ABSTRACT: The purpose of this study was to describe the health care access provided to a low-income urban population by a system of county run public clinics. We conducted a cross-sectional interview survey of a random sample of subjects applying for or renewing eligibility to use the public system. The setting was a public system consisting of inner-city community health centers and hospital-based clinics delivering primary care. We interviewed 547 adult nonpregnant subjects; mean age was 41 years; 55% were women, 54% were Hispanic and 28% were non-Hispanic Blacks; 78% had household income below $15,000 per year, and 75% had no health insurance. Access to health care was measured in three ways: physician contact during the year prior to survey; and answers to two separate questions concerning delaying needed medical care because it cost too much, and delaying care because it would take too long to be seen.

Although 80% of subjects had seen a physician at least once, 46% had stayed away sometime during the year due to financial reasons and 24% had stayed away because of waiting time. Surprisingly, 35% reported private sector use. These rates varied significantly with insurance status. Hispanics had significantly less access by all three measures, even after multivariable adjustment for potential confounders such as sex, age, chronic disease and insurance status.

We conclude that this study demonstrates financial barriers to access, while showing substantial private sector contact, even by low-income subjects already using the public sector.

INTRODUCTION

The provision of access to health care for the underinsured is the focus of intense national debate. Many urban areas have city or county public systems in place to provide care for those without insurance, but little is known about the quality and extent of access. This study was designed to describe the access provided by a system of county run public clinics to a low-income urban population.
health systems, which usually include outpatient facilities as well as public hospitals. While little has been published on the role of these systems in providing outpatient care, it is important to understand their role so that these resources can be incorporated into national health care reform.

In this study we surveyed current and newly registering users of an urban public system regarding health services utilization and access. Persons who had lost their health insurance in the last year were compared to the chronically uninsured, and to those who had some health insurance. We investigated the extent to which the public system actually provides access to people who use it by virtue of their low income.

METHODS

This cross-sectional face-to-face interview survey was conducted in the nation’s 4th largest city, where a county run system of two public hospitals with clinics, and nine community health centers delivers primary care. Every two years patients must apply for eligibility which requires income 170% or less of federal poverty levels; undocumented aliens may qualify. Eligible patients are assigned to one of the nine community centers based on zipcode of residence. Copayment requirements depend on income, and are waived at the lowest income levels.

A random sample of current users and persons establishing eligibility was obtained from master sign-in lists at eligibility centers, and inner-city community health centers. Sampling from each site was proportional to patient flow so that a representative sample of users and potential users of outpatient services was obtained. The sampling process is described in further detail elsewhere.¹

The study was restricted to nonpregnant persons over age 17 seeking health care for themselves and who spoke English or Spanish. A standardized questionnaire with English and Spanish versions was administered by trained bilingual interviewers. Patients were interviewed in either language, according to their preference. Compliance to random selection procedures and to interview protocols were monitored.

A total of 587 subjects were randomly selected to participate; 28 refused or were unable to cooperate, and 12 were called away before the interview could be completed, leaving 547 subjects for a 93% response rate.

Questions addressed demographics, socioeconomic status, preferred language, health services utilization, and health insurance. Health insurance status was categorized as: insurance now; insurance at some time