Articles

Access to Medical Care for Documented and Undocumented Latinos in a Southern California County

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To determine local access to medical care among Latinos, we conducted telephone interviews with residents of Orange County, California. The survey replicated on a local level the national access surveys sponsored by the Robert Wood Johnson Foundation. We compared access among Latino citizens of the United States (including permanent legal residents), undocumented Latinos, and Anglos, and analyzed predictors of access.

Among the sample of 958 respondents were 137 Latino citizens, 54 undocumented Latinos, and 680 Anglos. Compared with Anglos, Latino citizens and undocumented immigrants had less access to medical care by all measures used in the survey. Although undocumented Latinos were less likely than Latino citizens to have health insurance, by most other measures their access did not differ significantly. By multivariate analysis, health insurance status and not ethnicity was the most important predictor of access. Because access to medical care is limited for both Latino citizens and undocumented immigrants, policy proposals to improve access for Latinos should consider current barriers faced by these groups and local differences in access to medical care.

(Hubbell FA, Waitzkin H, Mishra SI, Dombrink J, Chavez LR: Access to medical care for documented and undocumented Latinos in a southern California county. West J Med 1991 Apr; 154:414-417)

Latinos—Mexican Americans, Mexican nationals, and other persons of Latino descent—face major barriers to access to medical care in the United States. Latinos are less likely than any other ethnic group to have health insurance. In a recent national survey,[1] Latinos were more than twice as likely as African Americans and nearly three times as likely as Anglos to lack health insurance. Latinos in that survey also reported deficiencies in other important measures of access, such as having a regular source of health care or having at least one ambulatory office visit during the previous year.

These findings are disturbing not only because of the potential effects on the health of this population but also because Latinos are the fastest growing minority in the United States.[2] Since 1980, the number of Latinos in the United States has risen by 39%, five times the growth rate of all other ethnic groups. The 20.1 million Latinos now living in the United States make up 8.2% of the population.

Although nearly a third of all US Latinos live in California, little reliable information exists about their access to medical care. As part of a community-oriented needs assessment, we studied access to medical care for Latinos in Orange County, an urban community in southern California. In 1989, Latinos accounted for approximately 23% of the county's more than 2 million residents.[2] Moreover, an estimated 150,000 undocumented persons live in the county. Thus, Orange County provides a good setting to study access in this important minority group.

We report herein a comparison of access measures among Latino citizens, undocumented Latinos, and Anglos; an analysis of the predictors of access among Latinos; and a discussion of the health policy implications of the findings.

Methods

During October 1987 and February 1988, we conducted telephone surveys of residents in the northern inland portion of Orange County, an area where many Latinos live, to determine access to medical care. A detailed description of our methods appeared in a previous report.[3] In the October survey, we contacted 652 families—300 families with incomes less than 125% of the national poverty level (which we classified as "poor") and 352 families with incomes between 125% and 200% of that level (which we described as "nearly poor"). The national poverty level at the time of the survey was $11,200 per year for a family of four. We chose these low-income families randomly from census tracts in which at least 100 households had incomes below the national poverty level (according to 1980 US census data). In the February survey, we contacted a group of 306 families with incomes greater than 200% of the national poverty level (which we classified as "nonpoor"). We selected these families from a random sample of telephone numbers of families living in the same geographic location as the low-income group.

Our survey instrument was designed to replicate on a local level previous national surveys on access to medical care supported by the Robert Wood Johnson Foundation.[1] The questionnaire consisted of closed- and open-ended questions that focused on demographic characteristics, access to care, and health status. We classified all respondents who identified their ethnicity as Mexican, Chicano, or Latino as Latino for the purposes of this study. Another demographic characteristic of interest was immigration status. Because of the sensitive nature of this question, we asked it at the end of the survey after reassuring respondents that their answers

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Supported in part by grants from the Center for Orange County Research, the St Joseph Health System Foundation (St Jude Hospital), the California Community Foundation, and the US Public Health Service (PE 19154-07).

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TABLE 1.—*Demographic Characteristics of Latino and Anglo Adults**

Characteristic	Latino			Anglo
	All (n = 191), %	Undocumented (n = 54), %	Citizen (n = 137), %	(n = 680), %
Age, yrs				
<40	65	87†	56‡	36
40-65	29	11	36	29
>65	6	2	8	34
Sex				
Male	33	46†	28	30
Female	67	54	72	70
Income§				
Poor	65	81†	59‡	21
Nearly poor	26	17	29	40
Nonpoor	9	2	12	38
Employment Status				
Employed	58	74†	52	47
Unemployed	11	8	12	8
Not in the work force (homemaker, retired, student)	31	18	36	45

*Percentages are of valid responses. Not all totals equal 100% because of rounding error.
†$P<.01$, which is the difference in frequency of a demographic characteristic between Latino citizens and undocumented Latinos by 2-tailed χ^2 testing.
‡$P<.01$, which is the difference in frequency of a demographic characteristic between Latino citizens and Anglos by 2-tailed χ^2 testing.
§"Poor" refers to families with incomes less than 125% of the national poverty level ($11,200/yr for a family of 4), "nearly poor" were those with incomes between 125% and 200% of that level, and "nonpoor" were those with incomes more than 200% of that level.

would remain confidential. The questionnaire segment on access contained questions about health insurance status, regular source of care, physician visits within the past year, and barriers to care. For purposes of the survey, respondents possessed health insurance if they had any private or government-sponsored health insurance, including Medicare, Medi-Cal (California's equivalent to Medicaid), and the county's indigent medical services program. The segment on health status included questions about the respondents' health compared to others (much better, better, the same, worse, or much worse) and about the presence of any chronic diseases.

Specially trained bilingual interviewers from the University of California, Irvine, Center for Survey Research conducted the survey. They chose as the respondent the adult member of a household who had the most knowledge about the health care of the family. This person responded to questions about access to health care for the entire family, for an adult designate (the household member older than 17 years with the most recent birthday), and for a child designate (the household member younger than 18 years with the most recent birthday). This approach allowed for a random selection of adult and child household members. The interviewers initiated calls at various times of day and evening and made a minimum of six attempts to reach each family. They gave the respondents the option of completing the questionnaire in either English or Spanish. The survey took about 22 minutes to complete.

We used descriptive statistics to provide an overview of the results and the two-tailed χ^2 test to analyze dichotomous variables. In addition, we used logistic regression to evaluate the relative contributions of ethnicity, income, health insurance, employment, and health status in predicting access to medical care. In constructing the logistic regression model, we included variables that previously have predicted medical care access and all variables that showed an association on initial χ^2 testing ($P<.01$). We calculated odds ratios and 95% confidence intervals for the various subgroups.[4]

The university's Human Subjects Review Committee reviewed and approved the study protocol.

Results

In the October 1987 survey, we contacted 973 families who met the income criteria, of whom 652 (67%) agreed to participate. In the February 1988 survey, we contacted 473 families who met the income criteria, and 306 (65%) agreed to participate. Thus, we interviewed a total of 958 families.

Demographic Characteristics

Among the 958 families, 197 were Latino, 680 were Anglo, and 81 were from other ethnic groups. Of the 197 Latino families, 54 were undocumented, 137 were US citizens or permanent legal residents (whom we considered citizens), and 6 did not provide information about immigration status. The analysis included only those Latinos who provided such information. The 81 respondents categorized as "other" composed diverse ethnic groups, with small numbers from any one group, and were not analyzed.

Table 1 shows the demographic characteristics of adult Latinos and Anglos. Compared with Anglos, Latino citizens were younger, poorer, and more likely to be employed. Likewise, compared with Latino citizens, undocumented Latinos were younger, more likely to be men, poorer, and more likely to be employed.

Statistical Analysis

Univariate. According to all measures of access to medical care analyzed in this study (Table 2), Latino citizens had less access than Anglos. Compared with Anglos, they more often lacked health insurance ($P<.01$), a regular source of care ($P<.01$), and a physician visit within the previous year ($P<.01$). They were also more likely than Anglos to perceive access to medical care as difficult ($P<.01$) and that medical care created financial difficulty ($P<.01$). Not surprisingly, language was also more likely to create barriers to access among Latino citizens than among Anglos ($P<.01$).

Although undocumented Latinos lacked health insurance more often than did citizens ($P<.01$), 40% of the undocumented Latinos had some form of health insurance, usually provided by their employers. Undocumented Latinos also reported difficulty obtaining care more often than did citizens ($P<.01$). No significant differences existed between these groups in other access measures, such as regular source of care, physician visit during the previous year, financial barriers, and language.

Multivariate. Logistic regression, with control for age, sex, employment status, health status, and income, revealed that although Anglo versus Latino ethnicity did not emerge as a strong predictor of access, insurance status was a very strong predictor (Table 3). Insured respondents were less likely than uninsured respondents to lack a regular source of care (odds ratio 0.3, confidence interval [CI] 0.2 to 0.4) and to report no physician visit within the previous year (odds ratio 0.4, CI 0.3 to 0.6). Other variables also predicted access to care to a lesser extent. For instance, after controlling for other variables, poor respondents tended to be more likely than nonpoor respondents to lack a regular source of care (odds ratio 1.5, CI 0.9 to 2.6) and to report no physician visit during the previous year (odds ratio 1.4, CI 0.8 to 2.7).

TABLE 2.—*Measures of Access to Medical Care Among Latino and Anglo Adults and Families*

Measure of Access	Latino All (n = 191), %	Latino Undocumented (n = 54), %	Latino Citizen (n = 137), %	Anglo (n = 680), %
Adult Designates*				
Lack health insurance	44	60†	38‡	16
No regular source of care	29	37	26‡	17
No physician visit in the previous year	23	24	23‡	11
Families§				
Access was somewhat or very difficult	21	30†	17‡	8
Medical care created financial difficulty	35	41	33‡	22
Language created difficulty in obtaining care	24	33	20‡	2

*Respondents answered these questions about access for the adult designate.
†$P<.01$, which is the difference in frequency of an access measure between Latino citizens and undocumented Latinos by 2-tailed χ^2 testing.
‡$P<.01$, which is the difference in frequency of an access measure between Latino citizens and Anglos by 2-tailed χ^2 testing.
§Respondents answered these questions about access for the whole family. For example, "Is medical care very difficult, somewhat difficult, somewhat easy, or very easy to obtain for your family?"

Adults in the work force (employed and unemployed) were more likely than adults not in the work force to lack a regular source of care (odds ratio 2.0, CI 1.3 to 2.2) and to report no physician visit during the previous year (odds ratio 1.6, CI 1.0 to 2.7). Persons younger than 65 years also tended to have less access to health care. For instance, adults younger than 65 were more likely than older adults to report no physician visit in the previous year (odds ratio 1.6, CI 0.8 to 3.2).

Discussion

Latinos, whether citizens or undocumented, reported less access to medical care than Anglos by all measures used in this survey. The most important explanation for these findings was the relatively low prevalence of Latino families with health insurance. A lack of health insurance was reported by 38% of Latino citizens and 60% of undocumented Latinos. The percentage of uninsured Latino citizens exceeded the 31% found in a recent national access survey.[1] Overall, Latinos were nearly three times more likely than Anglos to be uninsured. Moreover, multivariate analysis confirmed insurance status as the strongest predictor of access to medical care.

We found surprisingly few differences in access between undocumented Latinos and Latino citizens. As expected, those in the undocumented group were less likely to possess health insurance. In California, this group is not entitled to government-sponsored insurance except for coverage of prenatal and emergency care. By other measures of access, however, such as regular source of care and visiting a physician in the previous year, no significant differences existed between the undocumented and Latino citizens. The results emphasize that access to medical care was limited for all Latinos in this study.

TABLE 3.—*Predictors of Lack of Access to Medical Care**

Predictor Variable	No Regular Source of Care Odds Ratio (95% CI)†	No Physician Visit Within the Previous Year Odds Ratio (95% CI)†
Anglo heritage	0.9 (0.6-1.6)	1.3 (0.8-2.3)
Age < 65 yrs	1.2 (0.7-2.2)	1.6 (0.8-3.2)
Female sex	0.8 (0.6-1.3)	1.1 (0.7-1.7)
In the work force	2.0 (1.3-3.2)	1.6 (1.0-2.7)
Income status		
Poor	1.5 (0.9-2.6)	1.4 (0.8-2.7)
Nearly poor	1.0 (0.6-1.7)	1.5 (0.9-2.5)
Insured	0.3 (0.2-0.4)	0.4 (0.3-0.6)

CI = confidence interval
*The logistic regression models controlled for ethnicity, age, sex, employment status, income, insurance status, and health status.
†The odds ratios are given for Anglos compared with Latinos, respondents younger than 65 years compared with those older than 65 years, for women compared with men, for respondents in the work force compared with those not in the work force, for the poor compared with the nonpoor, for the nearly poor compared with the nonpoor, and for the insured compared with the uninsured.

Our findings do not support the notion that health beliefs in the traditional Mexican culture strongly influence the behavior of Latinos seeking medical care. After controlling for age, sex, employment status, insurance status, income, and health status, ethnicity was not a strong predictor of access. The findings do support results of recent studies that have stressed the importance of socioeconomic factors as the causes of underusing health services.[5-8] For example, Chavez found that a belief in folk illnesses and folk practitioners did not significantly deter Mexican immigrants from seeking conventional medical care in San Diego, California.[8] He concluded that the primary reasons for underusing health services were economic and, for the undocumented, the fear of being deported.

Limitations of the study are inherent in surveys of this type. The data are self-reported and therefore based on respondents' memories. The sample excluded households without telephones, but in similar surveys, the omission of such households has not significantly altered the findings.[9] Finally, undocumented persons may have been reluctant to reveal their immigration status to the interviewers. If so, we may have included some undocumented Latinos in the Latino citizen group.

Our results have important health policy implications for improving access to medical care among Latinos. Most important, they suggest that providing health insurance for Latinos would improve their access to care. National polls indicate widespread public support for health care reform in this country ("The Times Poll—Majority Favors Reform of US Health Care System," *Los Angeles Times*, February 4, 1990, p A-1), and many proposals for universal health insurance are being discussed (J. Kosterlitz, "Kennedy's New Tack," *National Journal* 1987; 19:608-611).[10,11] If health insurance were made available to all Americans through a national health program, access for Latino citizens would likely improve. Such a program, however, must also address other barriers faced by poor Latinos because the insured poor tend to report less access than the insured nonpoor.

Providing health insurance for US citizens will not address the problem of limited access for undocumented Lati-

nos who live and work in the United States. Despite recent changes in immigration laws, undocumented immigration is likely to continue as long as economic underdevelopment continues in Mexico and Central America and as long as jobs are available in the United States. Therefore, plans for providing health insurance to the undocumented population should be considered. Rumbaut and co-workers found that long-term undocumented immigrants would participate in a health insurance plan if the costs were manageable within their family incomes and if they could participate without being asked about immigration status.[12] These investigators suggested that partial funding for such a program should come from federal sources because the federal treasury receives most of the undocumented immigrants' taxes.

Finally, our results point out the importance of studying local conditions when planning health policies. For example, by some measures Latinos in Orange County experience less access to medical care than a national sample. Moreover, Latino citizens and undocumented Latinos face similar barriers to access. Such local findings are not evident in national investigations. The results of community-oriented research may be used to guide the development of new health care programs and to influence public funding for indigent health care services.[13]

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