

The Problem of Accessing Health Care

By Michelle Meadows

Closing the Gap, The Problem of Accessing Health Care • August/September 1999

Paying for family health insurance would have lopped off \$200 from each paycheck, said Glynis, a 35-year-old African American beautician in Maryland. “The options through my company were outrageous,” she said. “That’s about \$400 a month that we really needed.” So she and her three children lived without coverage for seven years.

“When my kids needed shots, I took them to free clinics,” she said. “If they had to go to the emergency room, then I’d just end up with a big bill.” Fortunately, one of her customers recently told her about the new Maryland Children’s Health Insurance Program (see CHIP article on page 3 of issue).

Now, Glynis buys her individual health insurance through the hair salon at a price of \$54 every two weeks. And her kids are covered through the Maryland program, which provides comprehensive services for eligible children and pregnant women in families with an income at or below 200 percent of the federal poverty level.

Experts say such insurance programs are critical because even though our economy is booming, lack of health insurance remains a significant problem. Americans at the bottom half of the income distribution feel the hardest hits.

Many under the median income of \$35,000 are uninsured, go without the care they need, have trouble paying medical bills, and report poor health, according to a new study called, *Can’t Afford to Get Sick: A Reality for Millions of Working Americans*. The report is based on The Commonwealth Fund 1999 National Survey of Workers’ Health Insurance (<http://www.cmf.org>).

For many, the problem involves not having the option of obtaining health insurance from their jobs. According to the Commonwealth Fund study, two of five workers with incomes less than \$20,000 either weren’t offered a plan through their employers or weren’t eligible to participate. For others like Glynis, the only options are too expensive.

Hispanics are least likely to be insured

According to the Commonwealth Fund report, Hispanics were generally at high risk of being uninsured and lacking access to employer plans. That’s in sync with the Health and Human Services’ Agency for Health Care Policy and Research (AHCPR) report, *Racial and Ethnic Differences in Health 1996*. Released earlier this year, the report found that more than one-third of Hispanics had no insurance coverage. While Hispanics represent 11.6 percent of the U.S. population under age 65, they make up more than 21 percent of the uninsured.



“Though the differences in insurance rates between Hispanics and other Americans are striking, racial and ethnic minorities generally fare worse than whites—a fact that often goes unmentioned in health coverage debates.”

“A main reason is that many Hispanics work in industries that don’t offer health benefits,” said Joan Jacobs, a policy analyst in the Office of Minority Health’s Division of Policy and Data. According to the National Council of La Raza, many Hispanics are employed in manual labor and service occupations. More white men and women, however, are concentrated in managerial and professional specialty occupations.

According to E. Richard Brown, PhD, director of UCLA’s Center for Health Care Policy Research, many Latino immigrants come to this country with low levels of education. “That is often exacerbated by a non-citizen status,” he said. Many are scared to apply for health services for fear of possible penalties by the

Immigration and Naturalization Service (INS), he adds. (See INS article on p. 14 of issue).

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in health coverage debates, Dr. Brown said. His center recently released results from state studies that showed that while 76 percent of white non-elderly Californians had private health insurance in 1997, only 43 percent of Latinos, 60 percent of African Americans, and 65 percent of Asian Americans and Pacific Islanders were privately insured. As a result, minorities are at greater risk of being uninsured altogether.

“For Asians and Pacific Islanders, it’s important to understand the differences between subgroups,” Dr. Brown said. For example, those populations who are more acculturated into the American society, such as the Japanese, tend to have higher levels of education and health coverage comparable to whites. But newly arrived immigrants, such as those from Southeast Asia, have lower education levels and much higher uninsured rates than whites.” UCLA’s Center for Health Policy Research will release a national study in October. Look for it on the Web: <http://www.healthpolicy.ucla.edu>.

Insurance isn’t the only barrier

A basic issue in health care access is coverage versus no coverage, OMH’s Jacobs said. “Then we have to look at the fact that when there is coverage or when care is available, many Americans still aren’t getting it. Access to insurance doesn’t necessarily mean access to care, or even high-quality care for that matter.”

Carrie Jones, executive director of the Family Services Institute, Wichita, KS, said she finds that residents in her area face

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considerable transportation barriers. Through the Institute's Black Infant Mortality Project, case workers use community outreach to help African American women navigate the health system and get their babies off to a healthy start. "Many women don't have cars or have to deal with our limited public transportation system," Jones said. "So we go pick them up and take them to appointments because that's the only way they'll get there." Jones said one woman died in her home during labor because she couldn't get to a hospital. "She didn't even have a phone to call for help."

Other times, women don't know about available services. "The free clinics are there, but they might not know it," Jones said. "So we do a lot of connecting—connecting them to the providers and helping them with the paperwork they have to fill out to obtain services." Sometimes, women start to fill out papers and then put them aside because it's too much to deal with.

For minorities, it's important that programs are offered in a community setting that makes them comfortable, Jones said. That could involve speaking the right language, respecting a patient's cultural beliefs, or using appropriate body language. "But it has to be a culturally sensitive environment," Jones added. "And we'll get the best results, if the decision-makers find out from the community what the community needs." ♦

