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POLICY brief

County Residency and Access to Care for Low- and Moderate-Income Californians

E. Richard Brown, Shana Alex Lavarreda, Ying-Ying Meng, Ronald M. Andersen, Andrew B. Bindman, Lillian Gelberg, Lida Becerra, Melissa Gatchell, Jean Yoon

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Californians at all income levels experience differences in health care access, due in part to the community in which they reside. Community characteristics, such as the number of primary care physicians and specialists in the area, ultimately affect individuals' access to health care services. In addition, for low-and moderate-income Californians, access also depends on the accessibility of social services, the number and proximity of government and community clinics, and the presence or absence of a nearby public hospital.

Health insurance also plays a major role in determining access to care. Not only does the type of health insurance coverage influence the ability of individuals to seek out and obtain health care services, but also the consistency and continuity of such coverage play a critical role. In fact, nonelderly adults and children at all income levels who experience even some period of uninsurance during the year have much lower levels of access to care than similar populations with continuous insurance coverage.[1]

This policy brief uses data from the 2001 California Health Interview Survey (CHIS 2001) to examine differences in four key measures of access to care related to the county in which a person resides. Specifically, we looked at whether or not a person has a regular place to go for care and whether or not that source of care is a part of the safety net. We also considered the overall rate of uninsurance in each county as well as whether county residents delayed or did not seek care in the past year because of issues related to cost or insurance status.

Why Counties are an Important Focus

Counties bear the responsibility for all aspects of their residents' health – from personal medical care to community and population health. Under the state's Welfare and Institutions Code Section 17000, counties must either be the "provider of last resort" or assure that residents who cannot get care elsewhere have at least their basic health care needs met.

As part of this obligation to residents, counties have the option of operating a public hospital and health clinics and/or contracting with private hospitals and community clinics to serve low- and moderate-income residents. Access to these county hospitals and clinics, as well as access to community clinics, varies widely across the state.

Counties are also responsible for public health at the local level. Local public health agencies monitor and assure the health of residents at all income levels. Three cities – Long Beach, Pasadena, and Berkeley – have formed their own public health departments and share public health responsibility with their counties, though responsibility for "indigent medical care" in these cities continues to remain primarily a county function. These broad domains of responsibility underscore the relevance of examining access at the county level.

This Study

In order to focus on the population most likely to be affected by any policy changes, affecting either public coverage or clinic availability, we restricted our analysis to low- and moderate-income persons in California. Specifically, we analyzed data for children (ages 0-18) and nonelderly adults (ages 19-64) who live in households with total household income below 300% of the Federal Poverty Level (FPL) – that is, less than about $46,000 a year for a family of three in 2001.

Nonelderly persons below 300% of the poverty level represent half of the population under the age of 65, including six in 10 children in California and nearly five in 10 nonelderly adults. This income restriction includes one-third of the population of persons with employment-based insurance – the income group most likely to lose their coverage and become either uninsured or to

1 Brown ER, Ponce N, Rice T, and Lavarreda SA. *The State of Health Insurance in California: Long-term and Intermittent Lack of Health Insurance Coverage.* Los Angeles, CA: UCLA Center for Health Policy Research, November 2003.

Exhibit 1: Percent Reporting Selected Access Measures by Past 12-Month Insurance Status, Ages 0-64 with Family Income Below 300% FPL, California, 2001

Source: 2001 California Health Interview Survey

	UNINSURED ALL YEAR		UNINSURED PART YEAR		INSURED ALL YEAR	
	%	(95% RANGE)*	%	(95% RANGE)*	%	(95% RANGE)*
HAVE A USUAL SOURCE OF CARE	57.1	(55.2-59.0)	73.3	(71.2-75.4)	92.0	(91.5-92.6)
USE CLINICS AS THEIR USUAL SOURCE OF CARE**	58.7	(56.2-61.1)	37.9	(35.2-40.6)	24.0	(23.1-24.9)
HAVE DELAYED CARE BECAUSE OF COST AND/OR INSURANCE	72.0	(68.0-75.9)	59.8	(55.3-64.3)	29.7	(27.7-31.7)

* The "95% range" (also called a "confidence interval") provides a more reliable estimate of the uninsured rate for persons in the population group than does the "point estimate." Point estimates with narrower 95% ranges are more precise or reliable than those with wider ranges.

** Includes only those who reported having a usual source of care.

qualify for Medi-Cal or Healthy Families (the requirements for which depend on age and other factors, but for which the income limits are below 300% FPL).

The CHIS 2001 sample draws from 41 geographically defined "sampling strata," which includes 33 individual-county strata and eight grouped-county strata. Data provided in this policy brief include these 41 strata.

Continuity of Health Insurance and Access to Care Statewide

California residents experience varying levels of access to care depending on the continuity of their health insurance coverage. For those who are uninsured for the entire year, even having a usual source of care – an important indicator of whether people have a connection to the health care system – poses a considerable challenge. Among low- and moderate-income nonelderly adults and children who lack insurance for the entire year, only 57.1% have a usual source of care (Exhibit 1). Those with insurance for part of the year fare better, with 73.3% having a medical home. By far, though, having any type of insurance for the entire year provides the best assurance that a person would know where to go for care, with 92% reporting access to a source of care (Exhibit 1).

The safety net is intended to help low- and moderate-income individuals to get care. Many of those who are uninsured all, or even part of the year, rely on safety-net clinics as their usual source of care. Those with continuous coverage all year rely on clinics as their usual source of care much less than those who experience uninsurance part of the year (24% as compared to 37.9%, respectively; Exhibit 1). People who are uninsured all year depend on clinics as their usual source of care (when they have one) at an even higher rate of 58.7%.

Many people delay or forgo seeking care because of reasons related to cost or health insurance. These delays in care follow the same pattern as the use of safety-net providers, with 72% of the uninsured all year delaying or not getting care due to cost or insurance barriers (Exhibit 1). This is compared to 59.8% of those uninsured part year and 29.7% of those who had continuous coverage for the past year. Thus, consistent and continuous insurance coverage is essential to assure access to timely medical care.

County Differences in Access to Care

We examined four key indicators of access at the county level – the percent of low- and moderate-income nonelderly residents with a usual source of care, the percent who used community or hospital clinics as their usual source of care, the percent who were uninsured at any time during the year, and the percent who delayed or did not get care due to cost or insurance problems.

The percent reporting a usual source of care ranges from slightly below 80% in Napa and Imperial Counties to nearly 90% in Placer County (Exhibit 2). A high proportion of even less-affluent residents in all counties report a connection to health care services, a place they can turn when they need medical care or advice about their health. However, this basic connection to health care services should be virtually universal.

Among low- and moderate-income residents who report having a usual source of care, the proportion that rely on clinics varies much more widely, ranging from about one in 10 in Placer County to nearly half in Monterey and San Benito Counties (Exhibit 2). This measure suggests the important role played by these clinics in meeting the health care needs of less affluent residents — and thus the relative burden borne by the health care safety net.

The percent of these nonelderly residents who are uninsured at some time during the year indicates the likely need for subsidized health care services and the resulting demand on safety net providers. This measure of uninsurance among low- and moderate-income residents ranges from one in four in several counties in Southern

California (Los Angeles, Riverside, and Imperial Counties), the Central Coast (Santa Barbara and Monterey/San Benito Counties), and the San Joaquin Valley (Tulare, Kern, and Madera Counties) to about one in nine or 10 in Contra Costa, Solano, Marin, San Mateo, and Placer Counties (Exhibit 3).

Counties varied considerably more in the percent of their residents who delayed or did not obtain care they needed in the past year due to either cost or insurance problems. This ranges from about two in 10 in Solano County to nearly six in 10 in Shasta, Kings, Madera and San Luis Obispo Counties (Exhibit 3).

The four access measures in Exhibits 2 and 3 are interrelated, giving a broad picture of the challenges counties and communities face in providing adequate access to care for their residents. As shown in Exhibit 1, being uninsured reduces a person's access to care. County uninsurance rates, therefore, affect the percentage of the population reporting that they have a medical home, that use clinics as their source for care, and that have higher rates of delays because of cost or insurance issues. For example, rural Imperial County has one of the highest rates of uninsurance (24.6%) and also one of the lowest levels of residents having a usual source of care (79.5%) combined with high rates of clinic use (37.1%) and delays of care (50.7%).

However, other factors certainly influence access to care as demonstrated, for example, in Madera County. The uninsured rate for the county is relatively high (25.9%) as is the percent of individuals delaying care (56.7%) and using clinics (33.1%). However, the proportion of the population reporting a usual source of care is also high (86.2%), which may not be expected based on these other measures. Thus, although these measures of access certainly show a correlation in many counties, the relationship is affected by other factors that must also be considered when examining access to care.

Policy Implications

The results presented in this policy brief demonstrate that low- and moderate-income children and nonelderly adults in California with continuous coverage experience better access to needed health care than those with intermittent coverage and dramatically better access than those who were uninsured all year. Coverage affects whether or not a person has a usual source of care — an important indicator of whether people have a connection to the health care system that facilitates their use of health services.

Among children and adults with a usual source of care, we found clear evidence that clinics serve those with the greatest health needs who also bring the least favorable reimbursement. Children and adults who are uninsured part of the year and those uninsured all year are far more likely to turn to community, public and hospital-based clinics for care than those with continuous coverage.

These findings demonstrate that, for moderate-to-low income children and adults, both persistent uninsurance and intermittent coverage reduce access to care and place a larger burden on community and public clinics and hospital-based clinics. The demands on this already-stretched safety net will likely rise with any increase in the number of uninsured people, whether that lack of coverage is short-term or long-term.

Counties differ, however, in the levels of access experienced by their low- and moderate-income populations. While nearly 90% of residents in counties at the upper end of the range report a usual source of care, there is room for improvement within the lower end of this range. Similar patterns can also be seen for the other three access measures studied. Combined, the four measures paint a picture of the challenges faced by each county in providing an adequate level of access to care for their residents.

The results of this study point to two broad policy implications. First, continuous coverage is critically important to enable low- and moderate-income children and adults to obtain access to important health services. Lack of coverage for even part of the year results in significantly poorer access, especially for preventive care, putting children's and adults' health at risk. Potential cutbacks in the Medi-Cal or Healthy Families programs, therefore, will predictably have serious adverse effects on the access to care of moderate- and low-income adults and children.

Second, because those who lack continuous coverage rely more heavily on community, public, and hospital-based clinics, these health care providers will bear the burden of any reductions in coverage. These safety-net and related clinics already serve a disproportionate share of children and adults with intermittent coverage. And the safety net serves an even larger share of those who are uninsured all year. Cutbacks in Medi-Cal or Healthy Families coverage, benefits, or provider payments will both increase the demand for care on these clinics and decrease the available resources necessary to meet these demands.

Exhibit 2:
Usual Source of Care by Counties and Regions, Ages 0-64 with Family Income Below 300% FPL, California, 2001

Source: 2001 California Health Interview Survey

	% WITH A USUAL SOURCE OF CARE		% WHO USE CLINICS AS THEIR USUAL SOURCE OF CARE	
	%	(95% RANGE)*	%	(95% RANGE)*
NORTHERN AND SIERRA COUNTIES	**85.6**	**(83.1-88.1)**	**36.1**	**(32.9-39.3)**
BUTTE	**85.4**	(81.1-89.7)	**36.7**	(31.4-42.0)
SHASTA	**84.2**	(79.9-88.5)	**35.4**	(29.8-41.0)
HUMBOLDT, DEL NORTE	**87.7**	(83.6-91.8)	**35.8**	(30.3-41.4)
SISKIYOU, TRINITY, LASSEN, MODOC	**91.9**	(89.3-94.6)	**40.8**	(35.3-46.3)
MENDOCINO, LAKE	**82.3**	(77.5-87.1)	**37.2**	(31.7-42.8)
TEHAMA, COLUSA, GLENN	**82.0**	(78.0-86.1)	**48.2**	(43.0-53.4)
SUTTER, YUBA	**90.2**	(87.0-93.4)	**44.5**	(38.9-50.1)
NEVADA, SIERRA, PLUMAS	**85.7**	(81.1-90.4)	**26.6**	(20.8-32.5)
TUOLOMNE, CALAVERAS, AMADOR, INYO, MARIPOSA, MONO, ALPINE	**84.5**	(79.8-89.2)	**34.6**	(28.8-40.4)
GREATER BAY AREA	**85.1**	**(83.4-86.9)**	**26.9**	**(24.5-29.3)**
SANTA CLARA	**82.4**	(77.5-87.2)	**29.4**	(23.1-35.8)
ALAMEDA	**84.9**	(80.9-88.9)	**24.3**	(19.3-29.3)
CONTRA COSTA	**86.9**	(82.2-91.6)	**20.9**	(15.1-26.6)
SAN FRANCISCO	**85.5**	(82.0-89.0)	**33.8**	(28.5-39.0)
SAN MATEO	**88.5**	(83.9-93.0)	**31.0**	(22.8-39.3)
SONOMA	**87.9**	(83.4-92.3)	**28.2**	(20.7-35.6)
SOLANO	**86.6**	(83.0-90.1)	**23.2**	(19.0-27.4)
MARIN	**83.9**	(77.2-90.6)	**19.8**	(11.7-27.9)
NAPA	**76.5**	(69.8-83.1)	**24.2**	(17.3-31.1)
SACRAMENTO AREA	**87.5**	**(85.2-89.8)**	**17.8**	**(14.9-20.6)**
SACRAMENTO	**87.6**	(84.6-90.6)	**15.2**	(11.4-19.0)
PLACER	**89.7**	(85.1-94.3)	**9.9**	(5.28-14.6)
YOLO	**88.3**	(84.3-92.2)	**39.1**	(33.1-45.1)
EL DORADO	**83.0**	(77.7-88.2)	**20.0**	(14.0-26.0)
SAN JOAQUIN VALLEY	**84.0**	**(82.5-85.4)**	**32.4**	**(30.5-34.3)**
FRESNO	**84.9**	(81.4-88.4)	**29.0**	(24.4-33.6)
KERN	**81.8**	(78.5-85.1)	**38.0**	(33.7-42.3)
SAN JOAQUIN	**83.6**	(79.7-87.5)	**25.6**	(21.1-30.1)
STANISLAUS	**83.9**	(79.7-88.1)	**22.2**	(17.0-27.5)
TULARE	**83.9**	(79.8-87.9)	**42.5**	(37.3-47.7)
MERCED	**86.3**	(82.7-89.9)	**37.1**	(31.8-42.4)
KINGS	**85.2**	(81.7-88.7)	**41.9**	(36.9-46.9)
MADERA	**86.2**	(82.3-90.2)	**33.1**	(27.9-38.3)
CENTRAL COAST	**81.7**	**(79.4-84.1)**	**35.1**	**(32.2-38.1)**
VENTURA	**80.7**	(75.4-86.0)	**25.6**	(19.8-31.4)
SANTA BARBARA	**82.6**	(78.5-86.6)	**40.4**	(34.3-46.5)
SANTA CRUZ	**86.1**	(81.9-90.3)	**38.8**	(31.9-45.7)
SAN LUIS OBISPO	**81.4**	(76.7-86.1)	**27.5**	(21.3-33.7)
MONTEREY, SAN BENITO	**80.7**	(76.1-85.3)	**46.1**	(39.7-52.4)
LOS ANGELES	**80.4**	**(79.2-81.6)**	**32.6**	**(31.1-34.2)**
LOS ANGELES	**80.4**	(79.2-81.6)	**32.6**	(31.1-34.2)
OTHER SOUTHERN CALIFORNIA	**83.1**	**(81.7-84.5)**	**27.9**	**(26.0-29.7)**
ORANGE	**80.1**	(77.1-83.1)	**23.5**	(19.8-27.2)
SAN DIEGO	**86.6**	(84.2-89.0)	**35.9**	(32.5-39.4)
SAN BERNARDINO	**82.2**	(79.0-85.3)	**26.2**	(22.2-30.1)
RIVERSIDE	**83.6**	(80.5-86.6)	**22.3**	(18.5-26.1)
IMPERIAL	**79.4**	(75.7-83.2)	**37.1**	(32.2-42.0)

* The "95% range" (also called a "confidence interval") provides a more reliable estimate of the uninsured rate for persons in the population group than does the "point estimate." Point estimates with narrower 95% ranges are more precise or reliable than those with wider ranges. Readers should note the lack of statistical precision in the estimates for smaller counties and consider the range as well as the "point estimate."

Exhibit 3: Uninsurance and Delays in Care by Counties and Regions, Ages 0-64 with Family Income Below 300% FPL, California, 2001
Source: 2001 California Health Interview Survey

	% UNINSURED AT ANY TIME		% DELAYING CARE BECAUSE OF COST/INSURANCE	
	%	(95% RANGE)*	%	(95% RANGE)*
NORTHERN AND SIERRA COUNTIES	**20.6**	**(19.5-21.8)**	**51.4**	**(45.6-57.2)**
BUTTE	**20.8**	(17.4-24.2)	**48.7**	(38.9-58.5)
SHASTA	**20.2**	(16.8-23.6)	**57.3**	(47.3-67.4)
HUMBOLDT, DEL NORTE	**19.3**	(16.2-22.5)	**48.1**	(37.9-58.3)
SISKIYOU, TRINITY, LASSEN, MODOC	**21.5**	(18.1-24.9)	**54.3**	(44.0-64.7)
MENDECINO, LAKE	**24.5**	(20.9-28.0)	**55.1**	(45.6-64.7)
TEHAMA, COLUSA, GLENN	**23.5**	(20.1-26.8)	**54.9**	(44.8-65.0)
SUTTER, YUBA	**18.5**	(15.3-21.8)	**52.5**	(41.7-63.4)
NEVADA, SIERRA, PLUMAS	**18.0**	(14.7-21.4)	**49.9**	(37.8-62.0)
TUOLOMNE, CALAVERAS, AMADOR, INYO, MARIPOSA, MONO, ALPINE	**20.2**	(16.7-23.7)	**54.7**	(44.4-65.0)
GREATER BAY AREA	**14.1**	**(13.2-15.1)**	**34.6**	**(29.7-39.4)**
SANTA CLARA	**14.0**	(11.7-16.3)	**35.9**	(21.7-50.0)
ALAMEDA	**13.8**	(11.5-16.1)	**36.4**	(26.1-46.6)
CONTRA COSTA	**11.0**	(8.8-13.1)	**33.0**	(19.4-46.6)
SAN FRANCISCO	**20.9**	(18.5-23.3)	**36.2**	(26.6-45.8)
SAN MATEO	**12.0**	(9.2-14.7)	**	**
SONOMA	**17.4**	(14.0-20.8)	**40.2**	(27.0-53.4)
SOLANO	**10.7**	(8.9-12.4)	**21.6**	(14.4-28.8)
MARIN	**11.9**	(8.9-14.9)	**46.6**	(29.1-64.1)
NAPA	**18.3**	(14.2-22.3)	**50.5**	(36.6-64.3)
SACRAMENTO AREA	**15.6**	**(13.8-17.3)**	**42.5**	**(35.6-49.4)**
SACRAMENTO	**16.0**	(13.6-18.3)	**42.4**	(32.7-52.1)
PLACER	**9.9**	(7.5-12.2)	**33.6**	(21.0-46.2)
YOLO	**16.3**	(13.0-19.5)	**44.8**	(32.8-56.7)
EL DORADO	**20.6**	(16.9-24.3)	**51.2**	(39.7-62.7)
SAN JOAQUIN VALLEY	**22.7**	**(21.5-24.0)**	**49.3**	**(45.0-53.5)**
FRESNO	**22.5**	(19.2-25.8)	**54.3**	(43.9-64.8)
KERN	**24.7**	(21.9-27.5)	**44.9**	(36.5-53.3)
SAN JOAQUIN	**19.8**	(16.9-22.7)	**44.1**	(33.0-55.2)
STANISLAUS	**18.3**	(15.0-21.6)	**52.0**	(40.5-63.6)
TULARE	**28.7**	(24.9-32.4)	**41.9**	(30.7-53.1)
MERCED	**23.1**	(19.8-26.4)	**52.4**	(42.1-62.6)
KINGS	**21.4**	(18.2-24.5)	**57.1**	(46.6-67.6)
MADERA	**25.9**	(22.0-29.7)	**56.7**	(44.0-69.4)
CENTRAL COAST	**22.5**	**(20.9-24.2)**	**38.2**	**(32.8-43.6)**
VENTURA	**21.0**	(17.8-24.1)	**32.2**	(20.5-43.9)
SANTA BARBARA	**25.6**	(22.1-29.1)	**36.0**	(25.9-46.1)
SANTA CRUZ	**20.7**	(17.3-24.2)	**35.7**	(24.6-46.8)
SAN LUIS OBISPO	**19.9**	(16.5-23.2)	**56.3**	(45.1-67.4)
MONTEREY, SAN BENITO	**24.9**	(21.2-28.6)	**38.1**	(25.7-50.4)
LOS ANGELES	**25.7**	**(24.8-26.6)**	**42.7**	**(39.3-46.0)**
LOS ANGELES	**25.7**	(24.8-26.6)	**42.7**	(39.3-46.0)
OTHER SOUTHERN CALIFORNIA	**22.1**	**(21.1-23.2)**	**47.1**	**(43.0-51.1)**
ORANGE	**22.0**	(20.0-24.1)	**51.2**	(42.7-59.6)
SAN DIEGO	**21.1**	(19.2-23.0)	**42.4**	(35.2-49.5)
SAN BERNARDINO	**22.0**	(19.6-24.4)	**46.7**	(37.8-55.6)
RIVERSIDE	**24.1**	(21.5-26.8)	**49.2**	(40.1-58.2)
IMPERIAL	**24.6**	(21.1-28.0)	**50.7**	(40.7-60.7)

* The "95% range" (also called a "confidence interval") provides a more reliable estimate of the uninsured rate for persons in the population group than does the "point estimate." Point estimates with narrower 95% ranges are more precise or reliable than those with wider ranges. Readers should note the lack of statistical precision in the estimates for smaller counties and consider the range as well as the "point estimate."

** The estimate is not statistically stable because the coefficient of variation is over 30%.

Data Source

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