to the survey.

Barriers

According to the OCHNA survey and focus groups, there are both perceived and actual barriers to obtaining health care. This research confirmed a large number of adults and children in certain ethnic and economic groups are in greatest need for basic health care and preventive services. Unfortunately, they experience more barriers to obtaining those services.

The lack of knowledge of where and how to access health care services was cited as a major barrier. Yet, it was evident among immigrant groups that it was very important for their children to receive care. Often, adults would forgo care and treatment in order to ensure their children would obtain services.

The information also indicated a lack of knowledge within the immigrant community of how the health care system is set up and how it operates. Because many immigrants are unfamiliar with the various programs, they may be afraid of the cost associated with accessing care. Additionally, there is a perception that even if they attempt to access care, they will not be taken care of if they cannot afford it. Word of mouth is the most frequently used and most relied upon way to communicate in this population. When someone in the community is mistreated and has a bad experience, such information spreads quickly through the community. Such information often prevents others from seeking care. Trust is of great importance among these groups and in certain ethnic groups, trust in the government is not an option due to past experience in their country of origin.

Language was acknowledged as a barrier by the focus groups. Yet, survey participants did not indicate language was of great concern. The focus groups emphasized language abilities pertained to both the spoken and written word. Many immigrants indicated they could not communicate with health care personnel, nor could they comprehend instructions or educational materials. Furthermore, since there is a cultural predisposition to refrain from questioning members of respected professions, the communications barrier is further complicated.

Transportation was identified in the focus groups as yet another barrier. Although phone survey participants did not identify transportation as an impediment, the focus groups agreed it was an enormous barrier. Traveling on buses in Orange County is extremely difficult. Many focus group participants described the number of buses that must be taken to get to different hospitals and clinics. A trip to the doctor could require 4 bus transfers and 4 hours of time. Because a trip to the doctor could take several hours, many parents opt not to go because they would not make it back in time before their other children got out of school for the day. Additionally, if the parents did not have child care and had to take all of their children with them to the doctor, they felt like they were mistreated and looked down upon by providers. Many providers may not want others present besides the client.

Along with the issue of transportation, rigid office hours were seen as an obstacle to accessing health care. When scheduling appointments and setting hours of operation, many providers do not take into consideration the amount of time that it may take for clients to get to their facility. In addition, once clients make it to a facility, many people described how they had to wait for several hours for their appointments. They felt by having to wait so long for appointments, their time was not considered important by the

providers. Many parents explained, because of inflexible office hours and long travel time, they did not take time off during the work day to seek medical treatment either for themselves or their children because they would lose their jobs.

Many residents living in poverty in Orange County face numerous barriers to accessing health care. One consequence of such barriers has been the emergence of unqualified and unlicensed practitioners. Some have harmed and, in some cases, killed their patients who turned to them for health care services.

Some reasons cited for not accessing or receiving health care services:

- ❖ Lack of trust or understanding within certain ethnic communities of health care providers and government programs. They do not feel comfortable questioning authority.
- ❖ Many are unable to afford services because of lack of or inadequate health care coverage. They believe if they are unable to pay for services, they will not receive care.
- ❖ Many cited both written and spoken language as a barrier. By not understanding the language, they do not know where or how to obtain services provided to low income groups.
- ❖ Traveling by bus is extremely difficult. Bus stops are frequently far from medical facilities. Often, several bus transfers are necessary to get to one destination. Consequently a single trip to the doctor may take 4 hours. This concern was very big for the senior population and presented an insurmountable obstacle for the frail elderly.
- ❖ Many people lack child care; therefore, they must figure out how to bring all their children to a doctor's appointment.
- ❖ Most providers have inflexible hours of operation. Many people forgo going to the doctor so they won't miss work.
- ❖ The poor attitude of providers toward clients was cited as an obstacle. Clients often feel a lack of respect from their providers.
- ❖ Lack of knowledge regarding appropriate use of hospital emergency room services
- ❖ A shortage of nurses in the schools to provide an important portal of entry to health care services for children and their families.
- ❖ Lack of services or lack of knowledge about services that are easily accessible in their communities
- ❖ Belief that health care providers are motivated by profit; only those with money will receive quality care.
- ❖ Difficulty in receiving referrals to a specialist
- ❖ Lack of coverage for mental health services

In Orange County, as elsewhere, families with lower incomes are likely to experience limited access to health care services. Both the direct consequences for those living below or near the federal poverty level, and the indirect consequences for the rest of the community are very serious. For families living in poverty, limited access significantly decreases their quality of life. Furthermore, the quality of life of the entire

community is impaired due to having to bear the burden of substantial costs, both economical and healthwise.

The economic costs to the community resulting from limited access to health care for the poor are well documented. Lack of access to prenatal care results in enormous costs in perinatal care. Lack of access to early detection and treatment of any disease inevitably results in expenditures many times greater when the disease progresses and becomes more difficult and costly to treat. It is evident the impact of not addressing health care safety net issues in the long run will be costly in the extreme, both financially and in terms of the community's overall quality of life.