Access to Health Care

"Of all the forms of inequity, injustice in health care is the most striking and inhumane.”
—Martin Luther King, Jr.

Historical Overview

Modern health insurance in the United States dates back to 1929 when it was linked to employment and employers assumed the administrative tasks of enrolling employees and collecting premiums. Health insurance spread during World War II after employers were permitted to increase their provision of health insurance and to consider those premium payments as legitimate costs of doing business. Rather than being guided by consistent policies aimed at equitable access to health care for all, the growth of an employer health insurance system was not conceived or driven as intentional government policy. The expanding private market private for health insurance over the years opened the door to for-profit insurers who were able to compete by offering narrower and customized benefit packages at lower premium costs. The entry of the for-profit sector shifted the system from the traditional “community-rated” models to “experience-rated” premiums (meaning that the healthier or younger the employees, the lower the premium) and provided an incentive to “disengage” from those who were higher risk (among whom were the sick and the aged). These features continue to characterize many private health insurance plans offering coverage or employer health benefit management services today. In 1965, the federal government enacted legislation for programs to cover most individuals 65 years and older (Medicare) and some discrete categories of the poor (Medicaid)—the major sources of public health insurance today. The expanding power of medicine to help the sick and the spread of private and public health insurance in the twentieth century resulted in a great increase in medical care utilization and investment in the expansion of for-profit hospitals, long-term care institutions, and Health Maintenance Organizations (HMOs). Moving into the 21st century, as health care costs skyrocketed and rates of the uninsured rose drastically; several efforts to reform the broken system have been attempted by both national and state legislators. Changes have been piecemeal and profound inequities in access to needed care persist.1
What Research Tells Us

Health Insurance: Not Universal, Not Affordable

Insurance coverage is a major determinant of access to health care services in the United States. The majority of Americans have private health insurance through their own, a spouse’s, or a parent’s employment. A small percentage has coverage through directly purchased private insurance. Government provided health coverage—an important source of insurance—includes Medicaid (for low-income children and adults), the State Children Health Insurance Program (SCHIP) for low-income children, Medicare (for adults 65 years and older), and military veteran’s coverage. Medi-Cal—California’s Medicaid program—has broader income eligibility criteria than the federal criteria. The Healthy Families Program—California’s version of SCHIP—provides low-cost health, dental, and vision coverage to children in families with income up to 250% of the federal poverty level.

Various factors including changes in the overall economy and the impacts on employment and family incomes, the rapid growth in health care costs and insurance premiums, and the inability of Medicaid and other public programs to cover more of the uninsured largely explain the decrease in insurance coverage over the past decade. Significant shortfalls and barriers in the current health care system contribute to inequities in health insurance coverage. The voluntary nature of employment-based coverage, the movement of employers away from “defined benefits” to “defined contribution”, higher premiums, higher out-of-pocket costs for employees, and lower take-up rates are among the reasons for declining employment-based insurance rates in recent years. Complex procedures for enrollment in public programs, lack of understanding or knowledge of eligibility criteria, and stigma are some of the reasons that a significant proportion of adults and children who are eligible are not currently enrolled or do not maintain enrollment in public programs. With few exceptions, growth in health insurance premiums has been outpacing overall inflation and increases in workers’ earnings since the late 1980s. The most current national data show that Americans who get health insurance for their families through their jobs have seen their premiums increase 10 times faster than their income in recent years. In California, not being able to afford health insurance was the most common reason for not having coverage in 2005—accounting for 43% of the uninsured. Employment-related factors (changing employers or losing a job) was the second most common reason (15% of the uninsured). Other barriers such as immigration status, exclusion from health plans due to health conditions, and administrative delays were the reason 16% of the uninsured did not have coverage.

A Profile of the Uninsured

In the United States, uninsured rates are on the rise. In 2006, the gaps in private and public health insurance left 46.5 million, or 18% of non-elderly, Americans without coverage. The overwhelming majority of the uninsured were those from working families or those with low incomes who fell through the cracks of the health care system. Over 8 in 10 of the uninsured are from families with at least one full-time worker (70%), or at least one part-time worker (11%). Although Medicaid covers 40% of the poor, its eligibility criteria leave 37% of those below poverty level uninsured. Two-thirds of the poor or near-poor (67%) are uninsured. The uninsured rate among the non-elderly poor is twice as high as the national average (37% vs. 18%); the near-poor also run a high risk of being unin-

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a. Only citizens and documented immigrant children below 5 years are eligible. Undocumented children, and recent immigrants children below five years are not eligible.
b. The elderly (age 65 and older) uninsured are not included because they have universal coverage by Medicare.
d. “Poor” is defined as those with incomes below the federal poverty level. “Near-poor” is defined as those with incomes 100-199% of the federal poverty level.
sured (30%) because their incomes are higher than the Medicaid cut-off point but too low to purchase private insurance.¹⁰

People of color are much less likely to be offered health insurance through their jobs, be eligible for health benefits, or be able to afford their share of the cost of health premiums. One-third of Latinos are uninsured compared to 13% of Whites.¹⁰ Non-citizens have high uninsured rates compared to citizens (47% vs. 15%) due to their employment in low-wage jobs that are less likely to offer health coverage and restrictions on their eligibility for public coverage.¹⁰ Undocumented immigrants make up a small share of the uninsured population. The great majority (about 4 in 5) of the uninsured in the United States and California are citizens and documented non-citizens.¹⁰,¹¹ Undocumented immigrants are more vulnerable than citizens to factors that lead to uninsurance, e.g., low wages or being ineligible for public programs.¹¹

The uninsured are more likely than the insured to be young (21% are below 18 and 63% are below 34 years of age). In addition, childless adults are less likely to be eligible for public coverage programs and are more likely to be uninsured than adults with children. Education also influences the chances of being uninsured—those who did not attend college are less likely than those with higher education to be insured. Type of employment (part- or full-time) and occupation determine health insurance coverage. The gap in coverage between blue- and white-collar workers in different industries is two-fold. Over 80% of the uninsured are in blue-collar jobs.²,¹⁰

In 2005, 6.5 million non-elderly Californians (20% of the state’s population) were uninsured all or part of the year.² The proportion of children and adults who were uninsured part of the year remained unchanged between 2001 and 2005. Even with the strong economic recovery, employment-based coverage of the non-elderly population declined during this period. Lack of insurance coverage was a persistent problem for at least three-fourths of the uninsured—not a short-term problem related to brief gaps in employment-based insurance. One in 4 Californians never had health insurance coverage.⁵

The Consequences of Uninsurance

Being uninsured even for a short period of time results in decreased access to care and can have serious health consequences.² The uninsured are more likely than the insured to report problems getting needed medical care. They are much more likely to have an unmet need for medical care or a prescription drug.² Having health insurance facilitates access to a usual source of care—a regular place to go to for medical advice. Those who have a usual source of care are more likely to receive preventive care, to have access to and utilize medical care, not delay seeking care, receive continuous care, and have lower rates of hospitalization and lower health care costs.¹²,¹³

The uninsured are in worse health than the insured. They are more likely than the insured to be hospitalized for avoidable health problems and to experience declines in overall health. In the United States the annual excess deaths due to lack of health insurance are estimated to be as high as 21%.¹⁴ Uninsured adults living with chronic diseases are less likely than the in-

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e. Based on the California Health Interview Survey, which is not directly comparable to the Census Bureau’s Current Population Survey.
sured to receive appropriate care to help manage their health conditions. They have worse outcomes than the insured for diabetes, cardiovascular disease, end-stage renal disease, HIV infection, and mental illness. The uninsured who are hospitalized for a range of conditions receive fewer needed services, worse quality care, and have a greater risk of repeat hospitalizations or dying shortly after discharge. Uninsured persons suffering from trauma and cardiovascular disease, in particular, are less likely to receive the same quantity and quality of hospital services and are more likely to die from their conditions than the insured. Health insurance coverage is associated with better access to prevention services and better quality care. Uninsured adults are less likely than insured adults to receive preventive and screening services such as mammograms, Pap tests, colorectal screenings, and prostate-specific antigen (PSA) test and to receive them on a timely basis. Uninsured cancer patients generally are in poorer health and are more likely to die prematurely than the insured, primarily due to delayed diagnosis. Furthermore, even after cancer is diagnosed, there are treatment disparities based on insurance coverage.

Uninsured women and children receive fewer prenatal and perinatal services than the insured. Uninsured newborns are more likely to have low birth weight and to die than insured newborns. Uninsured women are more likely to have poor outcomes during pregnancy and delivery than are women with insurance. Uninsured children have worse health care access and utilization than insured children.

Lack of health insurance coverage also has multiple economic consequences for individuals, employers, taxpayers, and the health care system. The costs of medical care for uninsured individuals are weighed against other essential needs such as housing, transportation, and food; treating catastrophic illness can result in serious financial consequences. Employers bear the economic burden of the uninsured in terms of reduced productivity and absenteeism for health reasons. Taxpayers also pay some of the hidden costs associated with the uninsured by shouldering the cost of financing public programs. Finally, the health care system may bear some of the avoidable costs of treating the uninsured, e.g. costly emergency room care for health conditions that can be managed in a low-cost primary care setting.

Beyond Insurance: Unequal Access and Unequal Treatment

As described earlier, having health insurance facilitates access to prevention services such as cancer screening. However, cultural and linguistic barriers also have a significant impact on participation in, and utilization of, cancer screening—regardless of insurance status. White women are much more likely than all other racial/ethnic groups to be screened for breast cancer and be diagnosed early. Low-income women are less likely to receive mammography screening than high-income women. White and African American men are more likely than Latino or Asian men to be screened for prostate cancer. Men from low-income households have significantly lower screening rates than those from high-income households. Asian and Latina women are at greater risk for cervical cancer, but are much less likely to be screened than White or African American women.
American women. This body of evidence suggests the need for culturally appropriate strategies to narrow the gaps in access to potentially life-saving prevention services such as cancer screening.

There is also compelling evidence of significant disparities in the quality of health care for different race/ethnic groups. An extensive Institute of Medicine (IOM) review found that people of color were less likely than Whites to receive needed services and that these disparities existed for a number of health conditions, including cancer, cardiovascular disease, HIV/AIDS, diabetes, and mental illness, and are found across a range of procedures, including routine treatments for common health problems. The sources of such unequal treatment at the health care service-level were also examined. The IOM review concluded that bias, stereotyping, prejudice, and uncertainty on the part of health care providers may contribute to racial and ethnic disparities in health care.

Working Toward Health Care Reform

Access to a high quality system of affordable health care is an important human right and a necessary strategy for improving health and quality of life and reducing health disparities. However, health care alone is not sufficient to “produce” health in populations.

Most people who live long and healthy lives in United States do so without much assistance from the health care system. In fact, a reasonable goal of most Americans is to avoid hospitalization, emergency room visits, and even our physician’s office, except for routine clinical preventive services. The best strategy for doing this is to avoid acquiring a chronic disease. Prevalence of chronic disease in a community is a primary driver of the demand for health care services. The medical care costs of people with chronic diseases account for more than 75% of the nation’s $2 trillion medical care costs. Chronic diseases, (primarily heart disease, stroke, cancer, and diabetes), are the cause of 7 of every 10 Americans deaths. Chronic disabling conditions cause major limitations in activity for more than 10% of Americans, or 25 million people. Relatively modest shifts in the overall chronic disease burden in a community can have dramatic effects on health care costs and utilization. In general, the current reactive health care system is primarily designed to mitigate the adverse consequences of, rather than prevent the occurrence of, chronic disease. Thus expansion of access to routine preventive services especially for chronic disease, should be a major strategy in future health care reform.

The IOM Committee on the Consequences of Uninsurance suggests five principles for reforming the U.S. health care system. It proposes that health care coverage should be 1) universal; 2) continuous; 3) affordable to individuals and families; 4) affordable and sustainable for society; and 5) enhancing to health and well-being. In recent years a number of legislative strategies addressing some or all of these IOM principles of health care reform have been proposed at the state and national levels.

Some of the recent California proposals to assure affordable coverage for those with low and moderate income that have been considered are 1) mandate that would require that employers offer and help pay for health benefits or pay into a public purchasing pool; 2) individual mandate that requires all individuals to buy health insurance; 3) single-payer program similar to Medicare for the entire population that would replace private health insurance. All of these options attempt to assure affordable, continuous care for children and adults. While there is considerable public interest and support from constituencies such as the medical community for these health care reform strategies in California, none has been successful in the legislative process due to the lack of political support or budgetary challenges. The future of health care reform at both state and national levels remains uncertain in the current economic climate.
The Safety Net: Critical to Ensuring Access to Health Care

While health insurance coverage cannot guarantee good health, it is clearly key to access and utilization of health care. However, insurance coverage alone is not sufficient to ensure access to necessary services, especially in light of recent market trends toward high-deductible health plans, reductions in benefits and greater patient cost-sharing. Many insured individuals may face diminished access to health care because they are essentially underinsured. Furthermore, not having a usual source of health care, also known as a “medical home” may result in reduced access and utilization of health care and worse health outcomes independent of insurance status. California’s system of safety net providers—which includes community health centers, public hospitals and clinics—can play a critical role in improving access to health care for the uninsured and underserved. This system of safety net providers was the source of regular care for almost a quarter of California’s non-elderly population in 2005. Four in 10 safety net users were covered all year by employment-based insurance, but they reported using these community health centers, public hospitals and clinics as their main source of care. Nearly 3 in 10 safety net users were covered by Medi-Cal or Healthy Families and reported their main source of care as the safety net. The safety net also served nearly 3 in 10 of those who lacked coverage part or all of the year.

California depends heavily on federally supported health centers and other non-federally funded community clinics to provide primary care to the uninsured and underserved. These primary care clinics, regardless of their funding source, are not traditional private medical practices. They provide comprehensive primary and preventive care, and assist patients in accessing care through enabling services such as case management, child care and health education. Providers who work in community-based primary care clinics and health centers are often better able to meet the complex needs of low-income populations and people of color that they typically serve. Their focus on culturally competent, high quality care includes support services such as transportation, child care, interpreters, etc. These types of services, designed to enable and improve access to care for vulnerable populations, have been shown to reduce health care disparities and result in better health outcomes (e.g. birth weight) than low-income populations who do not receive care at health centers. Health policy experts in California have proposed that in addition to expansion of insurance coverage, enhancing the health care safety net through the expansion of primary care and provision of a potential medical home, is an important strategy for improving access to the medical care system and health outcomes among the uninsured and underinsured.

Alameda County is distinct from many California counties in that there is a strong safety net comprised of a network of established health care providers that serve low-income persons regardless of their insurance coverage status. These providers currently serve a substantial proportion of the uninsured, who are largely low-income and people of color. Supporting this safety net provider network is a significant percentage of the county health budget. Though these funds are not enough to purchase full health coverage, they do ensure that the lowest-income (below 200% of the federal poverty level) Alameda County residents have access to a broad range of health care services. Currently, these providers are working together to coordinate services for the uninsured, and to increase the number of uninsured who have a usual source of care through a “medical home.”

f. Alameda County’s safety net includes: the Alameda County Medical Center (public hospital system), Children’s Hospital-Oakland, federally-qualified community health centers, the Alameda County Public Health Department, the Berkeley City Health Department, and many private hospitals, physician practices, and smaller clinic programs.
g. County budget sources for services for the uninsured include: disproportionate share hospital (DSH) funds, county indigent health care funds, e.g. County Medical Services Program (CMSP), Medi-Cal waiver funds, e.g., Alameda County Excellence (ACE) program, and a special county sales tax (Measure A).
A Look at Alameda County

Groups Affected by Lack of Access to Health Care

In Alameda County, as in the United States, profound inequities in health insurance coverage by racial/ethnic group exist today (Figure 53). Among non-elderly adults 18-64 years old, Latinos are 5 times as likely as Whites to be uninsured (33.0% vs. 6.6%). African Americans and Asian/Pacific Islanders are also more likely than Whites to be uninsured (21.1% and 15.2% respectively).

There are also substantial inequities in health insurance coverage by income among non-elderly adults—the poor are disproportionately burdened by lack of health insurance (Figure 54). Six in 10 adults from low- or moderate-income households have no health insurance.\(^h\)

Immigration status is a major determinant of health insurance coverage (Figure 55). Recent immigrants who are not U.S. citizens are twice as likely to be uninsured than are U.S.-born persons. An additional 1 in 8 immigrants who are naturalized U.S. citizens is uninsured.

Another important determinant of access to health care—having a usual source of care—is influenced by income (Figure 56 on page 128). Adults from low- and moderate-income households are over twice as likely to lack a usual source of care as adults from high-income households (18.8% and 19.5% vs. 8.2%).

Some Consequences of Inadequate Access to Health Care

Health insurance is a key to access to the health care system and to better health. In Alameda County, not having health insurance coverage is associated with poorer self-reported health. The uninsured are twice

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\(^h\) The federal poverty threshold is used to define income groups in terms of poverty level, a measure of material deprivation. A household between 0 and 99% of the federal poverty level is considered low-income; 100% to 199% of the federal poverty level is considered moderate income; households at or above 300% of the federal poverty level are considered high-income.
as likely as the insured to report being in poor or fair health. The uninsured experience barriers to health care; they are twice as likely as the insured to not have a place to go to when they need medical care or advice and much more likely than the insured to encounter problems getting necessary health care or delay getting needed medical care (data not shown).

Lack of health insurance also limits access to and use of critical prevention services. Significant inequities in access to prevention services by income, education, or race/ethnicity are evident from the differences in access to screening for breast, prostate, and cervical cancer among residents of Alameda County.

Women from lower income households are less likely to be screened for breast cancer than those from higher income households (Figure 57). Breast cancer screening rates are also determined by insurance status—a much higher proportion of women with health insurance report being screened for breast cancer than those lacking insurance (80.2% vs. 64.5%) (data not shown).

In the county, higher education is associated with higher rates of PSA screening for prostate cancer; the percentage of men screened increases with higher education level from 17.9% to 31.3%. Insured men are much more likely to have been screened for prostate cancer than the uninsured (Figure 58).

In Alameda County, Asian/Pacific Islander women (75.3%) are significantly less likely to be screened for cervical cancer than White (87.7%), African American (86.9%), and Latino women (85.5%) (Figure 59).
Women with health insurance are much more likely to be screened for cervical cancer than those lacking health insurance (84.9% vs. 75.3%) (data not shown).

Data to Action: Policy Implications

Access to a high quality system of affordable health care is an important human right and necessary for improving health and reducing health disparities. The clear inequities in access to health insurance and health care in Alameda County are profound and unjust. The poor, Latinos, and recent immigrants in the county are disproportionately burdened by lack of health insurance and have inadequate access to health care. Those who lack health insurance also experience significant barriers to health care. Additionally, there are inequities in access to and utilization of critical prevention services such as cancer screening by race/ethnicity and socioeconomic status. There is also notably less utilization of breast cancer screening by decreasing income, and significantly lower rates of prostate cancer screening by education. Asian women are substantially less likely to participate in cervical cancer screening than women of all other racial/ethnic groups. Being uninsured also contributes to the significant gaps in cancer screening. An important strategy in reducing health inequities in Alameda County is to increase the availability and utilization of prevention services in the health care system. The following policy goals and strategies are recommended to improve health care access.

- Support federal and state proposals aimed at continuous and universal access to affordable health care for all.
- Support local efforts to strengthen the health care safety net and increase the number of uninsured and underinsured who have a usual source of care through a “medical home.”
- In partnership with clinics, hospitals, policy-makers, employers, and elected officials, develop and advocate for policies that improve access to basic health care for the uninsured and underinsured. Support affordable health care options (private or employer based) for these groups. For example, young single adults (ages 18-24) and adults (particularly males) who are unemployed and most likely to be uninsured or underinsured.
- Support strategies to streamline public health insurance enrollment, e.g. enhanced application assistance and system navigation with attention to language and cultural competencies to assist consumers in better understanding and utilizing appropriate health services.
- Propose and support legislation to increase Medi-Cal provider rates to improve affordability of services in the health care safety net that many poorer residents depend on.
- Support State funding of undocumented health care to ensure the provision of preventive health and health care services to undocumented individuals to protect their health, the health of the public at large, and to prevent more costly health care costs.
- Support State statutes to maintain continuity of health coverage during budget gaps to ensure consistent support, especially to seniors and persons with disabilities who are dependent on health and social services.
- Support legislation to improve affordability of critical prevention services such as childhood immunizations, e.g., by eliminating deductibles.
- Promote culturally appropriate cancer screening programs for specific populations, e.g., Asian women for cervical cancer through partnerships with multicultural health care organizations.
- Support the implementation of targeted breast and prostate cancer screening programs among low-income and lower literacy groups in the county.
• Support private and public efforts to develop comprehensive chronic disease management programs for diseases such as diabetes, asthma, and high blood pressure, particularly those that employ peer-based and peer-led culturally relevant interventions.
References


**Data Sources**
