



Published in final edited form as:

J Community Health. 2000 February ; 25(1): 35–46.

UTILIZATION OF HEALTH CARE SERVICES AMONG ADULTS ATTENDING A HEALTH FAIR IN SOUTH LOS ANGELES COUNTY

Eduardo P. Macias, BS [fourth-year medical student] and Leo S. Morales, MD, MPH [Assistant Professor of Medicine]

the University of California, Los Angeles.

Abstract

A bilingual survey was developed to collect information regarding socio-demographics, access to medical and dental care, health insurance coverage, perceived health status, and use of folk medicine providers from 70 adults presenting to a health fair in South Los Angeles County. Ninety-seven percent of respondents were foreign-born. Seventy-nine percent reported having no health insurance during the year prior to survey. Of the uninsured, 61 percent lacked a doctor visit and 76 percent lacked a dental visit during the previous year. The high cost of care was the most frequently cited barrier to seeking medical (58 percent) and dental (67 percent) care even when respondents felt it was necessary. Respondents who felt they needed medical attention but did not seek it had a lower perceived health status (7.0 ± 2.2) than those who did (8.0 ± 2.0). Among respondents perceiving themselves in poor health, only 17 percent were insured. Relatively few respondents (7.2 percent) reported seeing a folk healer during the past year. Our results support the argument that the medically indigent in some localities face serious financial, as well as less salient, barriers to access. These local conditions reflect inadequate enforcement by local governments in correcting the difficult problems indigent populations face in accessing medical and dental care.

INTRODUCTION

The effect of socioeconomic status on the health and use of medical and dental services by the Latino population is receiving increasing attention.^{1–4} Nowhere else is this focus of attention needed more than in California, where the Latino population grew from 3.5 million in 1980 to 7.7 million by 1990. It is expected to reach 10 million by the year 2000. Latino's in California, which make up 34 percent of all Latinos in the United States, are largely of Mexican origin (80 percent) and are the fastest growing segment of the population.⁵

Lack of health insurance and underused health services are two important factors that affect the health status of Latinos. Nationally, Hispanic adults under age 65 are substantially more likely to be uninsured than Non-Hispanic white or black adults. In 1994–95, 34 percent of Hispanic adults 18–64 years of age lacked health care coverage, more than twice the percent of non-Hispanic white persons without coverage and about 60 percent more than the percent of blacks without coverage. Likewise, at each level of income, Hispanic men and women were more likely to be uninsured than their white or black counterparts.⁶

Californians are more likely than the average American to be uninsured. Among Latinos, 33.6 percent were completely uninsured in 1993, a rate one and one-half times as great as the rates

Requests for reprints should be addressed to: Leo S. Morales, MD, MPH, UCLA School of Medicine, 10833 Le Conte Avenue, Room B-252 Factor Building, Box 951736, Los Angeles, CA 90095-1736.

We thank Beverly Weidmer (RAND Survey Research Group) for her assistance in survey translation, the Lennox Science Education Partnership and the Chicano Latino Medical Student Association for health fair organization, and the interviewers from the UCLA School of Medicine.

for African Americans and Asians, and more than twice the rate for non-Latino whites.⁷ There is a significant correlation between health insurance coverage and access to health care rates among Latinos.⁸ Although, recent studies have shown that having insurance coverage alone does not guarantee use of medical services in a timely and appropriate manner.⁹

Among the Latino population, the most frequently cited reasons for the underuse of health care services includes lack of health insurance, communication barriers, cultural health beliefs, and immigration status. Other important causes of underuse of health care services have also been explored at the community level.^{10–11} These factors include lack of transportation, inconvenient hours of operation, and lack of childcare.

The Latino population in the U.S. has high dental treatment needs. Data from the 1985–86 National Survey of Oral Health in U.S. Adults and Seniors showed that the oral health of Hispanic adults was significantly poorer than their Non-Hispanic white counterparts.¹² Likewise, Larach-Robinson showed, with data from NHANES III, that low income and lack of dental insurance were inversely related to dental visits.¹³

This study surveyed adults presenting to a health fair in a poor, urban city in South Los Angeles County. We identify barriers to access to medical and dental care in this predominantly immigrant Latino community. In addition, we examine the effect of socio-demographic and structural barriers to access to health care, and whether or not they were significant deterrents to seeking care even when care was perceived to be necessary.

METHODS

Setting

This study was conducted in the city of Lennox, California, which had a population of 22,757 according to the 1990 Census.¹⁴ It is 1.5 square miles, making it one of the most densely populated areas in the state. Other demographic characteristics of this city are that 60.4 percent of residents are foreign-born and 85 percent of residents are of Hispanic origin. Among communities in the South Bay area of Los Angeles County, Lennox has the highest number of people living in poverty.¹⁴

The Lennox health fairs are an extension of the Lennox School District, Hughes Space and Communications Company, and the UCLA School of Medicine Science Education Partnership. The health fairs are organized and run by the Chicano/Latino Medical Student Association (CMSA) of the UCLA and Charles R. Drew University medical schools, in concert with volunteers from the Lennox School District. Each year, two health fairs are held on Saturdays at one of six elementary schools in the city of Lennox. Children attending the school hosting the health fair are sent home with flyers announcing the event. Adults in the community whose children do not attend the school hosting the event, but identified by the Healthy Start office as needing medical attention, are notified by telephone. Because of limited resources, and variability in physician, dentist, and medical student volunteers, the school hosting the event along with the Lennox Healthy Start medical staff identifies those children and families in most of need of medical attention. Volunteer physicians, nurse practitioners, and medical and dental students are notified by flyers advertising the event.

A detailed personal and family medical history, social history, and immunization history is recorded for every adult participant. A pregnancy and prenatal history is also obtained from women of childbearing age. Immunization records are checked for child participants and appropriate vaccines are given whenever necessary. Weight, height, temperature, and blood pressure measurements are performed by medical students and recorded. Basic laboratory tests are performed, consisting of hemoglobin level analysis and urinalysis. All participants receive

a free physical examination provided by UCLA and Charles R. Drew University faculty physicians and by volunteer physicians from the surrounding community. Third- and fourth-year medical students assist and observe physicians during the physical examinations. Faculty and students from the UCLA School of Dentistry provide free dental examinations. The Southern California College of Optometry provides free vision screening. Physicians, dentists, and optometrists record abnormal findings, and the appropriate referral is made to local county hospitals or free clinics by the Healthy Start office in Lennox. All services are offered free of charge.

Subjects

The respondent population for this study consisted of adults presenting to a health fair in the city of Lennox, in South Los Angeles County. As adults presented to the health fair, they were matched with a bilingual medical student who escorted them throughout the fair. At the time of the matching, a researcher approached each adult, obtained consent, and asked him or her their preference of survey language. At this time, the medical student was given the survey to be administered. This study was approved by UCLA's Office for Protection of Research Subjects.

Survey Instrument

To compile data for this study, a bilingual survey instrument was developed by the authors and pilot-tested with the assistance of a trained specialist in bilingual survey development. Participation in the survey was voluntary. Those who agreed to participate were administered the questionnaire, which consisted of both closed- and open-ended questions in a direct interview format. Instructions on survey administration were described to medical student interviewers in a brief training session. In total, 70 adults consented to participate in the survey. Sixty-eight completed the survey, with 2 break-off surveys reported due to participant time constraints.

RESULTS

Table 1 shows demographic characteristics by health status and access to medical and dental care. Overall, the sample mean age was 33 years (± 10.2) and 81 percent female. Ninety-seven percent of respondents were foreign-born, with Mexico being the most frequently reported country of birth. Ninety-three percent preferred to take the survey in Spanish. US-born respondents reported higher mean health status scores than foreign-born respondents. English speakers reported a higher mean health status score as compared to Spanish speakers. The foreign-born utilized both medical and dental services at lower rates than U.S. respondents did. Younger subjects compared to older subjects were more likely to report a doctor or dental visit during the past year and reported higher mean health status scores.

Table 2 shows use of medical services and perceived barriers to its access. Those respondents reporting at least 1 doctor visit in the past 12 months had lower health status than respondents not reporting a doctor visit. Respondents who felt they needed medical attention but did not seek it had a lower perceived health status than those who did seek care. High cost was the most frequently reported barrier to seeking medical care. Those respondents reporting the high cost of care prevented them from seeking care also reported the lowest health status score.

Table 3 shows use of dental services and perceived barriers to its access. Respondents who felt they needed dental attention but did not seek it had a lower perceived health status than those who did. High cost was the most frequently reported barrier to seeking dental care.

Table 4 shows demographic characteristics by insurance status. Respondents in poor health were more likely to be uninsured than respondents in good health. English speakers were twice as likely to be insured than Spanish speakers. All U.S.-born respondents were insured, while only 18 percent of Foreign-born respondents were. Insurance coverage increased with increasing length of residence in both the U.S. and Los Angeles County. A total of 66 percent of uninsured respondents reported having had contact with a doctor during the past year compared to 34 percent in the insured group.

DISCUSSION

Results from a similar study conducted in 1983 in a heavily Latino-populated section of Los Angeles found that the high cost of health care, lack of health insurance, and less salient factors such as lack of transportation and inconvenient hours of operation, were major reasons for not seeking care.¹⁵ We have also shown that the high cost of health care prevented almost 60 percent of participants from seeking care, even when it was felt necessary. Interestingly, participants reporting that the high cost of health care prevented them from seeking care also reported the lowest health status score. Thus, it is possible that individuals at increased risk for medical illness and its complications due to delayed attention are also the ones that are most unlikely to receive care due to barriers to health care such as high cost. This paradox reflects the current health care situation in the United States.¹⁸

Uninsured participants have a higher need for health care, as measured by perceived health status, than insured participants do. Other investigators have also reported similar findings. Among Mexican-Americans in South Texas, investigators found that the uninsured reported a greater need for health care as measured by health status than those with insurance.¹⁰ Franks et al, in an analysis of the 1987 National Medical Expenditure Survey found that the subjective health status of Americans without insurance is lower than the subjective health status of those with insurance.¹⁸ These studies support the hypothesis that individuals at higher risk for medical illness are also least likely to receive medical attention.

Surprisingly, our study has revealed that uninsured participants were almost twice as likely to have had a doctor visit during the past year as compared to those with insurance. This is contrary to studies among similar populations. In a nationally representative sample of Hispanics in HHANES, investigators found that persons without insurance were 50 percent more likely than insured persons not to have visited a physician in the past year.¹⁹ In South Texas, similar results were found: poor Mexican Americans with public insurance demonstrated higher health care access rates than did their poor uninsured counterparts.¹⁰ In comparison to our study, HHANES used general population samples, with possible over-representation of individuals with more years of education and higher incomes, while the Texas study included a large sample of individuals with private insurance. The small sample of insured patients at this health fair may not be representative of the Lennox population as a whole. Our study, compared to others, included a larger proportion of foreign-born. It is possible that our sample contained a significant number of undocumented immigrants, who are ineligible for government-sponsored health care. In California, this is a realistic notion. A study among a medically indigent population in Orange County, California, found 60 percent of patients presenting for financial assistance for medical care were undocumented.¹⁷ Thus, individuals in our sample of the population may pay cash to local physicians for their health care needs, without fear of being reported to authorities. Yet, this population has the highest number of people living in poverty in this part of Los Angeles county.¹⁴

With respect to dental care, we found that nearly seventy percent of respondents felt they needed dental care but could not obtain it, in most cases, due to high cost. Lack of insurance for dental services substantially add to other barriers because of the burden of higher out-of-

pocket costs. Understanding the barriers that prevent access to dental care among Hispanics may enhance planning and design of oral health promotion and disease prevention interventions and ultimately lead to improvement in their oral health status.

Utilization of folk medicine was surprisingly low among our sample. A study conducted among adult Hispanics in the Los Angeles area also revealed low utilization of folk healers.¹⁵ Yet, our results were significantly lower than the 21.4 percent reported among foreign-born Mexican-American women in the state of Washington.²⁰ Comparing our results with a nationally representative sample of Mexican-Americans, we found a higher prevalence (7.2 percent) of utilization of these services relative to the 4.2 percent reported from the HHANES data.²¹ We believe our sample population is similar to both the Los Angeles and Washington groups. Thus, it is not clear why there are such differences in utilization rates of these services among such similar groups. It is possible that different income levels, level of acculturation, as well as availability of these services in the community may play a role in their access.

Thamer et al, in an analysis of a nationally representative survey of foreign-born U.S. residents found that persons who had lived in the US for less than 15 years were almost five times as likely to be uninsured than were U.S.-born Whites.²² Our study substantiates these findings. We found that nearly 60 percent of participants residing in this country for more than 10 years were still uninsured, while the number of uninsured was higher for participants living in this country for less than 10 years.

We recognize several limitations. We report only on participants presenting to a health fair in an urban area and may not be representative of other non-urban disadvantaged populations. Nor can results be generalized to underserved populations outside the area served by our health fair. Our sample was predominantly female, which may not be representative of the population of Lennox. This can be explained by the fact that women generally use health services more often than men do. Furthermore, the lack of male participation at this health fair may reflect Latino presence in labor-intensive and low technology employment, as Latino immigrants have come to represent a large fraction of the manufacturing labor force in Los Angeles. Often, this sector is un-unionized, and employers may require employees to work an extra day of the week to meet production deadlines and compete with the cheaper labor costs of Third World countries. Low-skill trades such as upholstery, automotive repair, and construction, which are also represented heavily by Latinos, allows some individuals to supplement their incomes by working during their resting periods.

Because high morbidity from diseases such as diabetes may reflect the effects of delayed medical care, it is important to increase their health care access rates through universal health care or reduced financial barriers. For now, the availability of free community health fairs may prove useful in screening for such diseases, providing preventive care literature, as well as providing participants with referrals to free clinics in the area.

Community health fairs may also serve as an opportunity to investigate issues of access among a segment of the population that may not utilize hospitals or clinics in a high enough frequency to participate in surveys at these locations. Thus, this community-based survey may have revealed an even more extensive problem of access among a segment of the population that is understudied and difficult to access, than had a larger geographical area been investigated.

In conclusion, our results support the argument that the medically indigent in some localities face serious financial, as well as less salient, barriers to access. These local conditions reflect inadequate support and enforcement by local governments in correcting the difficult problems indigent populations face in accessing medical care.

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TABLE 1
Sample Characteristics by Health Status and Use of Health Care Services

<i>Characteristic</i>	<i>(%)</i>	<i>Health Status (Mean, (SD))</i>	<i>Doctor Visit in Last 12 Months (%)</i>	<i>Dentist Visit in Last 12 Months (%)</i>
Gender (N = 70)				
Female	81	7.2 (2.3)	51	30
Male	19	8.6 (1.2)	23	23
Age in years (N = 70) (mean, (SD)) 33(±10.2)				
18–29	34	7.5 (2.0)	56	38
30–49	35	7.4 (2.4)	38	22
50+	31	7.0 (2.4)	33	0
Language of interview (N = 70)				
Spanish	93	7.4 (2.5)	46	28
English	7	8.2 (0.8)	40	40
Immigration status (N = 68)				
US-born	3	8.5 (0.7)	50	50
Foreign-born	97	7.0 (2.0)	48	42
Mexico	52	7.7 (2.2)	46	27
Central America	14	6.3 (2.0)	54	31
Length of residence in US (N = 68)				
≤5 years	32	6.7 (2.7)	47	21
6–10 years	34	7.2 (1.9)	50	46
>10 years	34	8.2 (1.9)	45	18
Length of residence in Los Angeles County (N = 68)				
≤5 years	34	6.7 (2.7)	42	21
6–10 years	35	7.2 (1.9)	50	46
>10 years	31	8.2 (1.9)	48	19
Perceived health status* (N = 68)				
Poor (1–7)	14	5.0 (1.7)	50	13
Good (8–10)	54	8.7 (0.9)	45	36
Insurance Status (N = 68)				
Insured	21	8.0 (2.0)	79	43
Uninsured	79	7.3 (2.2)	39	24

* 1–10, 10 = best

TABLE 2
Use of and Barriers to Medical Care by Health Status

<i>Question</i>	<i>(%)</i>	<i>Health Status (Mean, (SD))</i>
Have you visited a doctor in the last 12 months? (N = 70)		
Yes	46	7.0 (2.3)
No	54	7.8 (2.0)
Have you ever felt you needed to see a doctor but did not go? (N = 70)		
No	41	8.0 (2.0)
Yes	58	7.0 (2.2)
If Yes, why didn't you go?		
Costs too much	58	6.8 (2.4)
Hours were not convenient	10	7.5 (2.4)
Did not know where to go	8	7.8 (0.5)
Long waiting time	8	7.5 (3.1)
Lack of transportation	6	8.0 (0.0)
Language barrier	6	7.7 (0.6)
Needed child-care	4	7.5 (0.7)

TABLE 3
Use of and Barriers to Dental Care by Health Status

<i>Question</i>	<i>(%)</i>	<i>Health Status (Mean, (SD))</i>
Have you visited a dentist in the last 12 months? (N = 70)		
Yes	29	8.0 (1.5)
No	71	7.2 (2.4)
Have you ever felt you needed to see a dentist but did not go? (N = 0)		
No	33	7.6 (1.9)
Yes	67	7.3 (2.3)
If Yes, why didn't you go?		
Costs too much	67	7.2 (2.5)
Hours were not convenient	9	7.8 (2.3)
Fearful of dentist/dental tools	7	7.2 (1.6)
Did not know where to go	6	6.7 (1.5)
Lack of transportation	2	8.0 (0.0)
Language barrier	2	5.0 (0.0)
Long waiting time	2	5.0 (0.0)
Needed child-care	2	8.0 (0.0)

TABLE 4

Sample Characteristics by Insurance Status

<i>Characteristic</i>	<i>Insured (%)</i>	<i>Uninsured (%)</i>
Sex		
Female	21	79
Male	17	83
Age in years		
18–29	19	81
30–49	19	81
50+	40	60
Language		
Spanish	19	81
English	40	60
Immigration status		
US-born	100	0
Foreign-born	18	82
Length of residence in US		
≤5 years	16	84
6–10 years	8	92
>10 years	41	59
Length of residence in Los Angeles County		
≤5 years	11	89
6–10 years	8	92
>10 years	43	57
Perceived health status		
Poor (1–7)	17	83
Good (8–10)	23	77
Doctor visit in last 12 months	34	66
Dentist visit in last 12 months	32	68