Title

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POLICY brief

Differences in Access to Health Care Among The Moderate- and Low-Income Population Across Urban Areas

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Urban areas in the United States vary widely in the proportions of their populations that lack health insurance coverage. Because health care coverage is critical to providing access to important health services, the uninsured, and particularly those with moderate and low incomes, experience problems with obtaining medical care.

This policy brief explores differences in access to health care services for the moderate- and low-income, nonelderly population residing in 29 metropolitan statistical areas (MSAs), focusing on the effects of insurance status on access to services. The moderate- and low-income population is defined here as those with family incomes below 250% of the federal poverty level, that is, below approximately $31,500 for a family of three in 1996. The data used in this study are from the 1995 and 1996 National Health Interview Surveys, the most recent years for which data are available for urban areas.

Variation Across Urban Areas in Access to Care

Across the 29 urban areas examined, 19% of the moderate- and low-income population lacks a usual source of care. Having an identifiable medical provider or place where care is received promotes access to care for both preventive and acute care needs. The proportion of the population without a usual source of care varies across MSAs, ranging from a low of 10% in both Nassau-Suffolk, NY and Baltimore, MD to a high of 39% in Fort Worth, TX (see Exhibit 1 for a complete list of MSAs). In seven MSAs, over one-quarter of the moderate- and low-income population is without a usual source of care.

Having at least one physician visit in the past year is a broad measure of access to the health care system for both acute and chronic conditions as well as preventive checkups. The percent of the moderate- and low-income population that has not had a physician visit in the past year varies across these urban areas, with nearly a three-fold difference between the lowest and highest MSAs. In Philadelphia, PA, 14% of the nonelderly population did not have a physician visit in the previous year, compared to 39% in both Fort Worth, TX and San Francisco, CA (Exhibit 1).

Differences within an MSA in Moderate- and Low-Income Uninsured and Insured Residents' Access to Care

Insurance coverage makes a difference in access to care within each MSA: the moderate- and low-income population that is uninsured is less likely to have a usual source of care and usually less likely to have seen a physician within the past year than the moderate- and low-income population with coverage (Exhibit 2).

In each of the MSAs examined that had sufficient sample size, the moderate- and low-income *uninsured* population is less likely to have a regular connection to the health care system than is the moderate- and low-income *insured* population (Exhibit 2). For example, of the moderate- and low-income

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Moderate- and low-income uninsured residents of these urban areas are two to eight times as likely as their insured counterparts not to have an identifiable medical provider or place to seek care.

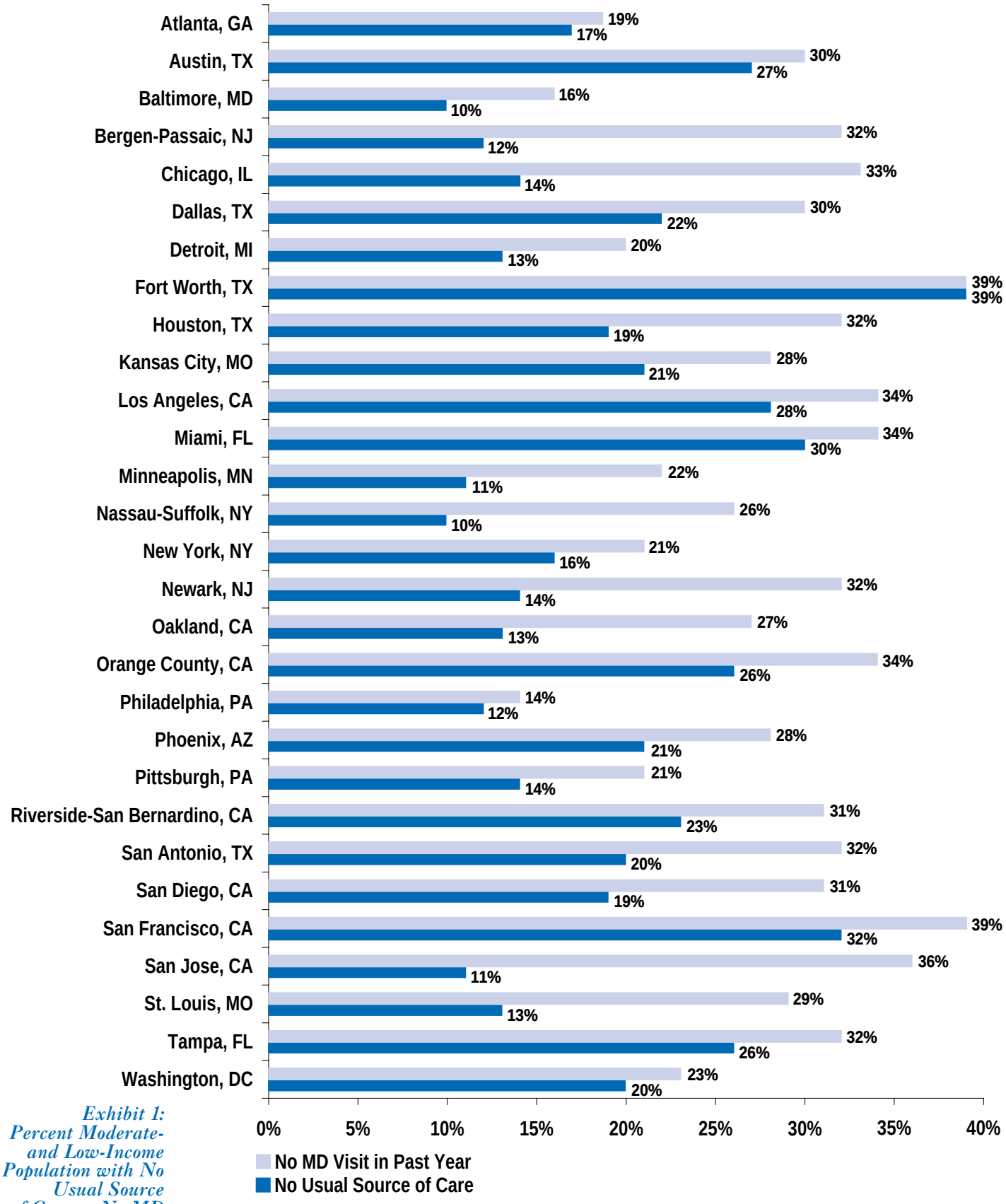

Exhibit 1: Percent Moderate- and Low-Income Population with No Usual Source of Care or No MD Visit by MSA, Ages 0-64, 1995-1996

Source: 1995-96, National Health Interview Survey

MSA	No Usual Source of Care		No Physician Visit in Past Year	
	Insured	Uninsured	Insured	Uninsured
Atlanta, GA	12%	30%	11%	39%
Austin-San Marcos, TX	17%	44%	22%	43%
Baltimore, MD	NR	30%	10%	32%
Bergen-Passaic, NJ	NR	NR	28%	37%*
Chicago, IL	6%	33%	26%	50%
Dallas, TX	12%	46%	26%	40%
Detroit, MI	6%	40%	16%	35%
Fort Worth, TX	27%	49%	33%	43%*
Houston, TX	10%	33%	21%	49%
Kansas City, MO-KS	14%	46%	21%	50%
Los Angeles, CA	8%	61%	23%	53%
Miami, FL	NR	67%	21%	53%
Minneapolis, MN-WI	6%	37%	17%	46%
Nassau-Suffolk, NY	NR	NR	18%	44%
New York, NY	5%	43%	14%	39%
Newark, NJ	NR	31%	27%	43%
Oakland, CA	8%	34%	23%	44%
Orange County, CA	NR	63%	23%	55%
Philadelphia, PA-NJ	5%	39%	8%	37%
Phoenix-Mesa, AZ	11%	45%	21%	47%
Pittsburgh, PA	10%	33%	20%	NR
Riverside- San Bernardino, CA	7%	54%	20%	53%
San Antonio, TX	10%	35%	22%	47%
San Diego, CA	12%	35%	22%	50%
San Francisco, CA	NR	71%	31%	52%
San Jose, CA	NR	28%	30%	59%
St. Louis, MO-IL	9%	27%	24%	47%
Tampa, FL	15%	48%	24%	47%
Washington, DC-MD-VA-WV	12%	40%	16%	43%

Exhibit 2: Uninsured and Insured Differences in Access Within an MSA, Residents with Moderate- and Low-Income, Ages 0-64, 1995-1996.

Source: 1995-96, National Health Interview Survey

Note: NR = Estimate not reported because too unstable.
**** The insured and uninsured are not statistically different.***

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uninsured population in Detroit, MI and Riverside-San Bernardino, CA, 40% and 54% (respectively) report having no usual source of care, compared with only 6% and 7% (respectively) of their insured counterparts in each MSA.

In nearly all of the MSAs that had adequate sample size, the moderate- and low-income uninsured population is often twice as likely as their insured counterparts not to have had a physician visit in the past 12-month period (Exhibit 2). In Tampa, FL, 47% of the uninsured moderate- and low-income population had no physician visits, compared to 24% of those with insurance. In

Chicago, IL, the proportions were 50% of the uninsured vs. 26% of the insured, and in Oakland, CA, 44% vs. 23%.

Variation in Access to Care Based Upon Urban Area's Uninsured Rate

Uninsured residents living in MSAs with higher-than-average uninsured rates have poorer access to health care than do residents in MSAs with lower-than-average uninsured rates. An MSA is classified as "high uninsured" or "low uninsured" if its uninsured rate is statistically different from the average for the population of the nation's 85 largest MSAs. Among the 85 largest MSAs in the nation, seven have uninsured rates that are significantly higher than the average (Dallas, TX; Houston, TX; Los Angeles, CA; Miami, FL; New York, NY; Phoenix, AZ; Tampa, FL.). Six MSAs have lower-than-average uninsured rates (Detroit, MI; Kansas City, MO; Minneapolis, MN-WI; Nassau-Suffolk, NJ; Oakland, CA; Pittsburgh, PA.). In Exhibit 3, the uninsured rates for 29 MSAs are shown. These 29 MSAs, a subset of the nation's 85 largest MSAs, are those for which *both* access and insurance data are available. These uninsured rates are based on residents of all income levels.

Slightly over one-half (52%) of the moderate- and low-income uninsured in high-uninsured MSAs have no usual source of care, compared to 36% of those in low-uninsured areas (Exhibit 4). In contrast, for those with coverage, the insurance status of the MSA had no effect: 8% of those in both high- and low-uninsured MSAs had no usual source of care.

The receipt of a physician visit also differed for the moderate- and low-income uninsured: 48% of those in urban areas with high uninsured rates had no physician visit in the past year, compared to 41% of those in areas with low uninsured rates (Exhibit 4). In contrast, the insured did not differ in the receipt of a physician visit: 20% of those in high-unisured MSAs and 19% of those in low-uninsured areas did not have a recent physician visit.

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Exhibit 3: Uninsured Rates by MSA, Residents of All Income Levels, Ages, 0-64, 1997.

MSA	% Uninsured
Los Angeles, CA	**31%**
Houston, TX	**30%**
Miami, FL	**27%**
New York, NY	**27%**
Phoenix-Mesa, AZ	**26%**
Dallas, TX	**25%**
Tampa, FL	**25%**
Fort Worth, TX	24%
San Antonio, TX	24%
Austin-San Marcos, TX	23%
San Francisco, CA	23%
Riverside-San Bernardino, CA	22%
San Diego, CA	22%
Orange County, CA	20%
Atlanta, GA	19%
Newark, NJ	19%
Bergen-Passaic, NJ	17%
San Jose, CA	16%
Baltimore, MD	15%
Chicago, IL	15%
Philadelphia, PA-NJ	15%
Washington, DC-MD-VA-WV	15%
St. Louis, MO-IL	14%
Kansas City, MO-KS	**14%**
Nassau-Suffolk, NY	**14%**
Detroit, MI	**13%**
Oakland, CA	**13%**
Pittsburgh, PA	**11%**
Minneapolis, MN-WI	**10%**

Source: March 1998 Current Population Survey

Note: Dark blue are "high uninsured MSAs" and light blue are "low uninsured MSAs."

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Policy Implications

Moderate- and low-income uninsured residents of these urban areas are two to eight times as likely as their insured counterparts not to have an identifiable medical provider or place to seek care. And they are about two or more times as likely not to have had even one physician visit in a year. Moderate- and low-income uninsured residents are less likely to have a usual place of care or a recent physician visit in urban areas that have especially high uninsured rates.

	No Usual Source of Care	No Physician Visit in Last Year
Uninsured		
High-uninsured MSAs	52%	48%
Low-uninsured MSAs	36%	41%
Insured		
High-uninsured MSAs	8%	20%
Low-uninsured MSAs	8%	19%

Source: 1995-1996, National Health Interview Survey and March 1998 Current Population Survey

Exhibit 4: Access to Care for Moderate- and Low-Income Residents in High-Uninsured and Low-Uninsured MSAs. Ages 0-64, 1995-1996.

Cities and counties have limited ability to provide health insurance coverage to uninsured residents. But states have been given expanded support to cover uninsured children and their families. The federal Children's Health Insurance Program (CHIP) gives states additional opportunities and funding to extend coverage to children in moderate- and low-income working families. Recent policy changes in Medicaid also give states considerable flexibility in setting income eligibility for Medicaid coverage for moderate- and low-income working families, an option that only 11 states are using to any extent.

While the states and federal government have the ability to extend health insurance coverage, cities and counties are in a position to provide direct support to safety net health care services. Public and community-sponsored clinics are important providers of care to the uninsured, as well as to moderate- and low-income community residents in general. Although many community-based clinics meet some of their expenses through charitable contributions, local governments and community foundations can—and in many cities and counties do—provide substantial support to their local safety net systems.

Thus, states can help these urban centers by expanding coverage to more of their uninsured populations. In the absence of universal coverage, however, cities and counties will bear responsibility for reducing their moderate- and low-income residents' barriers to needed care.

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This Policy Brief presents results that are drawn from a larger report published by The Commonwealth Fund and the UCLA Center for Health Policy Research.

Data Source

The findings in this Policy Brief are based on two data sources. The 1995 and 1996 National Health Interview Surveys (NHIS) were used to obtain information about access to health care and the insurance status of the population within 29 urban areas for which both access and health insurance information were available. The March 1998 Current Population Survey was used to characterize 85 urban areas (of which the 29 are a subset) as having high or low uninsured rates. Each MSA was classified according to whether it was significantly above or below the mean ($p<.05$) of the population of the 85 largest MSAs. Unless otherwise indicated, all differences between groups reported in this Policy Brief are statistically different at $p<.05$.

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