How Many Uninsured?

A Resource Guide for Community Estimates

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the access project

The Access Project is a national initiative of The Robert Wood Johnson Foundation, in partnership with Brandeis University's Heller Graduate School and the Collaborative for Community Health Development. It began its efforts in early 1998. The mission of The Access Project is to improve the health of our nation by assisting local communities in developing and sustaining efforts that promote universal healthcare access with a focus on people who are without insurance.

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If you wish, you can download a PDF version of *How Many Uninsured?* from our Web site.

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Introduction

This resource guide has been produced by The Access Project, a national initiative of The Robert Wood Johnson Foundation that is assisting communities to develop and sustain responses to health access problems. With the failure of national health reform, responsibility to improve access to health care has shifted not only to states, but also to local communities. Across the country, communities are responding to the challenge of providing healthcare access to increasing numbers of people without adequate insurance. But these efforts are often carried out in isolation, with little external support.

Among the Project's goals is to offer coalitions pursuing solutions to local health access problems assistance in assessing healthcare policies, developing strategies, and exchanging information.

One method the Project is using to achieve this goal is providing community groups with support and tools to collect data needed to aid local efforts to describe and document health access issues and problems.

Community groups need state and local data on the uninsured to enable them to participate actively in health policy debates and advocate for their constituencies. This guide is intended to assist in this work by helping local organizations and coalitions collect useful and defensible data on the number of uninsured people in their communities.

NORTH DAKOTA
MINNESOTA
SOUTH DAKOTA
WISCONSIN
IOWA
NEBRASKA
ILLINOIS
MISSOURI
KANSAS
OKLAHOMA
ARKANSAS
TEXAS
MISS.
LOUISIANA

Why Collect Data on the Number of Uninsured People?

- You've read about the problems of uninsured individuals in other towns and you don't know if this is an issue in your community. Your organization has decided to look into the matter but doesn't know where to begin.

- Your state legislature is considering a proposal to expand Medicaid coverage, but your group doesn't think the bill goes far enough. You need some detailed information on the number of people who are uninsured in the state so you can estimate how many people would and would not be helped by the proposal.

- Your local hospital is being taken over by a national for-profit company. As part of the conversion process, the new owners will need to ensure the continuation of the hospital's charitable mission, which includes providing care to the uninsured. Your group needs some reliable data on the number of uninsured people in the hospital's service area so you can determine the level of financial commitment that should be imposed on the new owners before the conversion is approved.

- Your community group has been approached by the local medical society about working together to set up a network of physician volunteers to provide care to the uninsured. Although you are not sure if this is a good idea, you want to do a quick analysis of how many doctors would be needed to establish a viable network and which local communities have the greatest need for free or low-cost health services.

- It's time to get the HMOs in your state to do good while they are doing well. Your organization thinks a premium subsidy program for uninsured individuals would be a good initiative for the managed care companies. You have the financial statements for the HMOs, so you have a sense of how much money they have. But you need to figure out what parts of the state and which income levels to target when designing the subsidy program.

- You've heard the statistics about the number of uninsured in your community, but no one seems to be listening. You're looking for an angle to raise awareness of the problem.

Knowing the number and percentage of individuals without health insurance is a concern to many community organizations and coalitions working to improve health access. According to the best estimates, there are at least 40-45 million Americans who have no health insurance. This means that 16% of the entire population, and 18% of nonelderly people, have no health insurance. Even worse, the percentage of the population that is uninsured is even higher in many states and local communities. And the number of uninsured people nationally and in most parts of the country is increasing.

Health insurance matters. Compared with insured people, individuals without health insurance have been shown to:

- Be less likely to have a regular source of medical care
- Have much lower use of health services, including doctor visits
- Be more likely to postpone receiving needed care
- Be refused care for financial reasons
- Be more likely to receive care in hospital emergency departments
- Have more avoidable hospitalizations (that is, hospital stays that could have been prevented if appropriate outpatient care had been received — for example, for asthma, pneumonia, or complications of diabetes)
- Have worse health outcomes (for example, are sicker at the time they are admitted to the hospital, or are diagnosed at later stages of life-threatening illnesses)

Since lack of health insurance is such an important factor in determining health access and influencing health, you would think that information on the number of uninsured people would be readily available. Unfortunately, this is not necessarily the case. The bottom line is this: in most cases, there are no perfect, easily available data on the number of uninsured at the national and state levels, let alone at the local community level. But the good news is that you don't need perfect numbers for most purposes. There are a lot of data already available that may meet your needs. Depending on your goals, there also may be ways that you can collect useful data if what you need doesn't already exist.

How to use this guide

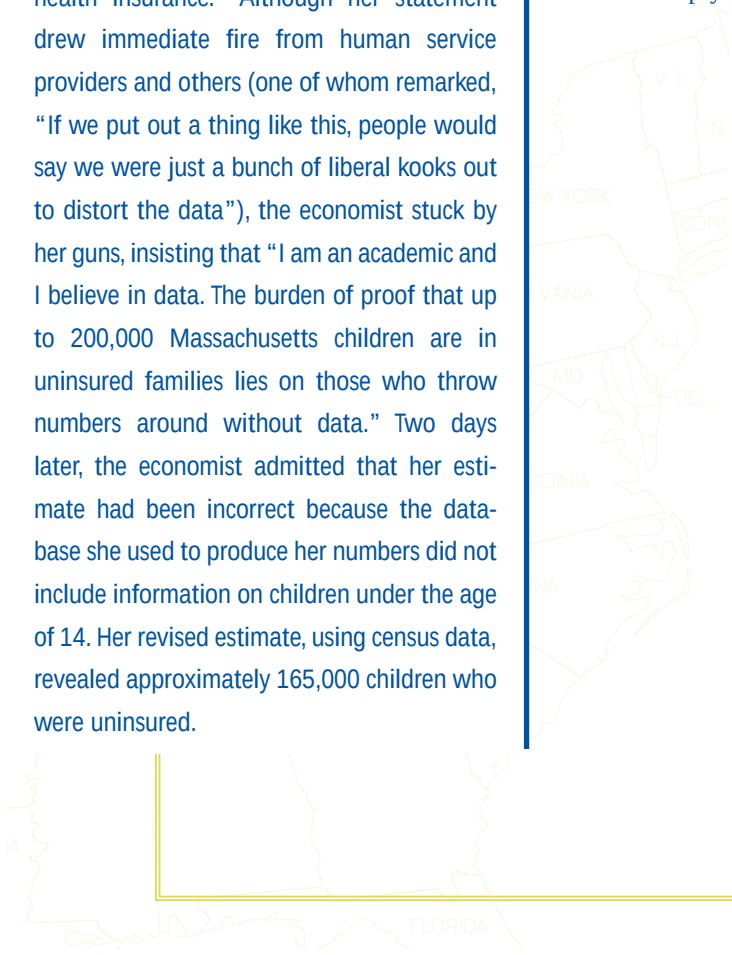
This guide is designed to share with community groups some ideas and approaches for estimating the number of uninsured people in your community. We also want to help you become more critical consumers of data that may be produced and used by others. Data can be a very powerful component of an argument when used correctly; unfortunately, people often use data to justify positions that the data do not really support. This is why it is extremely important to be able to understand what data about the number of uninsured do and do not say.

Another resource for helping you understand how to use, rather than abuse, data is "Getting and Using Community Data," also published by The Access Project as part of this series. This guide goes into more depth, than we do here, about how to analyze, interpret, and present numerical information and other types of data.

Our goal is to be practical and concise. The topic is a complicated one — and is fraught with caveats about methodological matters and sample size and lots of arcane jargon. Experts disagree about almost every number that already exists. We hope to simplify and clarify many of these issues, and help you find or collect information on the uninsured that will help you reach your goals.

That's One Way to Solve the Problem of Uninsured Children in Massachusetts

In 1998, a classic example of the perils of using data on the uninsured without understanding the underlying data sources happened in Massachusetts. An economist hired by the Pioneer Institute, a conservative think tank, analyzed national data to estimate the number of uninsured people in the state and announced, "There are no children—I repeat, no children—below the age of 14 in Massachusetts households who are without health insurance." Although her statement drew immediate fire from human service providers and others (one of whom remarked, "If we put out a thing like this, people would say we were just a bunch of liberal kooks out to distort the data"), the economist stuck by her guns, insisting that "I am an academic and I believe in data. The burden of proof that up to 200,000 Massachusetts children are in uninsured families lies on those who throw numbers around without data." Two days later, the economist admitted that her estimate had been incorrect because the database she used to produce her numbers did not include information on children under the age of 14. Her revised estimate, using census data, revealed approximately 165,000 children who were uninsured.



Challenges and Caveats

Before you get started, there are some things you need to understand about the task that lies ahead.

There are no perfect data on the uninsured

- While you may want to develop the perfect number for your purposes, remember: no number is perfect.
- National data are readily available (although estimates from different sources vary). There are also good estimates on the number of uninsured in the largest states. Some states, both large and small, have conducted studies of their own to measure the number of uninsured, but, in general, there are not good readily available data for many of the smaller states or for local communities.
- Uninsured people are not a static group. Since people go on and off insurance every day, the number of uninsured at any given time will change from day to day. In addition, the number of people uninsured at any given time will be different from the number of uninsured for a specific length of time (for example, the number of people who were uninsured on June 15 will not be the same as the number of people who were uninsured for the entire month of June).
- More recent data will better indicate the current situation.
- Even the best data are dated.

Jargon

Point-in-time estimate (also called a "snapshot"): This type of data estimates the number of people without insurance at a particular time (on a given day, for example)

Duration estimate: This type of data estimates the number of people without coverage during a particular time period (for the entire year, for example)

Don't let the perfect be the enemy of the good

- Precise estimates are not available. Don't worry about this — you generally don't need exact numbers.
- Data serve to help frame issues and to help start and maintain discussions. But data are just one tool among many in debates about health policy and the allocation of health resources.

Use ranges rather than specific numbers

- Even the best estimates are imprecise. You are always safer to talk in terms of ranges. This is particularly true if you are using data from surveys, which are subject to sampling error. When the U.S. Bureau of the Census reports the number of uninsured people, it does so using ranges. For example, the Current Population Survey (CPS) estimate of the number of people in the United States who were without health insurance for all of 1997 was 43.4 million plus or minus 0.5 million, or between 42.9 and 43.9 million people.

Having no data may be better than inaccurate and indefensible information

- Although no data are perfect, you might harm your credibility and cause by using data that are easily refuted or challenged. Be sure you understand the strengths and limitations of any information you use. If you believe your data cannot stand up to some degree of scrutiny, think hard about using it. But also remember that you'll be able to find experts who will disagree with every number you collect or develop. Don't let this stop you before you begin.

The cost to collect the data and the precision of the estimate you develop are related

Depending on the purpose for which you are using the data, increased precision may be irrelevant.

Be careful when using numbers developed by others

You can't reliably use data beyond the purpose for which it was collected. Understand the limits of your data.

- Although you need not become a statistician, you do need to understand some basics about the methods used to collect any estimates you use. Chapters 4 and 5 provide some tips about what you need to know about existing data sources.

- It is particularly difficult to use existing data sources to compare trends over time because survey questions change, as do the methods used to pick the samples of people who are surveyed.

Trust your gut

- Your own impressions and experiences are important: Data serve as a validation, not a replacement, for your own experiences and impressions.

- Beware of data that fly in the face of what you think is true in your community.

Be cautious about aggregating data from different sources

But consider involving other individuals, from other organizations, in reviewing the survey instrument.

- To the extent that people have had an opportunity to comment on the survey design, they may be more likely to accept the results.

- Of course, if you are going to follow this suggestion, you need to be sure that you are comfortable sharing your strategy in advance with the organizations you include in the design of the survey.

Getting Started

Before you decide what approach to take, you need to answer a series of questions.

Question 1: What do you want to use data for? What questions are you trying to answer?

Many people make the mistake of trying to find or collect data about the uninsured that will answer every question they ever had, rather than taking the time to determine up front exactly what they want to know and, therefore, exactly what pieces of information they need. Some important tips:

- Collect only what you want and need.
- Your approach and method of calculation will depend on the goal of your efforts.
- If you focus your analysis at the outset, you will save time, and others whom you ask for help will be better able to give what you need.

Question 2: What population group are you interested in?

Part of determining the goal of your data collecting is to determine which individuals or groups you are interested in learning about. Communities can be broken down into a number of different subgroups, with each individual belonging to more than one (for example, female, Latina, disabled). It is important to outline as specifically as possible the population(s) you are interested in knowing more about.

Another important aspect of the population description when you are dealing with health insurance, or lack thereof, is time frame. Since individuals go on and off health insurance every day, you need to be clear about not just the population of interest but also the time frame of interest. Some examples of subgroups you might be interested in are:

- The number of uninsured women of childbearing age
- Differences in rates of uninsurance by race and ethnicity
- The number of uninsured individuals in a particular county last year
- The number of uninsured individuals in a particular county last week
- The proportion of people with a particular health problem (for example, diabetes, HIV) that is uninsured

- the number of people in a particular population group (for example, the elderly, immigrants) who are uninsured

Question 3: How much do you want to know about the uninsured?

One problem common to many who attempt to answer questions about the number of uninsured is: how much information is enough? Do you just need to know how many people do not have insurance, or must you also know why they are uninsured? Is it enough to know the number of people who do not have health insurance, or do you need to know what the impact of being without insurance is on the health status of these people and on their ability to access healthcare services? The type and scope of information you need depends on the first question you need to answer: what do you want to use the data for?

Additional information you may want to know about the insured/uninsured individuals in your community is:

- The impact on health status of not having insurance
- The major reasons for lack of insurance coverage
- The types of employers who don't offer health insurance
- The relationship between income level, household size, and insurance coverage
- The relationship between prior welfare status and insurance coverage

It may be easier, cheaper, and faster to use qualitative data to answer some of these questions. The term "qualitative data" just means words. You can use experiences and anecdotes to illuminate your quantitative data (that is, your numbers). For example, your quantitative data may be: *25% of people in our community lack health insurance.* You could illuminate the impact of being without coverage by combining this estimate with real-life stories (for example, *a woman without insurance was unable to get primary care for her hypertension. Left untreated, her condition worsened to the point that she needed to be hospitalized.*)

Question 4: How quickly do you need the information?

Obviously, the amount of time you have before you need to use the information has a major impact on your ability to find and/or develop useful, and useable, data. If you only have a few days, certain options (for example, conducting a detailed survey of your local community) are not available. This doesn't mean there's no way to get *any* useful information. It just means you'll have to use existing data sources and understand the limits of the data you do use.

On the other hand, even if you have a long lead time before the information is needed, you may find that your questions can be answered with data that already exist. In this case, there's no need to collect data yourself, even if you do have the time and funds available to do so. This is why it's important to understand existing data sources and their strengths and weaknesses.

Question 5: Does your group have any resources to spend collecting its own data? If so, how much?

Using readily available information such as census data can be quite inexpensive, while doing your own survey can cost anywhere from $2,000 to $200,000 (and well beyond!), depending on whom you are surveying and how much information you are attempting to collect. Once you know what questions you want answered and have determined that existing data sources are inadequate, you are ready to look at the options available for collecting data on your own.

- If you don't have any resources, there's no use developing a survey.
- But even if you have only minimal resources, you may be able to undertake a limited but useful survey effort.

What Information Is Already Out There?

Even if you answered "unlimited" to the question about resources, it's still a good idea to learn about the information that other people have already collected. There's no use spending money to collect additional information if you don't have to.

- Depending on your goal, there's a lot of data already available. You may not have to collect your own.
- Learn what's out there on the national, state, and local levels.
- Then determine if it answers your questions and meets your needs.

The best sources of readily available data are discussed below. We provide a description of the data source, the major strengths and weaknesses of the data, the types of questions that the data can answer, and where you can find the data.

Current Population Survey (produced by the U.S. Bureau of the Census)

Description

As you probably know, the U.S. Bureau of the Census collects information about every resident of the United States (or, rather, every resident of the United States that it can find) every ten years. What's not as commonly known is that the Census Bureau annually collects additional information — employment, demographics, etc. — to help us understand population changes during the ten-year interval between major censuses. Every March the Census Bureau conducts a survey that includes questions about health insurance coverage. This survey is called the "March Current Population Survey" (CPS). Frequently, when you hear statistics about the number of uninsured people in the United States, the data being cited are from the March CPS. The CPS information on health insurance coverage is updated annually.

Note: Every data set has its strengths and weaknesses, and the census data are no exception. In addition, as the purpose for which you are going to use data moves further and further away from the purpose for which the data were collected, the weaknesses of the data increase. So what may be a strength of a data set for some purposes will be a weakness of that same data set when used for other purposes.

Strengths

- The Census Bureau data are readily and widely available.
- The data collected include demographics on income, job status, and industry, so it is possible to make connections between these items and health insurance coverage. The data are

readily available and accessible in late September or early October each year. (You'll see that in some instances, data being used now may have been collected many years ago.)

- Many healthcare researchers have worked with the data from the March CPS and are familiar with its strengths and weaknesses. Therefore, people are available to answer questions and help interpret the data.

- The total sample size is quite large — usually 55,000 households totaling some 150,000 people.

- The response rate is quite high. (The response rate is the percentage of people asked to participate in the survey who agreed to do so.) In some instances, other surveys can have response rates as low as 20–30%. In these instances, you need to think about whether your results would have been different if *everyone* had answered the survey, or if a *different* 20–30% had answered the survey. This is known as "non-respondent bias." (For example, certain population groups may be less willing to respond to surveys, particularly government-sponsored surveys, than other groups. Or people with insurance may be more likely to agree to be surveyed about health insurance coverage than individuals who are uninsured.)

- The sample of households surveyed for the CPS is drawn on a national level, so the data are reliable at that level. Most researchers, however, consider the results to be valid as well at the state level for the 30 most populous states.

- Many researchers also believe that the CPS can be used to produce relatively credible estimates for the 20 states with smaller populations by pooling, or combining, two or three years of data. (It's important to note, however, that the questions asked each March may change, so that data must be pooled with care.)

- The March CPS attempts to count the number of children who are uninsured and the number of individuals who are on Medicaid.

Weaknesses

- The sample for the March CPS is designed to provide national, rather than state-level, estimates. Therefore, even if a large number of individuals in a particular state have been selected for the sample, those individuals may not be representative of the state as a whole. For example, if all the individuals interviewed in a given state reside in urban areas, the results would not provide a valid description of the entire state, or of rural areas in the state.

- The CPS's definition of "household" may not be the same as that used by health insurance companies in determining family coverage. Therefore, there may be some confusion and/or difficulty if you use the CPS data to estimate the cost of providing health insurance coverage to all people who are uninsured.

- The CPS asks about different time frames of being uninsured: a full 12 months (that is, "During the previous year, was anyone in your household covered by health insurance?") and a point-in-time question (that is, "Was anyone in your household uninsured yesterday?"). Although the CPS asks about more than one time frame, most researchers think that information provided by survey respondents reflects their health insurance coverage at the time of the interview rather than during the previous year. The Census Bureau has work underway to correct this problem.

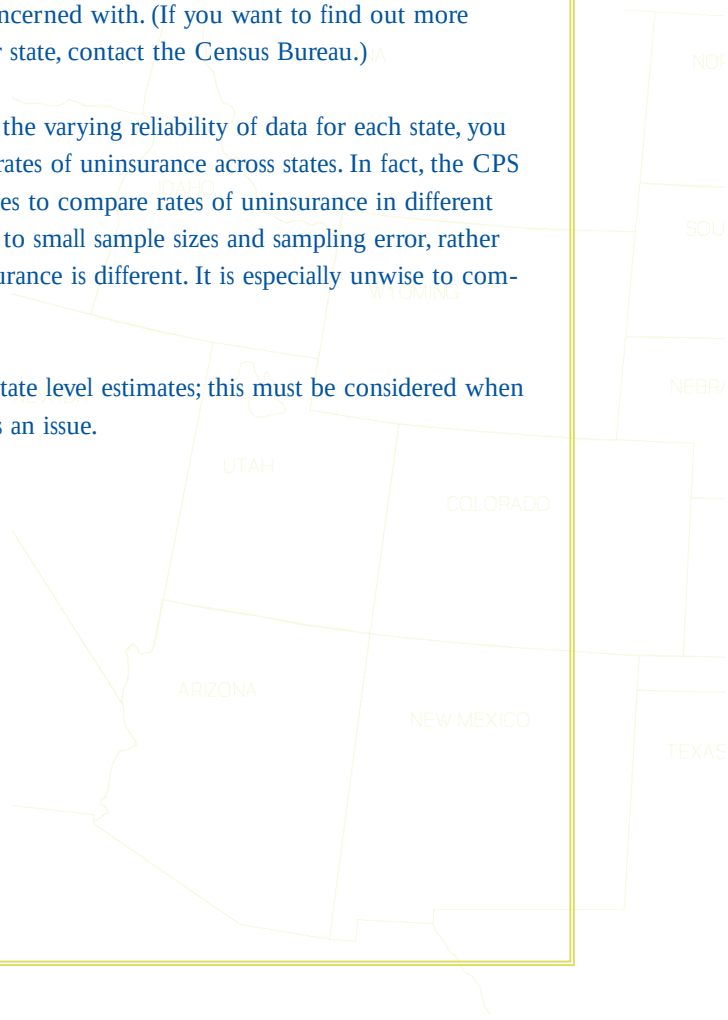
- The questions asked in the CPS each year are not exactly the same. Therefore, one must be very careful when discussing trends over time.

- Various researchers have concerns about the accuracy of the count of uninsured children and individuals on Medicare or Medicaid. For example, the CPS estimates of Medicare and Medicaid are lower than data produced by the federal Health Care Financing Administration, the agency that administers the Medicare and Medicaid programs. According to the September 1, 1998 *Current Population Report* of the Census Bureau, "This may be due to the fact that the CPS is a labor force survey with minimal interviewer training on health insurance concepts." Some researchers have devised ways to adjust the raw census data to account for these concerns.

- Results for the smallest 20 states must be used with the caveat that the samples for these states are not reliable. In addition, you need to understand the limits of the sample (for example, all urban) in the state you are concerned with. (If you want to find out more about sampling methods and data for your state, contact the Census Bureau.)

- Given the caveats we've mentioned about the varying reliability of data for each state, you need to be very careful when comparing rates of uninsurance across states. In fact, the CPS specifically advises against using its estimates to compare rates of uninsurance in different states because state estimates can vary due to small sample sizes and sampling error, rather than because the underlying rate of uninsurance is different. It is especially unwise to compare changes over time across states.

- The standard error can be quite high for state level estimates; this must be considered when using results for the states for which this is an issue.



Standard Error

The *standard error* is a measure of the reliability of a given estimate. The numbers from the CPS and other surveys are estimates because only a sample of the entire population is surveyed. Using data from the CPS, you can't tell *exactly* what proportion of people are uninsured in your state, but you do have one estimate. You can use the standard error to estimate the range in which the true uninsured rate falls.

For example, suppose the CPS data estimate that the uninsured rate in your state is *14%*, with a *standard error of 0.85%*. To find the true range of the estimate with 95% confidence,

1. Multiply the standard error by 1.96
   0.85% x 1.96 = 1.67%
2. Subtract the result from 14% to get the low end of the range
   14% - 1.67% = 12.3% (rounding to the nearest 0.1%)
3. Add the result to 14 % to get the upper end of the range
   14% + 1.67 = 15.7%

This means that *there is a 95% probability that the* true *uninsured rate in your state is within the range of 12.3–15.7%*.

You can also use the standard error to tell if the difference in the uninsured rates between states is statistically significant or merely the result of random variations in sampling. For example, the CPS estimated that the uninsurance rate in 1997 was 22.6% (standard error = 0.9%) in New Mexico and 24.5% (standard error = 0.5%) in Texas. Using the standard errors and the method above, you can calculate the range of the rate in both states:

New Mexico
0.9% x 1.96 = 1.76
22.6% - 1.76 = 20.8% lower end of range
22.6% + 1.76 = 24.4% upper end of range

Texas
0.5% x 1.96 = 0.98
24.5% - 0.98 = 23.5% lower end of range
24.5% + 0.98 = 25.5% upper end of range

The ranges for the two states overlap, which means that the actual uninsurance rate in New Mexico may be higher or lower than the rate in Texas; you can't tell from the sample. In statistical jargon, there was no "statistically significant" difference in the rate of uninsurance in the two states in 1997.

- Making conclusions about sub-areas of the state are generally *not* valid uses of CPS data except, perhaps, for some very large cities included in the sample.
- The March CPS does not include data on health status or the impact of insurance status on access to care.
- The Census Bureau notes in its September 1998 report, "Health Insurance Coverage, 1997," that the CPS is primarily a labor force survey and is not developed to specifically collect health insurance data.

What types of questions can you answer using this data source?

The data collected from the March Current Population Survey are designed to answer questions about the extent of health insurance coverage at the national level. Questions such as, "How many people in the United States are uninsured?" or "What percent of the people uninsured in the United States are employed?" are exactly the types of questions that the CPS is designed to answer.

How can you get the data?

Census data, both for the full ten-year census as well as the results of the March Current Population Survey, are readily available. The Census Bureau has offices and libraries in various regions of the country. Many local and university libraries carry reports using census data — the results of the March CPS are published annually. The Census Bureau's Web site is, of course, readily accessible. In addition, CPS documents can be purchased from the Government Printing Office and federal bookstores located regionally.

Private organizations also frequently publish analyses of census data. These organizations include the Urban Institute, which periodically publishes data books, and the Employee Benefit Research Institute (EBRI). The institute, a nonprofit research organization, uses data from the CPS to compile an annual "Issue Brief" that provides summary data on the insured and uninsured populations in the United States, in each state, and in "Consolidated Metropolitan Statistical Areas." (See Chapter 8, Resources, for more information on the Census Bureau, EBRI, and other organizations.)

Behavioral Risk Factor Surveillance System (BRFSS): U.S. Centers for Disease Control and Prevention

Description

Each state annually conducts the Behavioral Risk Factor Surveillance System (BRFSS), a survey jointly funded by the Centers for Disease Control and Prevention (CDC) and the state. All 50 states participate in this survey effort. Each state selects a random sample of residents. The data are collected in 12 monthly installments throughout each year.

The BRFSS was originally intended to collect information on people's health-related behaviors, such as smoking, drinking, seat belt use, and so on. The questionnaire used by each state consists primarily of questions that are asked throughout the country. In this way, the CDC can gain an understanding of health-seeking/health-risking behaviors across the United States. In addition, each state can, at its own expense, add additional questions to its survey instrument. Since 1991, the BRFSS has included questions about health insurance coverage in its standard questionnaire.

Strengths

- Each state selects a random sample of residents, so that the respondents are representative of the state's population. This is true even in states with small populations.
- Each state has immediate access to the data it collects.
- States can add questions of particular interest and oversample specific geographic areas or population groups to obtain additional information.

- While response rates do vary by state, the goal for all states is to strive for high response by performing up to 15 follow-up calls per household.

- Since questions about the uninsured have been asked since 1991, some trend information is available. (As with the census, however, questions must be compared across years to determine if the trend data are valid.)

- The CDC is testing questions about managed care coverage; such information may be standard in future surveys.

- The BRFSS questionnaire collects demographic data, so information on insurance coverage can be analyzed by characteristics such as age, gender, and income.

- In addition to demographic data, health insurance coverage information can be looked at in relation to various health-related behaviors, such as smoking, drinking, etc.

- Comparative data across states are available.

Weaknesses

- The BRFSS does not collect information about children. All of the survey data, including the health insurance information, deal with adults only.

- Most of the questions in the BRFSS relate to the respondent only, not the entire household. Thus, conclusions about entire households cannot be drawn.

- While each state selects a random sample of its residents, the sampling methodology may vary from state to state. This is not a problem when looking at data from only one state, but you do need to be careful when making comparisons across states.

- While states' goals may be to make multiple follow-up calls for each household, response rates can vary greatly from state to state. Again, this means you need to be cautious when comparing results across states, as differing response rates can mean differing levels of acceptability of the results.

- Standard errors can be quite high in some states.

- Few health policy researchers are very familiar with this data set; it's been used more by other disciplines. The CDC is starting to spread the word about the data, its availability, and its potential usefulness in health policy discussions, so in the near future more and more people will be comfortable with it.

What types of questions can you answer using this data source?

The BRFSS can be used to answer a number of questions not just about the level of uninsured adults in each state, but also about the types of behaviors these individuals engage in. For example, what percent of adult smokers are insured/uninsured? What percent of adults who do not use seat belts are insured/uninsured?

In addition, since each state has the ability to add questions, it is possible for community groups to work with a state to add questions about specific issues, or to oversample in a particular area. Because the surveys for the BRFSS are conducted in 12 monthly installments throughout the year, it will take quite a while to get results. However, if there is no rush, such a process might be an extremely effective method of obtaining additional information.

How can you get the data?

Because the CDC collates responses to survey questionnaires from all states, a report is available that provides information from every state. (Survey data are also available on the CDC Web site, www.cdc.gov/nccdphp/brfss).

In addition, each state generally analyzes its own survey results prior to publication by the CDC. In general, state public health departments are responsible for conducting the survey and analyzing the results.

If you want to find out more about the BRFSS survey and data in your state, get in touch with the state contact for the survey. A list of state contacts is available from the CDC Web site (www.cdc.gov/nccdphp/brfss/contacts.htm) or from your state department of public health.

Other Helpful Surveys

Large, periodically repeated surveys

Historically, the federal government has funded large, nationwide, household interview surveys to determine the extent of health care utilization, costs, and expenditures; health status; and/or insurance coverage. Sometimes it takes many years for the data from these surveys to be tabulated, analyzed, and available to researchers, so you need to be careful to understand what time period is covered by any information you are thinking of using.

If you see references in the literature to NMES (National Medical Expenditure Survey), NMCES (National Medical Care Expenditure Survey) or NHIS (National Health Insurance Survey), be sure to look at the date the data were collected. You may be reading an article describing the situation more than ten years ago or one that is using ten-year-old cost information to project future costs. In addition, because these surveys were all national, they do not enable reliable conclusions to be made at the state or local level.

The newest iteration of this national survey is the Medical Expenditure Panel Survey

(MEPS), co-sponsored by the Agency for Health Care Policy and Research (AHCPR) and the National Center for Health Statistics (NCHS). MEPS is designed to collect information on healthcare use, expenditures, sources of payment, and insurance coverage for the noninstitutionalized civilian population. In addition, information about nursing homes and their residents is also collected.

MEPS began in 1996 and is a continuing survey. The survey collects two years of information, over a two-and-one-half-year period, from a sample of households (referred to as a "panel"). A new panel is begun each year. Household interview data is corroborated and enhanced by data collected from medical providers, insurers, and nursing homes. Among the types of data collected are demographics, health conditions, health status, use of medical care services, charges and payments, access to care, satisfaction with care, health insurance coverage, income, and employment. Information about the presence or absence of insurance coverage can be linked to any of these variables, so you can study questions about the difference in utilization levels, for example, between those with health insurance and those without insurance.

Data from the first MEPS panel can be obtained from the AHCPR Web site at www.meps.ahcpr.gov. You can also find more detailed information about the MEPS, including the types of data collected, and the questions which this survey can help answer, at the AHCPR Web site at www.ahcpr.gov.

Another survey you may hear or read about is the Survey of Income and Program Participation (SIPP). This is an ongoing survey of some 20,000-30,000 households conducted by the Census Bureau. Panels of individuals are chosen for two-and-one-half years, with persons interviewed every four months and asked questions about a four-month time period. These data are not valid for state level assessments; only national and regional assessments can be drawn. In addition, this data set is considered quite difficult to use and is therefore not readily accessible to a wide audience. The results of the SIPP are used by researchers to look at the dynamics of insurance and uninsurance over time, the distribution of the lengths of time individuals are uninsured, and the reasons behind the lack of insurance.

Large, recent surveys

In addition to federally funded surveys, large research organizations and foundations periodically look at the issue of insurance, or lack thereof, in multiple states.

For example, the "Community Tracking Study" (CTS) is a household survey sponsored by The Robert Wood Johnson Foundation and conducted by the Center for Studying Health System Change. The survey is designed to track changes in the health care system over time and to gain a better understanding of how health system changes are affecting both consumers and health care providers. Data were collected between July 1996 and July 1997, primarily by telephone interviews, with a sample of 33,000 households that were representative of the contiguous 48 states. The project also conducts periodic surveys of a representative sample of public and private employers to track trends in employer-sponsored health insurance coverage.

The CTS is also looking in detail at trends in 12 communities (Boston; Cleveland; Greenville, SC; Indianapolis; Lansing, MI; Little Rock; Miami; Newark, NJ; Orange County, CA; Phoenix; Seattle; and Syracuse, NY). In-depth data are available on each community, including information on the rate of uninsurance in the community.

A variety of "Issue Briefs" and "Data Bulletins" from the project, along with other information, are available at the Web site of the Center for Studying Health System Change (www.hschange.com).

The Urban Institute, a nonpartisan research organization, has undertaken a multiyear project, "Assessing the New Federalism," which is looking in detail at the effects of the shift of responsibility for social programs from the federal government to the states. The project is focusing on 13 states: Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. Among the project's activities is conducting a survey of households in each state to collect information on a variety of factors, including health insurance coverage. If you live in one of the 13 states, you can obtain reliable information on rates of uninsurance in your state from the project. (A second household survey, to be conducted in 1999, will provide updated data on each of the 13 states.) The project also collects and makes available to the public a range of state-level information for all 50 states and the District of Columbia, including data on health insurance. It also publishes a variety of research reports. For more information, look at the project's Web site, located at www.urban.org.

The Kaiser Family Foundation also often undertakes studies of the levels of insurance coverage. It is always a good idea to contact The Robert Wood Johnson Foundation and the Kaiser Family Foundation when looking for information on the level of insurance coverage in your area, to see if your state or community is involved in any recent research studies. (See contact information in Chapter 8.) You can also check with any local foundations with an interest in health care to see if they have done, or are doing, any relevant survey work.

Other Possible Sources of State Level Data

In addition to ongoing, formal studies of insurance coverage conducted primarily by the Census Bureau and the CDC, various agencies of state and local government as well as trade associations may have statewide information that may help you. Community groups are often familiar with the demographics of their area, as well as the differences between the local community and the state as a whole. Thus, you may be able to critically assess statewide estimates and either use the estimates as is or adjust them for known demographic differences.

We'll discuss each potential source of statewide data in turn.

- Insurance Departments

Since insurance is regulated at the state level, all states will have a department that monitors the provision of insurance, including health insurance. States *may* have available information about the numbers of people insured and/or the types of insurance coverage people actually have. A call to your local insurance department is always a good idea when looking for information about the number of insured individuals in your state.

- State Medicaid Departments

Your state Medicaid program should be able to provide the number of individuals covered by its programs and any changes in coverage levels over time.

Perhaps of even more importance, the Medicaid program may be able to tell you the number of persons eligible for, but not enrolled in, Medicaid. While you can't assume that these individuals are uninsured, one focus of potential action for combating the lack of insurance is to encourage additional outreach efforts to enroll eligible individuals in Medicaid's programs. Thus, if you determine that there are a large number of unenrolled individuals in your area, your organization may want to rethink its focus. Some state Medicaid agencies may also have conducted special surveys on issues such as access to health care and trends in the number of state residents without insurance.

You can also obtain a variety of data on state Medicaid programs directly from the federal Health Care Financing Administration (www.hcfa.gov). Every state files a variety of statistical reports with HCFA, including state-level information on Medicaid enrollment and expenditures for various types of Medicaid service categories.

- Health Care Committees of State Legislatures

State legislatures frequently become involved in looking at the level of insurance coverage within a state. It is always worth checking to see if these committees have collected any data on the subject, either by conducting surveys directly or by collecting information on the subject from other parts of state government.

- Attorneys General

Attorneys General, as well as insurance departments, receive complaints from individuals about health insurance coverage. Again, while not directly a source of information about the number of uninsured, reviewing tabulations of responses may lead you to focus on a particular issue involving health insurance coverage, or lack of coverage. Reviewing complaints filed by people without insurance can also provide information about the impact of being uninsured.

In some states, Attorneys General oversee community benefit programs, in which hospitals and/or HMOs are required to demonstrate that they are working to increase access to health services in their communities. Information about programs in place can be obtained at the offices of the state attorney general. Information about data collected by organizations to plan for and/or develop programs may be available at each provider and/or HMO.

- Provider Organizations and Trade Associations

Provider organizations, such as state hospital associations and medical societies, are extremely interested in the extent of health insurance coverage in their area. This, of course, is because when individuals do not have insurance coverage, providers are frequently asked to provide care at no charge. Some states may have mechanisms in place to reimburse providers for such care, such as hospital free care pools. In these cases, hospitals will be able to tell you the number of people they have served and the extent of the service they provided. There may even be a state agency that collects and analyzes this information.

Even in the absence of official programs to help cover the cost of free care, providers may keep track of the care they provide to individuals who have no health coverage. This information can be useful in lobbying for programs and/or subsidies to help cover the cost of this care. Thus, hospital associations and medical societies may periodically collect data about the levels of care provided at no charge by their members. Again, while not providing a count of the number of uninsured, this type of data can provide interesting information about the extent of the need for coverage and an indication of the economic burden of providing care for these individuals. (Keep in mind that this information does not include a measure of *unmet* need.)

In addition, organizations representing specific provider types (for example, mental health providers), can be queried for information about the number of people lacking coverage for the type of services these providers offer.

It's very important to understand the meaning of the terms *free care*, *bad debt*, and *uncompensated care* if you are going to use these data, because definitions may vary from state to state. (See the sidebar.) For more information on this topic, see "The Free Care Safety Net," a fact sheet developed by The Access Project.

- Legal Aid Societies

Legal Aid Societies frequently become involved in dealing with individuals' attempts to obtain health care coverage (for example, persons contesting a denial of coverage by Medicaid). Again, while not necessarily able to provide an indication of the level of insurance coverage in an area, legal aid societies may be able to provide you with specific cases and other qualitative data to use in human interest stories, or to point you in the direction of recurring problems individuals are having in obtaining coverage.

- Chambers of Commerce and Other Local Business Groups

Many Chambers of Commerce and other business associations assist their members in obtaining health insurance coverage. Chambers, therefore, can be a good source of information about the problems businesses have finding health insurance coverage, and potentially about the level of coverage, or lack thereof, in a particular community. Chambers and other business groups may periodically perform surveys to determine if health insurance is a need of their membership, thus getting relatively up-to-date information about the issue.

- Local Foundations

Many large cities have local foundations that focus on health. If there are state or local foundations which have shown an interest in funding healthcare programs—for example, healthcare access studies, health center programs, women's health issues, etc.—it is definitely worth calling them to see if they have funded any studies of the level of health insurance in your community. Even if they haven't, foundation staff may be able to direct you to local residents, academics, or public figures who may have an interest in the issue and be able to help steer you toward whatever data are available.

- Business Groups on Health

In numerous large cities, businesses have banded together to form a local "business group on health." Started because of the high cost of health insurance, these groups frequently survey their membership to determine insurance status and frequently study the community at large as well. It may be worthwhile to check the Yellow Pages to see if such a group exists in or near your community.

Terms

Free care: These are free services hospitals provide to patients who show that they cannot afford to pay for their care. Hospitals do not expect to be paid for these services.

Bad Debt: These are the services hospitals provide for which they expect payment but never receive it. Bad debt usually arises out the failure of insurance companies or individual patients to pay their bills.

Uncompensated Care: These are the services that hospitals provide but for which they do not receive full payment. The term often includes free care and many categories of "unpaid care," including bills that insurance companies and individuals don't pay. "Uncompensated care" may also include the difference between what the hospital receives for treating Medicare and Medicaid patients and what it usually receives for privately insured patients. Hospitals may lump all these categories together and call them uncompensated care.

Source: "The Free Care Safety Net," a fact sheet by The Access Project.

- Small Business Organizations

Frequently, small businesses join together to take advantage of the economies of scale they can realize through joint purchasing arrangements. Small business associations often provide discounts on office supplies and telephone services, and the opportunity to purchase group health insurance. If such associations or organizations exist in your area, it is worth determining whether they have data on the extent of insurance coverage, or lack thereof, among small businesses and their employees. As with other local organizations, even if these groups do not have their own data, they may be able to put you in touch with individuals who do.

Other Possible Sources of Local Level Data

In addition to data at the state level, organizations in your local community may have useful data on the uninsured. A few potential sources of local information are described below.

- County Health Departments and RNs

County health departments can be a wonderful source of information about the healthcare problems affecting a particular locale or community. While local health departments may not conduct ongoing surveys, they are frequently called upon to handle difficult and/or unique health-related situations. County registered nurses (RNs) may treat the most disadvantaged individuals in the community and thus have a good sense of the most pressing problems of an area's most vulnerable populations. County health departments can provide invaluable and powerful qualitative data as well as an angle on which to concentrate your organizing and advocacy efforts.

- Local/County Medical Societies

Just as the statewide medical society may have information about the amount of free care provided, so may the local medical society. (Note: do not expect every city or county to have its own medical society.) These organizations may be better able than their statewide sisters to pinpoint the types of care provided, the types of individuals needing care, and the location of the residences of people needing care. A human interest story on the types and extent of care provided free of charge by your local physician, in an age when most people receive coverage through employer or government programs, can command a lot of attention.

- Local Hospitals

If your area happens to have a single hospital serving the geographic area you are interested in, you may be able to obtain quite a bit of information about the uninsured people in that area who need to rely on the local hospital to provide free care. In addition to information

on the extent of free care provided (for example, percent of ER visits, percent of preventable hospitalizations, etc.), a hospital may be able to help you create a powerful story on the impact of postponing care due to lack of health insurance coverage.

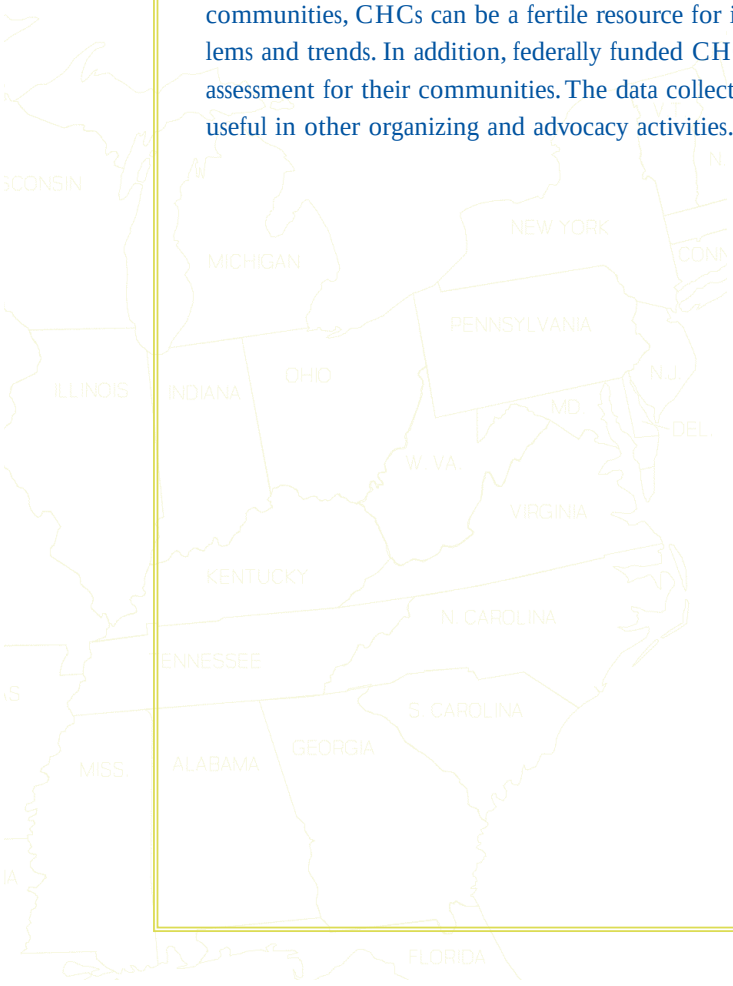
Social workers in discharge planning units of local hospitals can discuss the difficulties of arranging services for, or placing, individuals without insurance, as well as the magnitude of the problem.

- School Clinics

School clinics are another frequent source of care for children without health insurance. Even if adults may not readily give permission to use a child as the subject of a human interest story, you may still be able to obtain information from the school clinic about the types of concerns children without insurance bring to the clinic. And, if you are able to obtain permission, stories about difficulties children are having through no fault of their own often have the most impact on public opinion.

- Community Health Centers

Many areas have community health centers dedicated to providing medical and health services to individuals regardless of ability to pay. As an important part of the safety net in their communities, CHCs can be a fertile resource for information on coverage and access problems and trends. In addition, federally funded CHCs are required to conduct an annual needs assessment for their communities. The data collected for the needs assessment can be very useful in other organizing and advocacy activities.



So You Need to Collect Your Own Data?

If you still can't find the data you need, even after checking out existing sources of information, it's time to think about collecting your own data. Once you reach this point, it's a good idea to review the first steps you took when starting your search for data. Go back to Chapter 3 (Getting Started) and review your answers to the questions we posed:

1. What do you want to use the data for?

2. What population group are you interested in?

3. How quickly do you need the information?

4. Does your group have any resources to spend on collecting its own data? If so, how much?

In addition to reviewing your answers to the above questions, you need to take the additional step of considering very carefully the following question *before* embarking on a survey of your own: *What question do you want to answer*? Surveys are designed to answer *specific* questions. The number and type of questions you are trying to answer will have a direct bearing on the length of time you need to conduct a survey, as well as the cost of the survey itself.

But let's not get ahead of ourselves. It's worth taking a few minutes to look at the strengths and weaknesses of survey research in general, just as we looked at the strengths and weaknesses of other data sources. While each and every survey design may be different, we can make some generalizations about the approach.

Strengths

- Surveys can be conducted for any geographic entity, no matter how large or small.
- Survey research can select individuals using a random sample, so that valid conclusions may be made about the population as a whole.
- Surveys can be customized to answer very specific questions about a very specific population group or subgroup.
- If you are interested in learning even more about a subgroup of the overall population of interest, you can oversample that particular group of people to obtain reliable results.
- A survey may be the only way of finding information about a local community.
- If multiple interest groups work together to design the study and agree to the substance of the questionnaire, it is more likely that the results will be accepted by all parties.

Weaknesses

- Survey research can be quite time-consuming, depending on the number and types of questions and the number of individuals you are going to question. In addition, depending on the complexity of the survey, it can take a while to analyze the results you have collected.

- Trend data are usually not available—at least not right away—if you do your own survey.

- In situations where a group is designing and/or approving the content of a survey, it can often be difficult to confine a survey to the key area of interest. Group development processes often lead to lengthy, complicated interviews, which can be quite costly and time-consuming.

- The results of a one-time survey are quickly out of date.

- Response rates, and potential non-response bias, are factors to consider in every survey, no matter how short. Do people with certain characteristics not respond to surveys like yours? Are people without telephones different from those who responded to a telephone survey?

- If obtaining information quickly is key, you may not have time to develop and conduct your own survey.

- Depending on the type and extent of information you need to answer your questions, you may need expert assistance. This may increase the amount of time it takes to collect information.

Since different surveys may use different methodologies and sampling techniques, it will be difficult to make valid comparisons across communities if each community has done a different type of study. Also, if each community in a given state conducts a different type of study, you may not be able to aggregate the results to obtain a valid picture of the situation in the state as a whole.

If you decide to conduct a survey, be sure to talk and coordinate your efforts with your state data collection agency. By working together, you can get good advice about the types of questions to ask so that any data you collect will be broadly useful and comparable to information collected by other agencies.

Also consider involving other individuals, from other organizations, in reviewing the survey instrument.

- To the extent that people have had an opportunity to comment on the survey design, they may be more likely to accept the results.

- Of course, if you are going to follow this suggestion, you need to be sure that you are comfortable sharing your strategy in advance with the organizations you include in the design of the survey.

A. High Cost (more than $100,000)

If your group has quite a bit of money to spend, you could conduct a fairly comprehensive, unique community survey. Typically, a group would hire consultants, who would identify a random sample of the target population to survey, hire and train individuals to conduct the survey, and report the survey results in detail to the group. In such a survey, you could ask multiple questions and obtain information that would enable you to relate uninsured status to income, health status, and other characteristics. For example, by collecting household income, employment status, and employer size as well as insurance status, you could determine how many employed individuals at various income levels are insured/uninsured. By collecting information on people's perceptions of their health status, you could use the survey results to talk about the fact that employed working persons rate themselves as healthy "X" times as often as do employed persons without health insurance.

B. Medium Cost ($20,000–$30,000)

This amount of money would enable you to perform a telephone survey of perhaps four or five basic questions. You might ask, for example, "How many people are in your household?" For each individual, you could collect information about age and employment status and ask, "Did xxx have health insurance coverage for all of the last month?" "If yes, what type?" "Did your employer contribute to the cost of this coverage?"

This type of survey will enable you to make some conclusions about the number of uninsured and the relationship of health insurance to employment status, but not too much else.

Of course, if employment status is not the variable of interest to your organization, you could choose another variable to collect information on — for example, income.

C. Low Cost (less than $5,000)

If you don't have much more than $4,000–$5,000, don't despair. You can still collect information about your local community. You just need to be a little more creative about going about collecting the data. As discussed below, some community groups have trained their own volunteers to conduct door-to-door or telephone surveys. Examples of ways to collect information about particular population groups in your neighborhood include:

- Working with the Chamber of Commerce to survey small businesses
- Surveying Girl/Boy Scout members at regularly scheduled meetings
- Surveying Girls'/Boys' Club members at regularly scheduled functions

- Working with the schools and school clinics to survey subsets of the population (for example, students entering kindergarten each year; sixth-graders the first day of school; all who come into the school clinic in a given week; and so on)

- Surveying people at regular meetings in senior citizens' housing complexes

- Surveying residents at specific public housing developments

- Surveying all students interested in participating in a particular school sport

- Adding questions to someone else's survey instrument, even if that survey isn't about health care issues. Political parties, unions, and others frequently question members of the public about various issues. Piggybacking on another survey instrument is usually quite inexpensive.

While the populations you may be able to reach are more limited than those you could reach with more funds, depending on your goal and the question you want answered, these types of surveys may provide you with exactly the information you need.

Use of "Proxy" Measures

If you have absolutely no funds available, or even if you do, you may want to consider using existing information about other issues to help round out the picture of your community. Lack of health insurance is correlated with other social and demographic factors. Data on many of these factors are more readily available than information on the number or proportion of uninsured people. So it may be possible to collect and use "proxy measures" of uninsured status. Among the most important determinants of health insurance are:

Employment status: Although the majority of the uninsured live in families headed by employed workers, people who are not working or working only part-time, or intermittently, are much more likely to be uninsured. If the level of unemployment or partial employment is higher than average in your community, or is increasing, the proportion of people without health insurance is probably also increasing.

Industry: Workers are more likely to be uninsured if they are self-employed or working in certain industries (for example, agriculture, construction, retail trade, personal or business services). If your community has a significant proportion of these types of industries, it likely has a higher than average proportion of people who have no health insurance.

Company size: Almost half of all uninsured workers are either self-employed or working in firms with fewer than 25 employees. A much higher proportion of workers in small businesses lack health insurance compared to workers in larger companies. If your community has lots of small businesses, it probably also has a higher proportion of uninsured people.

Income: The uninsured are concentrated disproportionately in low-income families. Generally, as income increases, the proportion of the population without health insurance decreases (although, depending on your state's eligibility rules, the proportion of low-income people covered by publicly financed programs like Medicaid may also increase). If your community has a relatively high proportion of low-income families, particularly in the income categories that are not eligible for Medicaid in your state, it likely has a relatively higher level of uninsured people.

Citizenship: Citizenship is a primary factor in the likelihood of an individual having health insurance. Noncitizens are much more likely to be uninsured than citizens.

Age: Young adults (aged 18-24) are more likely to be uninsured than those in other age groups. On the other hand, elderly people (aged 65 and older) are much less likely to have no health insurance because of the federal Medicare program.

Race: People of color are more likely to be uninsured than whites. Latinos/Latinas are more likely to be uninsured than other groups, even at higher income levels.

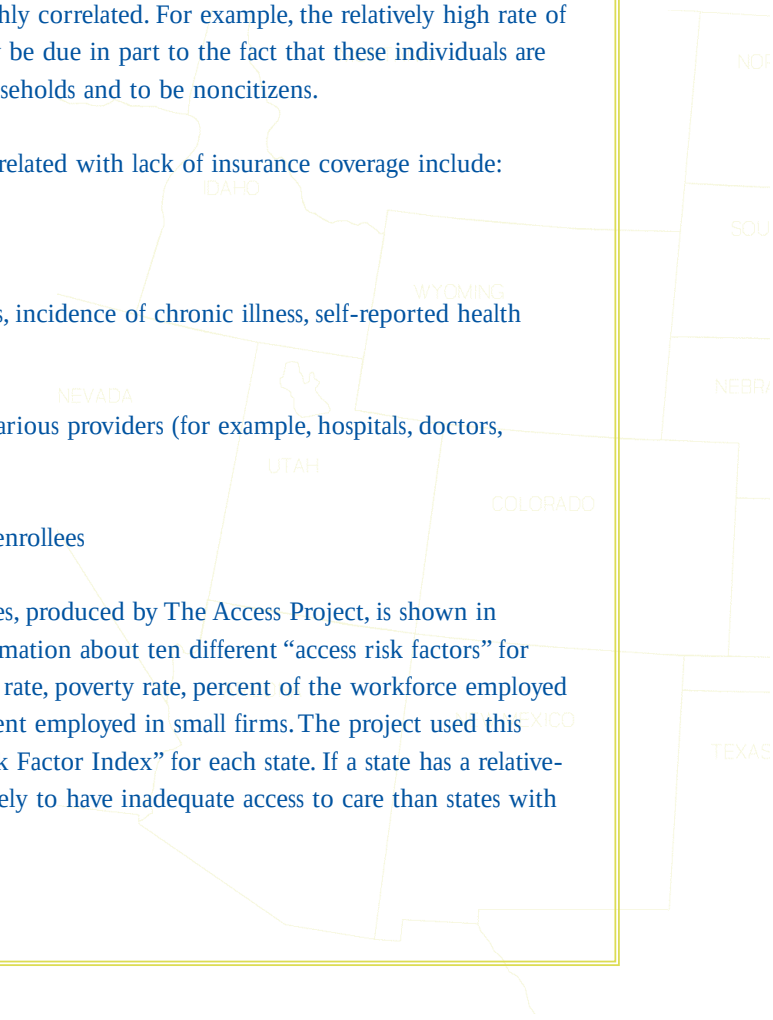
(Your state department of commerce, economic development, employment, or revenue should have data on employment and unemployment, types of industries, income, poverty, and other economic topics. Demographic data are available from the U.S. Bureau of the Census.)

Obviously, many of these factors are highly correlated. For example, the relatively high rate of uninsurance among Latinos/Latinas may be due in part to the fact that these individuals are more likely to live in lower income households and to be noncitizens.

Some other proxy measures that are correlated with lack of insurance coverage include:

- Infant mortality
- Health status measures (mortality rates, incidence of chronic illness, self-reported health status)
- The level of uncompensated care at various providers (for example, hospitals, doctors, community health centers)
- Changes in the number of Medicaid enrollees

An example of the use of proxy measures, produced by The Access Project, is shown in Appendix A. The project collected information about ten different "access risk factors" for each state, including the unemployment rate, poverty rate, percent of the workforce employed in service and trade industries, and percent employed in small firms. The project used this information to compute an "Access Risk Factor Index" for each state. If a state has a relatively high Risk Factor Index, it is more likely to have inadequate access to care than states with a lower score on the Index.



One Idea for Getting Some Free (Maybe!) Help

If you are feeling too overwhelmed and/or too short on resources to take on data collection and analysis entirely by yourself, you may be able to find experts in your community who can help. One possibility to explore is approaching your local college or university. Universities often have faculty members who have experience dealing with some of the data sets described earlier, in particular the census data. People in the academic community may also be able to help you with survey design and data analysis. If you're having trouble finding or understanding the data, try contacting the local university for assistance. Depending on the size and scope of the university, some good places to start could be the university's school of public health, school of public policy, the medical school's community medicine department, or even the economics department. Another way to find the academic experts in your community is to look at relevant published material (for example, articles and books) to see if any of the authors are from your local area. You can also look at recent newspaper articles to see if any of the "experts" quoted are affiliated with local institutions. Even if the experts you find don't live in your area, contact them anyway to find out if they can suggest local resources.

But be aware that most universities do not give their faculty encouragement or credit for helping community groups. So you need to be realistic in your expectations, especially if you are looking for free advice. A good approach may be to see if the appropriate school or department has an internship requirement. Many educational programs, particularly graduate schools, require, or at least encourage, their students to complete internships or field projects at local organizations. And more and more courses are trying to incorporate community projects into the curriculum. Students can be a valuable source of enthusiastic, low- or no-cost labor for community groups. An added bonus is that most programs require the students' work to be supervised or overseen by faculty, which means that you may also get some free assistance from more experienced faculty members as well as help from the students.

Successful Efforts by Community Organizations

CASE STUDY #1:

Using Existing Data Sources: Colorado Coalition for Health Care Access and Coalition for the Medically Under-served

The Colorado Coalition for Health Care Access (CCHA) and Coalition for the Medically Under-served (CMU) have produced three editions of a *Colorado Health Source Book: Insurance, Access & Expenditures.* The most recent version, issued in April 1998, contains 44 charts and tables that provide a wide range of information on the healthcare delivery and financing system in Colorado. Health insurance is a major focus of the source book, and the groups have used a number of existing data sources, including the Current Population Survey, to produce information on the insurance status of state residents by a variety of demographic characteristics. For example, data are provided on the number and percent of Coloradans who are insured and uninsured by age, race/ethnicity, income, work status of family head, employment status, size of employer, and industry.

The book also provides data on the number and percent of people who are uninsured in each county, using a methodology that estimates the percent of the population that is uninsured based on each county's unemployment rate. (For a detailed description of this methodology, please see "Estimating County Percentages of Uninsured People," *Inquiry* 28: 413-419 [1991].) According to the estimates, there is nearly a fourfold difference among counties in the percent of residents who are uninsured.

Although the source book uses publicly available data, the groups do a great deal of data manipulation and analysis to produce the information in the source book. Funding for the 1997 version was provided by the Rose Community Foundation and the Colorado Medical Society Foundation.

For more information, contact:

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Greenwood Village, CO 80111
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CASE STUDY #2:

A Medium Cost Approach to Developing Your Own Survey: The Massachusetts Fisherman's Partnership

The Massachusetts Fisherman's Partnership (MFP), an organization of 18 fishing organizations from around Massachusetts, sponsored a survey in 1996 to collect information about health access and coverage among workers in the state's fishing industry. The survey was a response to serious economic distress and dislocation in the fishing industry, which had left a large number of families without health insurance and with serious problems gaining access to healthcare services. The survey was designed to collect data that could be used to design a health plan, and then predict its costs and integrate it with existing public and private health coverage.

The MFP contracted with Health Care for All, a statewide consumer health care advocacy organization, to conduct the survey. Health Care for All obtained assistance with survey design and analysis from faculty at Brandeis University. To the extent possible, the survey incorporated questions modeled on standard national or state health surveys, tailored to the specific employment and cultural characteristics of the fishing community. (For example, the survey was translated into English, Italian, and Portuguese.) (See Appendix B for a copy of the health insurance questions from the MFP survey.) The MFP assisted with the development, pilot testing, and community distribution of the survey instrument. Caritas Christi, the health system of the Archdiocese of Boston, provided funding for the project. The total cost of the survey was approximately $38,000. (The survey collected a variety of data in addition to insurance status, including health status; usual source of medical care; use of doctors, hospitals, and emergency rooms; and satisfaction with care.)

The survey was distributed by mail to a sample of commercial fishing permit holders, as well as at selected locations in the state's major fishing communities. A total of 485 surveys were returned, representing information on a total of 1,479 adults and children. The survey found that 43% of adults and 34% of children were uninsured — triple the statewide average. Another 9% had had a spell of uninsurance in the previous year. Only half as many fishing families had access to insurance at work as other workers in Massachusetts. Those people without insurance were much less likely to go to the doctor than insured individuals, and they also had significantly fewer days in the hospital.

The results of its survey provided data to confirm what the MFP already knew: individuals and households in the fishing community were greatly in need of improved access to affordable health insurance. Armed with the survey findings, the MFP worked with Caritas Christi and federal and state officials to develop a comprehensive, affordable health plan for fishing families. The survey results were also used in estimating the costs of the program and developing the sliding scale premium structure. The Fishing Partnership Health Plan is now available to fishing families throughout Massachusetts, offering coverage on a subsidized basis to families that meet certain income criteria. The federal and state governments provide subsidy funding. As of September 1998, more than 1,000 people were covered by the plan.

For more information, contact:

Massachusetts Fishermen's Partnership
11-15 Parker Street, 2d floor
Gloucester, MA 01930
Telephone: 978-282-4847
Fax: 978-282-4798

Health Care for All
Attn: Marcia Hams
30 Winter Street, Suite 1007
Boston, MA 02108
Telephone: 617-350-7279
Fax: 617-350-7545

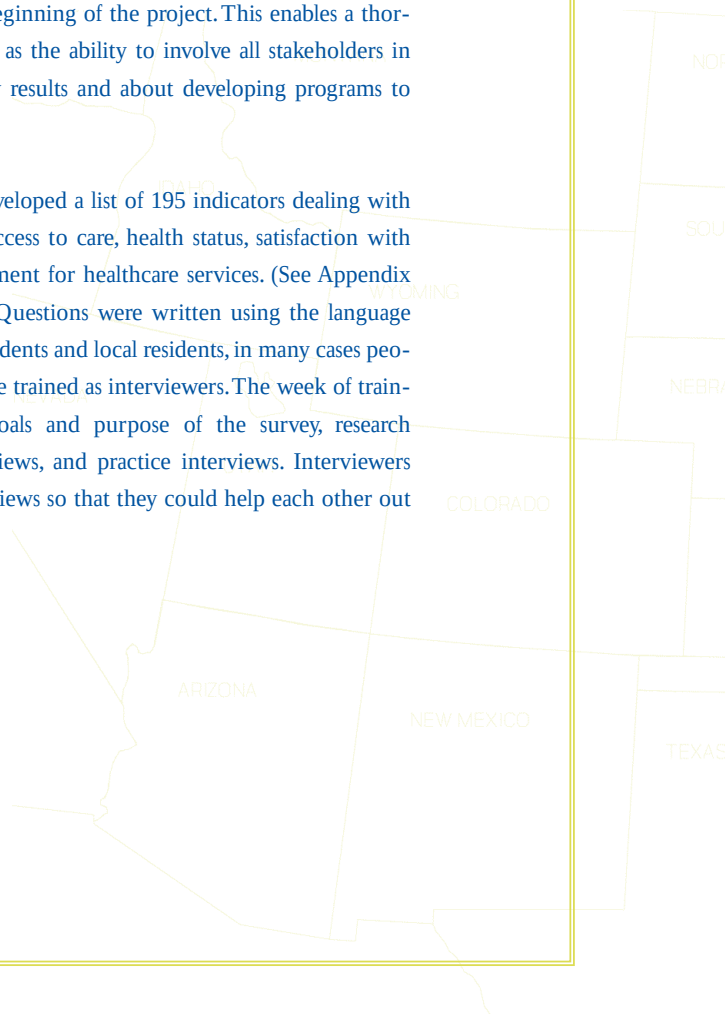
CASE STUDY #3:

Developing Your Own Survey: The Southwest Georgia Community Health Institute

The Southwest Georgia Community Health Institute (SOWEGA-CHI) works in the fourteen counties in southwest Georgia to collect and distribute information to improve the health status of all residents. In 1996, SOWEGA-CHI used funding from The Robert Wood Johnson Foundation's Community Health Leadership Program to develop the capacity to design and conduct a health status survey of households in each of the counties in its region.

When embarking on a survey in a new county, the Institute involves all the stakeholders in the particular county at the beginning of the project. This enables a thorough look at the local problems, as well as the ability to involve all stakeholders in discussions about the meaning of survey results and about developing programs to deal with the findings.

SOWEGA-CHI staff epidemiologists developed a list of 195 indicators dealing with a number of healthcare issues, such as access to care, health status, satisfaction with health care, insurance coverage, and payment for healthcare services. (See Appendix C for a copy of the survey questions.) Questions were written using the language and idioms of the area to be surveyed. Students and local residents, in many cases people looking to leave the welfare rolls, were trained as interviewers. The week of training concentrated on explaining the goals and purpose of the survey, research methods, role plays of telephone interviews, and practice interviews. Interviewers worked in teams for their first few interviews so that they could help each other out of uncomfortable situations.



The interviewers achieved a response rate of 50-60%. This high rate is due to the fact that numerous attempts were made to reach people on nights and weekends as well as during the day. Calls were made until 400 surveys were completed for each county studied. The completed sample size was large by design, so that valid conclusions could be made about various population subgroups.

The goal of the survey was to obtain the information needed to design a system of care to address the day-to-day needs of each area's residents. Survey results have been used by the local hospital to develop new programs, such as having a particular specialist hold office hours one day a week in a particular county, or revising a local hospital's program of providing car seats for children. Appendix D depicts the type of cross-county comparison one can do from a survey of this type.

The goal is to repeat the entire survey every three years in each county. This will enable the group to evaluate the impact of new programs that have been implemented as well as to identify any new problems that may have emerged. In addition, smaller, interim surveys may be done in particular areas to assess particular programs and/or needs.

SOWEGA-CHI also uses the survey information, along with data collected from other sources, to produce a report card for each county in its area of interest. The county report card provides comparative information about the county, the 14-county region, and the state as a whole. For information about risk factors, the county information is arrayed next to the national Healthy People 2000 Goals, so that people can see how the county measures up to numerous public health goals, such as smoking levels, seat belt use, and prevalence of hypertension or diabetes. Counties are left to grade themselves with respect to risk factors and health status indicators, such as number of physicians needed, AIDS rate per 100,000 people, and leading causes of death. (See Appendix E for an example of a county report card.)

The survey cost approximately $30,000 to conduct, which is very reasonable for the number and range of surveys conducted. SOWEGA-CHI was able to keep its costs relatively low by a combination of in-kind contributions, efficiencies in interviewer training, and use of low-cost students to do much of the interviewing.

For further information, contact:

Sandra Handwerk
Southwest Georgia Community Health Institute
500 Third Avenue
Albany, GA 31701
Telephone: 912-439-0020
Fax: 912-889-7384

Dr. James Hotz
Albany Area Primary Care
804 14th Ave.
Albany, GA 31701
Telephone: 912-888-6559
Fax: 912-436-4107

CASE STUDY #4:

A Shoestring Approach to Data Collection: Somerbridge Community Health Partnership

The Somerbridge Community Health Partnership (SCHP) was created to develop a prevention-focused, integrated service delivery system accountable to the residents of Somerville and Cambridge, MA. The Partnership is supported by funding from the Hospital Research and Educational Trust of the American Hospital Association, the Catholic Health Association of the United States, the W.K. Kellogg Foundation, and the Duke Endowment.

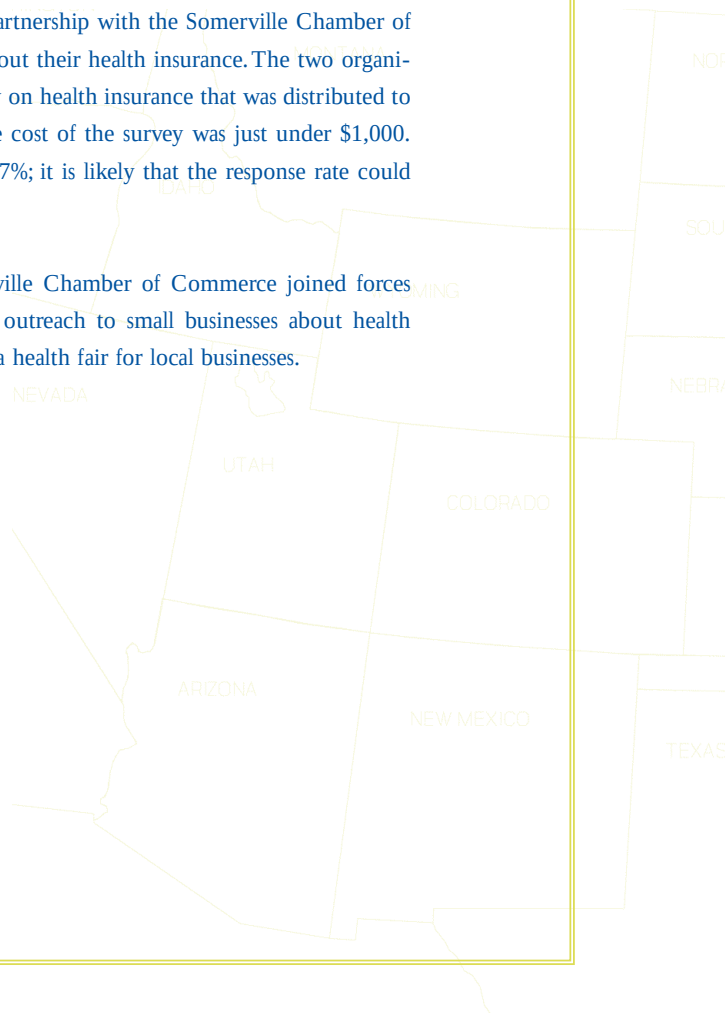
As part of its needs assessment and program development activities, SCHP wanted information on the insurance status of residents of Somerville. It developed two low-cost but effective techniques to collect the data it needed. The first was to add a health insurance question to the mandatory student registration form used in the city's public schools. The insurance question was included in a short section of the form entitled "health information." SCHP also trained the school nurses and parents in the school information centers to screen families for insurance. For the 1998-99 school year, 105 out of 607 new students were identified as having no health insurance. These students and their families were referred to appropriate public and private programs.

The second technique was to work in partnership with the Somerville Chamber of Commerce to survey small businesses about their health insurance. The two organizations designed a short, two-page survey on health insurance that was distributed to all 400+ members of the Chamber. The cost of the survey was just under $1,000. The survey response rate was only 16–17%; it is likely that the response rate could have increased with more follow-up.

Based on the survey results, the Somerville Chamber of Commerce joined forces with area providers and insurers to do outreach to small businesses about health insurance options, including sponsoring a health fair for local businesses.

For more information, contact:

Linda Cundiff
Somerbridge
230 Highland Ave.
Somerville, MA 02143
Phone: 617-591-6930
Fax: 617-591-6948



Resources

This list of resources includes selected specific national organizations. For state agencies and data, we have included Internet locations where you can find information on the relevant agency in each state.

1. Government

Federal Government

- **Census Bureau/Current Population Survey**: Information on the CPS is available from the Census Bureau Web site: www.bls.census.gov/cps. Each state has at least one location that is a repository of data from the U.S. Bureau of the Census. For a list of Census State Data Centers, contact the Customer Liaison Office, U.S. Census Bureau, Room 3612-3, Washington, DC 20233. Telephone: 301-457-1305; Fax: 301-457-4784. Or go to www.census.gov on the Internet.

- **Centers for Disease Control**: Information on the Behavioral Risk Factor Surveillance System (BRFSS), including state contacts, can be obtained from The Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Mail Stop K-40, 4770 Buford Highway NE, Atlanta, GA 30341-3717. Telephone: 770-488-5292. Or go to www.cdc.gov/nccdphp/brfss.

- **Bureau of Labor Statistics**: The BLS is the principal fact-finding agency for the federal government in the areas of labor economics and statistics. A variety of national and regional data on income, employment, and unemployment is available from the BLS Web site at http://stats.bls.gov. Telephone: 202-219-5000 (Washington, D.C.).

State Government

- **State Departments of Health:** To access a list of all state health departments, go to the Association of State and Territorial Health Officers' Web site at www.astho.org (Telephone: 202-371-9090, Washington, D.C.) or the Web site of the American Public Health Association at www.apha.org. Telephone: 202-777-2742 (Washington, D.C.).

- **State Departments of Insurance**: To find your state insurance department, go to the Web site of the National Association of Insurance Commissioners, www.naic.org. Or contact the NAIC at 1125 Grand Avenue, Kansas City, MO 64106. Telephone: 816-374-7231.

- **State Medicaid Agencies:** To find the agency that runs the Medicaid program in your state, contact the National Association of State Medicaid Directors, 810 First Street, NE, Suite 500, Washington, DC 20002. Telephone: 202-682-0100. Fax: 202-289-6555. Or go to http://medicaid.apwa.org/nasmdmembership.

Local Government

- **Local Health Departments**: For links to many local health departments, go to the Web site of the American Public Health Association: www.apha.org. Telephone: 202-789-5600 (Washington, D.C.).

- **Local Public Hospitals**: Contact the National Association of Public Hospitals, or go to www.naph.org. Telephone: 202-408-0223 (Washington, D.C.).

Nongovernmental Organizations

- **The Access Project:** The project, a national initiative of The Robert Wood Johnson Foundation, is assisting communities to develop and sustain responses to health access problems. Go to www.accessproject.org. Telephone: 617-654-9911 (Boston, MA).

- **Center for Studying Health System Change**: A variety of research reports and data bulletins are available, particularly for the 12 communities that are included in the Community Tracking Study. Go to www.hschange.com. Telephone: 609-799-3535 (Plainsboro, N.J.).

- **Community Health Centers**: Contact the National Association of Community Health Centers or state community health center associations, or go to the NACHC Web site at www.nachc.com. Telephone: 202-659-8008 (Washington, D.C.).

- **Employee Benefit Research Institute**: The Employee Benefit Research Institute (EBRI) is a nonprofit, nonpartisan organization committed to original public policy research and education on economic security and employee benefits. The Institute's mission is to advance the public's, the media's and policymakers' knowledge and understanding of employee benefits and their importance to our nation's economy. Go to www.ebri.org. To order individual copies, call EBRI publications at 410-516-6946 (Maryland).

- **Kaiser Family Foundation:** The Web site for the foundation includes a variety of basic information for every state on demographics, health needs, insurance coverage and the Medicaid program. There are also links to other on-line resources. Go to www.kff.org. Telephone: 650-854-9400 (Menlo Park, CA).

- **Robert Wood Johnson Foundation:** The foundation's Web site contains a range of information about projects funded by the foundation, as well as summaries of research findings and data surveys. Go to www.rwjf.org. Telephone: 609-452-8701 (Princeton, N.J.).

- **Schools of Public Health**: To find a school of public health in your area, go to the Web site of the American Public Health Association at www.apha.org. Telephone: 202-789-5600 (Washington, D.C.).

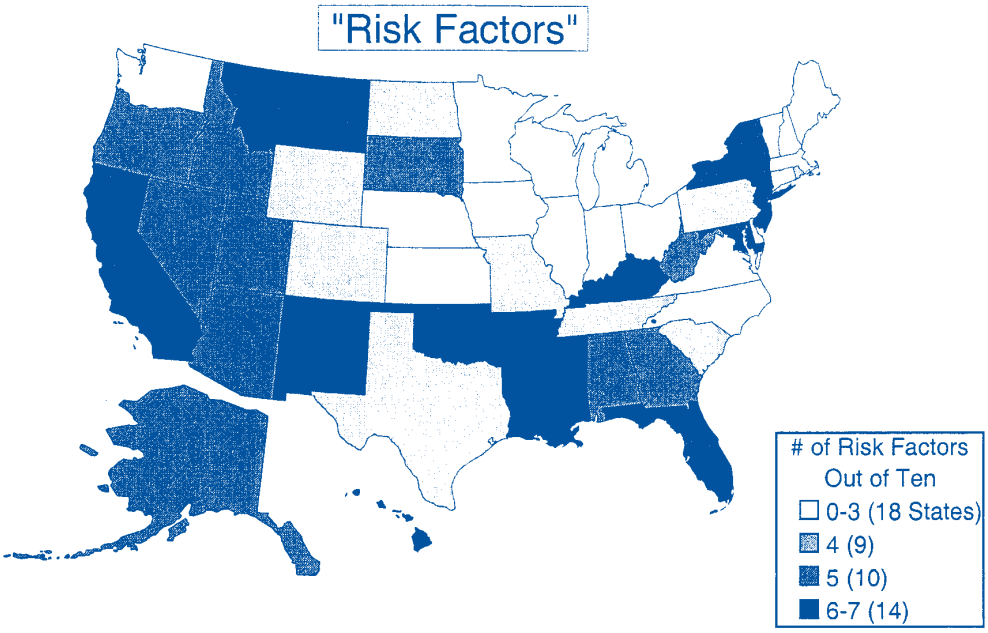
- **Urban Institute:** You can obtain policy briefs and a variety of data from their Web site at www.urban.org. Telephone: 202-833-7200 (Washington, D.C.).

The Access Project would like to thank the authors, Elinor Socholitzky and Nancy Turnbull, for their work in creating this guide.

Elinor Socholitzky is an independent healthcare consultant based in the Boston area. She has more than twenty years of experience in a wide range of organizations, and has worked as a researcher, a senior executive in a health insurance company, and a state health policy-maker. Elinor's undergraduate degree is from the University of Chicago. She received her Master's Degree in Business Administration from Cornell University.

Nancy Turnbull is on the faculty of the Harvard School of Public Health and the Simmons College Graduate School for Health Studies, where she teaches courses on healthcare financing and managed care. She is a former state health insurance regulator. Nancy received her undergraduate degree from Mount Holyoke College and her Master's Degree in Health Policy and Management from the University of Pennsylvania.

NORTH DAKOTA
MINNESOTA
SOUTH DAKOTA
WISCONSIN
IOWA
NEBRASKA
ILLINOIS
MISSOURI
KANSAS
OKLAHOMA
ARKANSAS
TEXAS
MISS.
LOUISIANA



Access "Risk Factors"

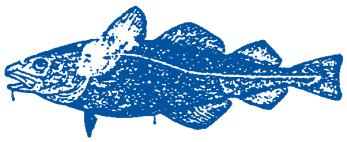
Differences among states in demographics and employment patterns contribute to variation in access. Groups with certain characteristics are more likely to have inadequate access to care, evidenced by higher than average rates of uninsurance or by direct measures of access (such as having a usual source of care or being able to obtain care when needed).

These characteristics can be thought of as "risk factors" for inadequate access.

1. **Uninsurance rate higher than average**
   (16.1 percent in 1997)
   2. Unemployment rate higher than average
   (4.9 percent in 1997)
   3. Poverty rate higher than average
   (13.5 percent in 1996-97)
   4. Percent minority population higher than average
   (17.4 percent in 1997)
   5. Overall HMO penetration rate higher than average
   (25.2 percent in 1997)
   6. Medicaid managed care penetration rate higher than average
   40.1 percent in 1996)
   7. Percent of population underserved by primary care M.D.s higher than average
   (10.0 percent in 1997)
   8. Percent metropolitan population lower than average
   (79.7 percent in 1996)
   9. Percent employed in service and trade industries higher than average
   (54.2 percent in May 1998)
   10. Percent employed in firms with fewer than 100 employees higher than average
   (43.4 percent in 1993)

This does not mean that any state in the nation can be said to have no access problem. Even within states with few risk factors statewide, there may be local areas where elements combine to hinder access.

Fishing Community Health Plan Survey



This survey will be used to design an affordable, comprehensive health plan for people in the fishing community. The plan will be designed and implemented through the efforts of the Archdiocese of Boston and its health network, Caritas Christi, Senator Edward Kennedy, the Massachusetts' Fishermen's Partnership, and other organizations and supporters.

Please assist us in this important effort by answering the survey questions, which ask about the health care, health needs and current health coverage of your family. Fill out one survey per family. If you have any other questions or comments about this survey, please feel free to call Caritas Christi at **617-562-5444**.

ALL OF YOUR ANSWERS WILL BE KEPT CONFIDENTIAL AND NO ONE WILL BE ABLE TO TELL WHO FILLED OUT THE SURVEY.

Question: If I already have health insurance, do I need to fill out the survey?
Answer: Yes. We need everyone's input in order to design the best plan for the community. You may want to switch to the new plan in the future.

Question: I have a history of medical problems. Will the new plan exclude me, like some insurance companies do?
Answer: No. No one will be excluded or charged more for previous medical problems. We ask some questions about your health in order to accurately design the plan's benefits and budget.

Question: Will the premiums be less expensive than what is now available?
Answer: Our goal is to develop an affordable health plan with good benefits.

Question: Will you have to be Catholic to join the plan?
Answer: No. Caritas Christi is a health care system welcoming to all.

Batch No.

INSTRUCTIONS:

Please answer every question by circling the appropriate number (1, 2, 3...) or filling in a blank. If you are unsure about how to answer a question, please give the best answer you can and make a comment in the margin.

This survey asks questions about you, your spouse and the dependent children of you and/or your spouse. **"YOU" refers to the person actually filling out the survey.** You may use the "SPOUSE" column to refer to your spouse or your mate, even if you are not legally married. If you do not have a spouse/mate or children, circle items only in the columns that apply to your family.

SECTION A: WORK

In this section we will be asking questions about the type of work done by you and your spouse. Remember, "YOU" refers to the person filling out the survey.

A-1. What best describes the type of work that you or your spouse do in the fishing industry? *(circle one number in each column)*	You	Spouse
Fisherman(harvester)	1	1
Shore Side Support	2	2
Processor	3	3
Fishing Industry Buyer/Seller/Retailer	4	4
Other work in fishing industry	5	5
Don't work in fishing industry	6	6

A-2. If you or your spouse were out of work or between trips would you be eligible for state unemployment insurance?	You	Spouse
No	1	1
Yes	2	2

A-3. If you or your spouse works as a fisherman (harvester), what best describes your type of work? If you or your spouse is not a fisherman, please circle "does not apply." *(circle one number in each column)*	You	Spouse
Dragger	1	1
Gillnet	2	2
Long Line	3	3
Commercial Hook	4	4
Shellfish/Scalloper	5	5
Lobsterer	6	6
Other Hook	7	7
Aquaculture	8	8
Other	9	9
Does not apply	10	10

A-4 If you or your spouse work on or own a boat, how many people work on the boat, including the captain?	Your boat	Spouse's boat
Write in the number of people here	____	____
Does not apply, do not work on boat *(please check)*	____	____

A-5. Do you or your spouse own a fishing boat?	You	Spouse
No	1	1
Yes	2	2
Own Together	3	3

A-6. What is your main home port? (*please circle*)

Boston	1
Chatham	2
Gloucester	3
New Bedford	4
Scituate	5
Other (*write in*):	_____

A-7. What is the zip code of your **residence**? _____

A-8 What was the main activity of you and your spouse last week? (*circle one number in each column*)

	You	Spouse
Homemaker full time	1	1
Working outside home full-time	2	2
Working outside home part-time	3	3
Student full time	4	4
Not working because of injury or illness	5	5
Looking for work, collecting unemployment benefits	6	6
Looking for work but no unemployment benefits	7	7
Retired	8	8
Other	9	9

A-9. In the past twelve months, about how many total days or months did you or your spouse work in the fishing industry?

	You	Spouse
# of days	____	____
or		
# of months	____	____

SECTION B: CURRENT HEALTH COVERAGE

B-1. At the present time, do you and your spouse have health insurance?

	You	Spouse
No	1	1
Yes	2	2

B-2. At the present time, do your children have health insurance? (*circle one answer*)

All have insurance	1
Some have insurance	2
None has insurance	3
Do not know	4
I do not have children	5

B-3. During the last twelve months, was any member of your family uninsured for at least one month?

	You	Spouse	Children
No	1	1	1
Yes	2	2	2

B-4.. If your family has health insurance, how are they covered? (*circle all that apply*)

	You	Spouse	Children
At work (employer or union)	1	1	1
Insurance you purchased directly from an insurance company or broker	2	2	2
State or federal program	3	3	3
Other	4	4	4
None, no insurance	5	5	5

B-5 If your family has health insurance through an employer, union or other group, who is the subscriber?

You	1
Spouse	2
Other family member not in household	3
Do not know	4
Does not apply	5

B-6. Below is a list of various state or federal programs. Please circle any program which covers you, your spouse or your dependent children.
(circle more than one in each column if necessary.)

	You	Spouse	Children
Medicaid	1	1	1
Medicare	2	2	2
CHAMPUS (military)	3	3	3
Medical Security Plan (unemployed program run by Blue Cross)	4	4	4
Children's Medical Security Plan (run by John Hancock)	5	5	5
V.A.	6	6	6
Other	7	7	7
Not sure which program	8	8	8
None	9	9	9

B-7. Are you or your spouse working out of the house or out of the fishing business just to get medical insurance?

	You	Spouse
No.....	1	1
Yes.....	2	2

B-8a. In the past year, have you, your spouse or your dependent children received free medical care or reduced cost services from a hospital or clinic?

No	1
Yes	2
Don't Know	3

B-8b. Free or reduced cost care from a doctor?

No	1
Yes	2
Don't Know	3

B-9. If you have a health plan now, does it require you to pick a primary care doctor, nurse or clinic for routine care?

No	1
Yes	2
Do not know	3
Does not apply, no plan	4

B-10. How do you and your family usually travel to get medical care?

By car	1
By public transportation	2
By taxi	3

B-11. Please try to estimate how much on average you paid last year for health insurance premiums for the whole family. Fill in whichever is easiest to estimate. Check here if this does not apply to your family: ☐

$ _____ /week $ _____ /month $_____/quarter $_____ /year

B-12. Approximately how much on average do you pay per month for health care costs that are not covered by insurance for the family? (*Including dental and eyeglasses*).

Amount per month $ _____

B-13. If you had to drop your medical coverage because of the cost, about how much were you paying for the family at that time? Check here if this does not apply to your family: ☐

$ _____ /week $ _____ /month $_____/quarter $_____ /year

SECTION C: YOUR FAMILY'S HEALTH

In this section we would like you to answer some general questions about your health and the health of your family.

C-1. In general, would you say your health and your spouse's health is:	You	Spouse
Excellent	1	1
Very Good	2	2
Good	3	3
Fair	4	4
Poor	5	5

C-2. In general, how is the health of your children? (please include all dependent children)

How many children are in **excellent** health? _____

How many children are in **very good** health? _____

How many children are in **good** health? _____

How many children are in **fair** health? _____

How many children are in **poor** health? _____

Do not have children _____

C-3. During the past 4 weeks, have you or your spouse had any of the following problems with your work or other regular daily activities as a result of your physical health? *(Please answer each question yes or no for you and your spouse)*

(Did health problems cause you or your spouse to....)	You		Spouse	
	No	Yes	No	Yes
a. Cut down on the amount of time spent on work or other activities?	1	2	1	2
b. Accomplish less than you would like?	1	2	1	2
c. Limit the kind of work or other activities you did?	1	2	1	2
d. Have difficulty performing the work or other activities? (for example, it took extra effort?)	1	2	1	2

C-4. During the past 4 weeks, how much has your or your spouse's physical health or emotional problems interfered with your or your spouse's normal social activities with family, friends, neighbors or groups?	You	Spouse
Not at all	1	1
Slightly	2	2
Moderately	3	3
Quite a bit	4	4
Extremely	5	5

C-5. Do health problems, such as chronic illness, prevent any of your children from fully participating in school or other activities?

No 1
Yes 2

If yes, how many of your children have these problems? (*Please indicate the number*) _____

SECTION D. CURRENT USE OF HEALTH CARE SERVICES

D-1. Where do you and your family go regularly for medical care?	You	Spouse	Children
Private doctor or group practice	1	1	1
Neighborhood health clinic	2	2	2
Hospital clinic (outpatient department)	3	3	3
Hospital emergency room	4	4	4
Other location	5	5	5
No regular source of care	6	6	6

D-2. How do you feel about the care you or your family receives there?	You	Spouse	Children
Very Satisfied	1	1	1
Satisfied	2	2	2
Somewhat Unsatisfied	3	3	3
Very Unsatisfied	4	4	4
Does not apply	5	5	5

D-3. About how many times did you and your family go to a doctor or clinic in the past year?	You	Spouse	Children
0 to 1 visits	1	1	1
2 to 5 visits	2	2	2
6 to 12 visits	3	3	3
13 to 25 visits	4	4	4
over 25 visits	5	5	5

D-4. How many times have you or your family been to the Emergency Room in the past year?

# of times: _____

D-5. What are the main reasons that you and your family use the Emergency Room? (*you may circle more than one*)

Serious illness or injury	1
Regular doctor or clinic closed	2
Have no regular doctor or clinic	3
Have no insurance	4
Does not apply	5

D-6. In the past 2 years how many days did you or your family members spend in the hospital as an inpatient (overnight) (*if none write 0*)

	You	Spouse	Children
Number of days in past 2 years:	____	____	____

D-7. If your family has used a hospital for any reason in the past 2 years how did you feel about the care you or your family received?

	You	Spouse	Children
Very Satisfied	1	1	1
Satisfied	2	2	2
Somewhat Unsatisfied	3	3	3
Very Unsatisfied	4	4	4
Does not apply	5	5	5

D-8. Please print the names of your family's regular doctor or clinic.
Optional, but this information will help us design the health plan.

Your doctor/clinic _____

Spouse's: _____

Childrens': _____

D-9. Please print the name of the hospital or hospitals that you and your family use. *Optional but this information will help us design the health plan.*

_____

_____

SECTION E: YOUR HOUSEHOLD.

E-1. Please write in the age and circle the sex of each family member. Include only yourself, check off your spouse or mate, and dependent children.

	AGE	Check one MALE	FEMALE
YOU	____	____	____
SPOUSE (or mate)	____	____	____
Child 1 (oldest)	____	____	____
Child 2	____	____	____
Child 3	____	____	____
Child 4	____	____	____
Child 5	____	____	____
Child 6	____	____	____
Child 7	____	____	____
Child 8	____	____	____
Child 9	____	____	____
Child 10	____	____	____
Others: (Please list age and sex)			

E-2. Are you currently:
(*all information is confidential*)

Married	1
Not married, living with mate	2
Divorced	3
Separated	4
Widowed	5
Single	6

E-3. What is the primary language spoken in your household

English 1
Italian 2
Portuguese 3
Other (*please write in*): _____

SECTION F: HEALTH PLAN PREFERENCES

We are very interested in knowing what you value in a health plan. To keep costs lower, some health plans require members to follow certain procedures. Please take a few moments to answer the following questions about your preferences.

F-1. Would you consider joining a plan if it was easily affordable and it required you to get permission from your primary care doctor or nurse to go to other, specialty doctors?

No 1
Yes 2

F-2. Would you join a plan if it was easily affordable and you had to change some or all of your doctors or other caregivers because they were not in the new network?

No 1
Yes 2

F-3. What is the amount of time you are willing to spend traveling to? (*Please Circle*)

	Under 15 min.	From 15 to 30 minutes	Over 30 min.	Does not Matter
Go to a regular doctor or clinic for a routine visit.	1	2	3	4
Go to a specialist (such as a cardiologist, etc.)	1	2	3	4

F4. How many family members (you, spouse and children—not elderly parents) would want to have an interpreter when they go to the doctor or the hospital?

Total number:_____

SECTION G. ELIGIBILITY FOR STATE HEALTH PROGRAMS

To make a health plan for the fishing community affordable, we need to know how many people may currently be eligible for state or federal health care programs.

Please look at the chart below and find your family size in the left column. (Include yourself, your spouse and all dependents). Then look across and find your approximate taxable family income in one of the columns.

G-1. Please circle the letter of the column in which you find your taxable family income last year:

Circle one: A B C D

Approximate Total Taxable Household Income.

Family Size	A.	B.	C.	D.
1	Less than $ 7,500	$7,500 - $15,000	$15,000 - $30,000	Above C
2	Less than $10,000	$10,000 - $20,000	$20,000 - $40,000	Above C
3	Less than $12,500	$12,500 - $25,000	$25,000 - $50,000	Above C
4	Less than $15,000	$15,000 - $30,000	$30,000 - $61,000	Above C
5	Less than $17,500	$17,500 - $35,000	$35,000 - $71,000	Above C
6	Less than $20,500	$20,500 - $41,000	$41,000 - $81,000	Above C
7	Less than $23,000	$23,000 - $46,000	$46,000 - $91,000	Above C
8	Less than $25,500	$25,500 - $51,000	$51,000 - $102,000	Above C
9	Less than $28,000	$28,000 - $56,000	$56,000 - $112,000	Above C
10	Less than $30,500	$30,000 - $61,000	$61,000 - $122,000	Above C
11	Less than $33,000	$33,000 - $66,000	$66,000 - $132,000	Above C
12	Less than $35,500	$35,500 - $71,000	$71,500 - $142,000	Above C

Note: If your income is in column A, you maybe eligible for Medicaid. (Call 1-800-841-2900). If your income is in column B or C, you maybe eligible for the Children's Medical Security Plan (Call 1-800-909-2677), or reduced cost hospital care (Call Health Care For All, 1-800-272-4232).

ID# ____________

Start Time of Survey ________

COMMUNITY HEALTH INSTITUTE STATUS SURVEY INSTRUMENT©

Hello, my name is ________, calling for the Southwest Georgia Community Health Institute. We're doing a study of health status and health care in Southwest Georgia and your number was randomly chosen to be part of our study for your county.

I need to confirm the telephone number that I dialed, is it ________?

Could I please talk to an adult head of the household who lives at this address. ***If someone else is called to the phone, repeat the first paragraph then proceed with the first question.***

1. Is your home in ________ County?

I'd like to ask you some questions about your family's health status and health care. We're asking the same questions of people in Clay County to help us to understand the health of people throughout Southwest Georgia. All of your answers will be kept confidential and any information given will be as a summary so that no one will know your answers. I'll be glad to answer any questions you have about the survey.

NOTE: For persons with additional questions, Dr. Sandra Handwerk can be called at (912) 439-0020.

2. How many people live in your home, including yourself? ________

Please tell me the age, sex, and martial status of each person living in your household, beginning with the youngest. How old is the youngest? Is that a male or a female? ***(indicate respondent with**)***

Age	Sex	Marital Status	
___	___	________	How old is the next youngest? Male or female? Martial status?
___	___	________	How old is the next youngest? Male or female? Martial status?
___	___	________	How old is the next youngest? Male or female? Martial status?
___	___	________	How old is the next youngest? Male or female? Martial status?
___	___	________	How old is the next youngest? Male or female? Martial status?
___	___	________	How old is the next youngest? Male or female? Martial status?
___	___	________	How old is the next youngest? Male or female? Martial status?
___	___	________	How old is the next youngest? Male or female? Martial status?
___	___	________	How old is the next youngest? Male or female? Martial status?
___	___	________	How old is the next youngest? Male or female? Martial status?

ID# _____

If there are children under 15 in the family, ask By their ages, can you tell me if the children are up to date on their immunizations or shots?

	age		
3. Is the	_____	year old up to date?	3.Y or N
4. Is the	_____	year old up to date?	4.Y or N
5. Is the	_____	year old up to date?	5.Y or N
6. Is the	_____	year old up to date?	6.Y or N
7. Is the	_____	year old up to date?	7.Y or N
8. Is the	_____	year old up to date?	8.Y or N

For all say, People go to health care providers when they are sick, but also for visits for checkups when they aren't sick but to keep them well. For children we call these "well child" visits and for adults we sometimes call them preventive visits.

If there are children under 15 in the household say, First I'd like you to think about how long ago each of the children under age 15 went to a provider for a "well child" visit and what provider they saw.

9. _____
10. _____

age		
9-10.For the	_____	year old was that?
11-12 .For the	_____	year old was that?
13-14. For the	_____	year old was that?
15-16. For the	_____	year old was that?
17-18. For the	_____	year old was that?
19-20. For the	_____	year old was that?

A. within 1 month — 11. _____
B. from 1-3 months — 12. _____
C. from 3 to 6 months
D. from 6 months to 1 year — 13. _____
E. from 1 to 2 years — 14. _____
2. more than 2 years ago
{N. never} — 15. _____
{U. unknown} — 16. _____

And was that at

17. _____
18. _____

F. Community Health Center
G. Public Health Department — 19. _____
H. Private doctors office — 20. _____
I. Hospital sponsored clinic
J. Hospital Emergency Room
K. other private (list) _____
{U. unknown}

ID# _____

61. Have any of the adults in your household been told to take medication for high blood pressure or hypertension? — 61. Y or N

62-65. ***If yes, ask*** What is/are their age(s) ***{and sex}***? — 62. _____ 63. _____ 64. _____ 65. _____

Of those told to take medication, how many are currently taking medication?

If yes, age(s) and sex

If no, ask What is the reasons they aren't"t taking mediation?

A There wasn't enough money after paying the bills
B The insurance deductible or co-payment was too high
C Insurance didn't cover the medication
D There was no insurance coverage
E No transportation to drug store

66. Do any of the adults in your household have diabetes or sugar in their blood? — 66. Y or N

67-70. ***If yes, ask*** What is/are their age(s) ***{and sex}***? — 67. _____ 68. _____ 69. _____ 70. _____

Of those told to take medication, how many are currently taking medication?

If yes, age(s) and sex

If no, ask What is the reasons they aren't"t taking mediation?

A There wasn't enough money after paying the bills
B The insurance deductible or co-payment was too high
C Insurance didn't cover the medication
D There was no insurance coverage
E No transportation to drug store

If there are no women in the household, go to Question 80, below.

The next questions are about the women in the household, those 15 years old or older. By age, for each of the women in your household, when did each of them have their last pap smear, which is a special test for cervical cancer that is done during a pelvic examination?

age

71. For the _____ year old was that? — A. within 6 months — 71. _____
72. For the _____ year old was that? — B. 6 months to 1 year — 72. _____
73. For the _____ year old was that? — C. 1 to 2 years — 73. _____
74. For the _____ year old was that? — D. more than 2 years — 74. _____
75. For the _____ year old was that? — ***{N. never}*** — 75. _____
76. For the _____ year old was that? — ***{U. unknown}*** — 76. _____

ID# _____

By age, when did each of the women in your household have their last mammogram (an x-ray of the breast to check for tumors)?

age		
77. For the _____year old was that?	A. within 6 months	77. _____
78. For the _____year old was that?	B. 6 months to 1 year	78. _____
79. For the _____year old was that?	C. 1 to 2 years	79. _____
80. For the _____year old was that?	D. more than 2 years	80. _____
	{N. never}	
	{U. unknown}	

If there are no men in the household over 40, go to question 84 below.
This next question is about the men in your household, those 40 years old or older. By age, when did each of the men in your household have their last prostate exam (when the doctor puts a finger in the rectum to check for cancer or other problems)?

age		
81. For the _____year old was that?	A. within 6 months	81. _____
82. For the _____year old was that?	B. 6 months to 1 year	82. _____
83. For the _____year old was that?	C. 1 to 2 years	83. _____
84. For the _____year old was that?	D. more than 2 years	84. _____
	{N. never}	
	{U. unknown}	

85.	During the last week did anyone in your household smoke at least one cigarette each day?	85.Y or N or U
		86. _____
		87. _____
	85-94 ***If yes, ask,*** What is/are their age(s) ***{and sex}?***	88. _____
		89. _____
	If respondent said no to question 84 but then indicated that doesn't really know, circle both N and U.	90. _____
		91. _____
		92. _____
		93. _____
		94. _____
		95. _____

96.	During the last week did anyone in your household have least one drink of alcohol, such as beer, wine, wine coolers or liquor?	96. Y or N or U
		97. _____
		98. _____
	96-101. ***If yes, ask,*** What is/are their age(s) ***{and sex}?***	99. _____
		100. _____
	If respondent said no to question 95 but indicated that doesn't really know, circle both N and U.	101. _____
		102. _____

ID# _____

I have some questions about everyone in the household. I'd like you to think about how the people in your household get health care. For each person in your household, by age, when was the last time they were sick enough to go for health care? And where did they go for that care?

	age	
103-104. For the _____ year old was that?	A. within 6 months	103._____
105-106. For the _____ year old was that?	B. 6 months to 1 year	104._____
107-108. For the _____ year old was that?	C. 1 to 2 years	
109-110. For the _____ year old was that?	D. more than 2 years	105._____
111-112. For the _____ year old was that?	*{N. never}*	106._____
113-114. For the _____ year old was that?	*{U. unknown}*	
115-116. For the _____ year old was that?		107._____
117-118. For the _____ year old was that?	and was that at a	108._____
119-120. For the _____ year old was that?		
121-122. For the _____ year old was that?	E. community health center	109._____
	F. private doctor's office	110._____
	G. public health department	
	H. hospital sponsored clinic	111._____
	I. emergency room	112._____
	J. other care provider	
	{unknown}	113._____
		114._____
		115._____
		116._____
		117._____
		118._____
		119._____
		120._____
		121._____
		122._____

123. Are any members of your household in school, college, or taking technical or training classes? 123. Y or N

ID#_____

If yes ask, By age, which members of the household are in school, and what type of school and grade are they in?

age	# of Grade level K-9	
124. Is the _____year old in?	A. Preschool or Head Start	124._____
125. Is the _____year old in?	S. Sophomore-high school	125._____
126. Is the _____year old in?	J. Junior-high school	126._____
127. Is the _____year old in?	R. Senior-high school	127._____
128. Is the _____year old in?	T. Technical/training school	128._____
129. Is the _____year old in?	C. Community or 2 year college	129._____
	D. Four year degree program	
	P. Professional/graduate program	

For those members of the household who are no longer in school, please tell me the highest grade in school they completed, by age.

age	# of Grade level K-9	
130. For the _____ year old?	H. High school graduate or GED	130. _____
131. For the _____year old?	T. Technical or training program	131. _____
132. For the _____year old?	C. Community college (2 year)	132. _____
133. For the _____year old?	D. College graduate	133. _____
134. For the _____year old?	P. Post-graduate or professional degree program graduate	134. _____
135. For the _____year old?		135. _____

Please tell me which members of your household are over 12 years old, by age, are employed, work either in or outside of the home, are retired, or are unemployed.

age	A. In a part-time job	
136. Is the _____year old?	B. In a full time job	136. _____
137. Is the _____year old?	C. In more than one job	137. _____
138. Is the _____year old?	D. Homemaker/home worker	138. _____
139. Is the _____year old?	R. Retired	139. _____
140. Is the _____year old?	U. Unemployed	140. _____
141. Is the _____year old?		141. _____

Could you tell me which people in your household, by age, have health insurance, Medicaid, Medicare, or health coverage?

age		
142. Does the _____ year old have?	I. Insurance	142. _____
143. Does the _____ year old have?	D. Medicaid	143. _____
144. Does the _____ year old have?	C. Medicare	144. _____
145. Does the _____ year old have?	E. Medicare + Insurance	145. _____
146. Does the _____ year old have?	F. Medicaid + Medicare	146. _____
147. Does the _____ year old have?	O. Other(list)	147. _____
148. Does the _____ year old have?	*{N. none}*	148. _____
149. Does the _____ year old have?		149. _____
150. Does the _____ `year old have?		150. _____
151. Does the _____ year old have?		151. _____

ID#_____

I'd like to ask you a few questions that are only about you, not the others in your household.

152. How often do you use a seat belt when you drive or ride? 152. _____

A. Always
U. Usually
S. Sometimes
N. Never

153. Have you had a child under 4 in the car with you in the last 3 months? 153. Y or N

154. ***If yes ask,*** How often do you use a baby or child car seat when you have a baby or child under 4 in the car with you? 154. _____

A. Always
U. Usually
S. Sometimes
N. Never

155. Do you regularly exercise for 30 minutes or at least three times each week? 155

A. Always
U. Usually
S. Sometimes
N. Never

156. Do you think that anyone in your household is overweight, including yourself? 156. Y or N

157. ***If yes ask,*** How many members of your household do you think are overweight? 157. _____

158. What is the place where you usually go for health care, is it a 158. _____

A. Community Health Center
B. Private doctor's office
C. Public Health Department
D. Hospital sponsored clinic
E. Emergency Room
F. Other health care provider?
{G. don't have provider/doesn't go for care}

159. You said you usually go to a ***{insert prior response}*** for health care. Have you used other providers in the past 2 years? 159. Y or N

ID# _____

If yes, say Please respond yes or no to each of these reasons that you might have used another provider.

160.	I have another regular provider or specialist	160. Y or N
161.	I was referred to a specialist.	161. Y or N
162.	I was hospitalized for illness, delivery or planned admission.	162. Y or N
163.	My provider moved, retired, or transferred my care.	163. Y or N
164.	I moved and changed providers.	164. Y or N
165.	I went to the Emergency Room for care.	165. Y or N
166.	I lost insurance and had to change providers.	166. Y or N
167.	I use an alternative provider.	167. Y or N
168.	Other _____	168. Y or N
{169.	*Don't know/unknown}*	169. *U*
{170.	*Refused}*	170. *R*

171. When you call your provider to make an appointment for a "well" visit, how long is it before that visit? 171. _____

172. When you call you provider to make an appointment for a "sick" visit, how long is it before that visit? 172. _____

173. How long do you usually have to wait to see your provider once you get to the office? 173. _____

174. How far do you have to go to get to your provider? 174. _____

175. How do you get to your provider, do you 175. _____
A. Drive your own car?
B. Drive a family member's car?
C. Have a family member drive you?
D. Have a friend or neighbor drive you?
E. Take a bus or a cab or taxi?
F. Ride your bicycle?
G. Walk?
H. Other

176. On a scale of 1 to 5, with 5 being the highest, how complete and thorough is your provider in his/her examinations, procedures, and treatment of you? 176. _____

177. On a scale of 1 to 5, with 5 being the highest, how well do you feel your provider explains examinations, procedures and treatment to you? 177. _____

178. On a scale of 1 to 5, how frequently would you recommend your provider to a friend who was looking for a new health care provider. 178. _____

ID#_____

179. In the past six months, have you been able to get all the medical care you needed, such as prescriptions, laboratory tests or monitoring, eye glasses, dental care, provider visits or referrals to specialists? 179. Y or N

If NO, then say, Please respond Yes or N to each of these possible reasons why you weren't able to get all of the care you needed, was it because

180. There wasn't enough money after paying the monthly bills. 180. Y or N
181. My insurance deductible or co-payment was too high 181. Y or N
182. My insurance didn't cover what I needed. 182. Y or N
183. I didn't have insurance coverage. 183. Y or N
184. There wasn't a provider who would accept my insurance. 184. Y or N
185. There wasn't a provider in my area for the care I needed. 185. Y or N
186. I didn't have transportation to get to the appointment. 186. Y or N
187. There was no local emergency care center. 187. Y or N
188. There were cultural or other barriers to my getting care. 188. Y or N

189. Please tell me your race, is it 189. _____
A. African-American
C. Caucasian
H. Hispanic
O. Other
{R. refused}

190. Which of these is your household income? 190. _____
A. less than $10,000
B. 10,000 - 15,000
C. 15,000 - 25,000
D. 25,000 - 35,000
E. 35,000 - 50,000
F. over 50,000
{U. unknown}
{R. refused}

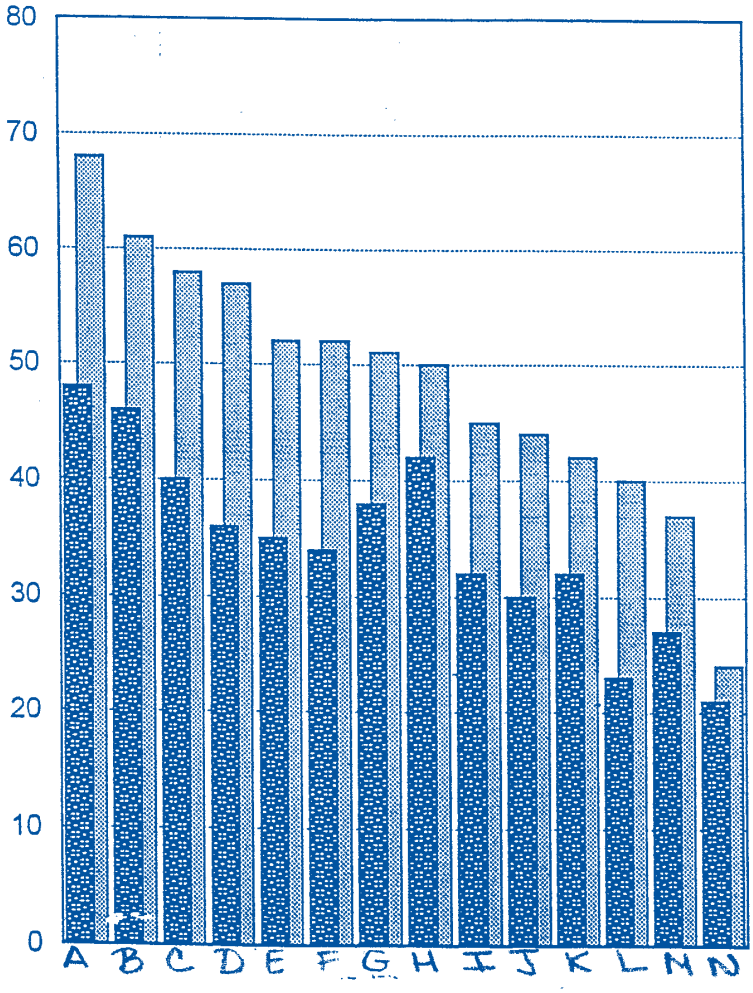
THAT IS THE LAST QUESTION IN OUR SURVEY. THANK YOU FOR PARTICIPATING IN OUR SURVEY ON HEALTH CARE IN YOUR COUNTY.

End Time of Survey _____
Interviewer's initials _____

71.6% of Households With At Least one Member Uninsured Have At Least One Full-Time Worker.

Households With At Least One Member Uninsured

Number of Households and Number of These With At Least One Full Time Worker



Average of households with at least one member uninsured who have at least one member employed full time-71.6%

Source: Health Status Survey, 1996

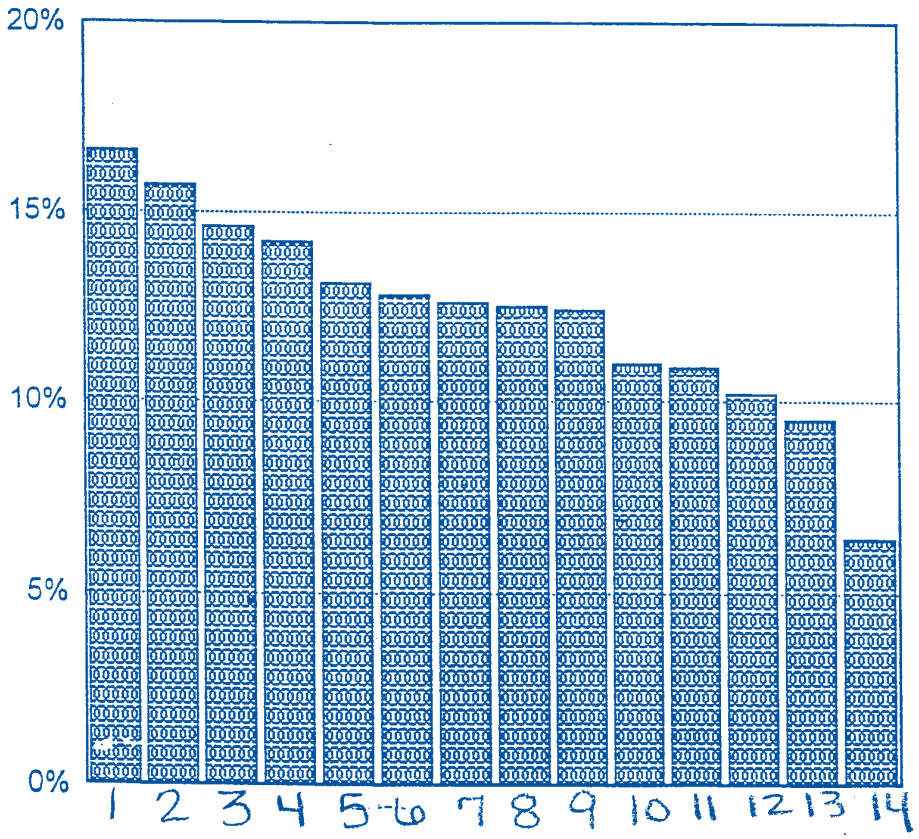
The Voices of Southwest Georgia

Southwest Georgia Community Health Institute

More than 1 in 8 Households Report At Least One Household Member is Uninsured.

Households with at Least One Member Uninsured

Percent



Average % of households surveyed reporting at least one member of the household is uninsured-12.3%

The Voices of Southwest Georgia

Southwest Georgia Community Health Institute

Source: Health Status Survey, 1996

1216 DAWSON ROAD, SUITE 202
ALBANY, GEORGIA 31707
912-439-0020 / FAX 912-439-0036

Building Partnerships for Healthy Communities.

Report Card

THE HEALTH OF COUNTY

We gratefully acknowedge funding for this project from:
Public Health District, 8/2
The Robert Wood Johnson Foundation/
Community Health Leadership Project
Robert W. Woodruff Foundation, Inc.

Introduction

This Report Card is the result of the Health Status Survey, 1996©, which was done throughout Health District 8 Unit 2 between February and July, 1996. This telephone survey was developed with the specific goal of assessing the health behaviors and status of household members in each of the 14 counties in the health district.

In addition to the results for your county, we have included some other information that will help you to evaluate your county's health status; you can review the material and then, in the column provided, grade your county on the specific indicators of health presented.

Our goal was to complete surveys on about 400 households in your county. Because this was done by telephone, we miss an important segment of the population, those households without telephones. Research from many sources have reported that people without telephones frequently have lower income levels, lower educational levels, and jobs with less status, all of which have also been related to lowered health care access and health status. In fact, by including only those with telephones, your county is likely to look somewhat better than it would actually be if we were able to get the same answers from representative households without telephones.

The long-range goal is to have adequate health care available to all residents of southwest Georgia, and elsewhere. When we consider the levels of health status reported here, which may be better than that of all county residents, we see why there are more premature deaths. Only when we can improve the factors that lead to disease and death can we begin to reduce the premature deaths due to heart disease, stroke, and accidents.

We are presenting these results so that you can begin to understand the kinds of factors that indicate how good or bad the health of a community is likely to be. We also are presenting comparison rates of these factors and some common diseases that lead to high levels of death, specifically from heart disease and stroke. We hope that you will use this report card to begin a broader discussion with your colleagues, family, and friends, as a spring-board to promote making decisions which can result in improved health throughout your county.

Explanation of the Questions

The questions in the Health Status Survey, 1996©, were developed specifically to elicit responses reported on the previous pages. The following describe the context of the individual questions asked, although only selected categories of responses appear in the report card. (Topical areas are in bold for easier coordination with the prior pages.)

Respondents were asked whether their **race** was African American, Caucasian, Hispanic, or another category.

Marital status was asked for each household member, selected responses are reported for each household member 15 years of age or older.

Level of **education** completed was asked for those no longer in school; categories reported reflect low, moderate, and high levels of educational attainment.

Type of **insurance** coverage or third party payment for medical care was asked for each household member; reported are the percent of household members who do not have any insurance or other third party coverage.

Respondents to the survey were asked several two part questions, if they said yes to the first part they were asked the second part.

Respondents who thought someone in the household was **overweight** were asked how many household members they thought were overweight. We report percent of households with overweight members and perceived prevalence of overweight.

Respondents who reported that someone in the household **smoked** at least one cigarette each day for the past month were asked the ages of those who smoked. Reported are the percent of households with at least one person who smokes and the percent of household members who are or who live with a person who smokes.

Respondents were asked several questions about their own behaviors and not those of all household members.

We asked how often they **exercise** 30 minutes or more at least three times a week; reported are the percent who always or never exercise at that level.

We asked how often they **use a seat belt** when riding or driving; reported are the percent who always or never use a seat belt.

For those who ride or drive with a child under 4 years old, we asked how often they **use a child car seat**; reported are the percent who always or never use a child car seat.

Each respondent was asked what is their **usual source of health care**, within a broad range of provider possibilities. We report the percent of respondents reporting that the county health department is their usual source of health care.

Respondents were asked about household members who have hypertension and diabetes. These are closely linked, as are their risk factors, to the leading causes of death found on subsequent pages, particularly coronary heart disease and stroke.

The prevalence of **high blood pressure or hypertension** (per 100 persons, a percent) is reported for those 18 years old or older.

The prevalence of **high blood sugar or diabetes** (per 100 persons, a percent) is reported for all household members.

Respondents were asked how long ago each household member had their **last dental visit**; reported are the percent with a dental visit within one year.

A

County Health Status Survey

The following tables are the result of the survey in County, with comparisons to Georgia or Healthy People 2000 goals. We have included a column to grade your county on each of the indicators.

A Superior
B Good
C Needs Improvement
F Needs Immediate Action

Demographics:	County	Georgia**
Number of households	411	2,366,615
Number of members	2.8 Per household	2.66 Per household
Race		
Black	42%	27.4%
White	56%	71%
Gender		
Male	46%	27.4%
Female	54%	71%
Marital Status		
Married	57.4%	56%
Single	32.4%	27%
Divorced	1.9%	10%
Education		
<9th grade	17.8%	12%
High School Graduate	53.6%	29.6%
College Graduate or above	10.6%	6.4%
Income		
<$10,000	28%	20%
>$50,000	9%	28%
Insurance		
Uninsured	11.4%	12.4%

*Georgia Behavioral Risk Factor Survey **1996 Georgia County Guide

***1994 National Household Survey on Drug Abuse

Risk Factors:	County	Healthy People 2000 Goals	Grade
Overweight			
Households	52%	20% adults over 19	
Individuals	27%	15% children 12-19	
Smoking			
Households	36%	15% adults over 19	
Household Members Living with a Smoker	40%	20% passive smoke exposure	
Drinking			
Households	17%		
Individuals	11%	54%, 1 or more drinks in the last month***	
Exercise			
Always	37.4%	20% over age 17	
Never	38.6%		
Seat Belt Use			
Always	66.4%	85%	
Never	4.2%		
Child Car Seat Use			
Always	90.6%	85%	
Never	2.6%		
Disease Prevalence:			
Hypertension	24.4%	18.0%*	
Diabetes	8.3%	2.5%	
Access to Health Care:			
Dental Visit Within Last Year	58.9%	70% of adults age 35 or over	
Health Department for Care	14.8%	Not Applicable	

County Health Status Indicators

Demographic Indicators:	County	Region	Georgia
1995 population	3,766	334,561	7,200,882
%<20	33%	32.6%	29.9%
%>65	13.1%	13.5%	10%
%African-American	52.4%	44.2%	27.3%
%White	47.5%	55.4%	70%
%Other race	0.7%	1.9%	3.4%

Economic and Education Indicators:	County	Region	Georgia	Grade
1989 Median Household Income	$18,489	$20,279	$29,021	
1990 % Not Completing High School	46.4%	42.3%	29.1%	
1994-1995 %High School Dropout	N/A	8.6	9.1	
1995 % Unemployed	7.9%	6.7%	4.9%	

Health Status Indicators:	County	Region	Georgia	Grade
Additional MDs Needed	6	186	1988	
AIDS Cases	2	474	14481	
AIDS Rate/100,000	53.1	110.7	201.1	
AIDS Rate/100,000	53.1	110.7	201.1	
TB Cases	0	38	746	
TB Rate/100,000	0	10.45	10.4	
Deaths per 1,000	10.5	10.4	8.1	
Leading Causes of Death Rate/100,000:				
Acute Myocardial Infarction	167.7	117.1	74.7	
Other Heart Disease	90.7	100.4	92.3	
Cerebrovascular Disease	79.7	75.6	55.8	
Ischemic Heart Disease	495	69.2	62.3	
Lung Cancer	55	56.7	53.5	
COPD	27.5	43.6	35.1	
Influenza and Pneumonia	38.5	42.7	29.4	
Motor Vehicle Accidents	46.7	22.9	21.2	
Accidents	46.7	24.7	19	
Diabetes	N/A	22	15.6	

Socio-Cultural Indicators:	County	Region	Georgia	Grade
1990-1994 Teen Pregnancy Rate/1,000	40.2	53.7	55.3	
% Low Birth Weight	18.2%	11.2%	8.6%	
Unwed Birth Rate/1,000	27.1	35.5	23.5	
1994 Infant Mortality Rate/1,000	45.5	12.8	10.1	
% Below Poverty	24.8%	25.1%	14.7%	
%Medicaid	31.3%	29.2%	16.7%	
%Food Stamps	20.9%	20.9%	11.4%	
%SSI	6.7%	5.5%	2.8%	
%Social Security	17.9%	18.5%	14%	
%AFDC	8.6%	9%	5%	
Index Crime Rate/100,000	677.1	3287.3	5641.5	

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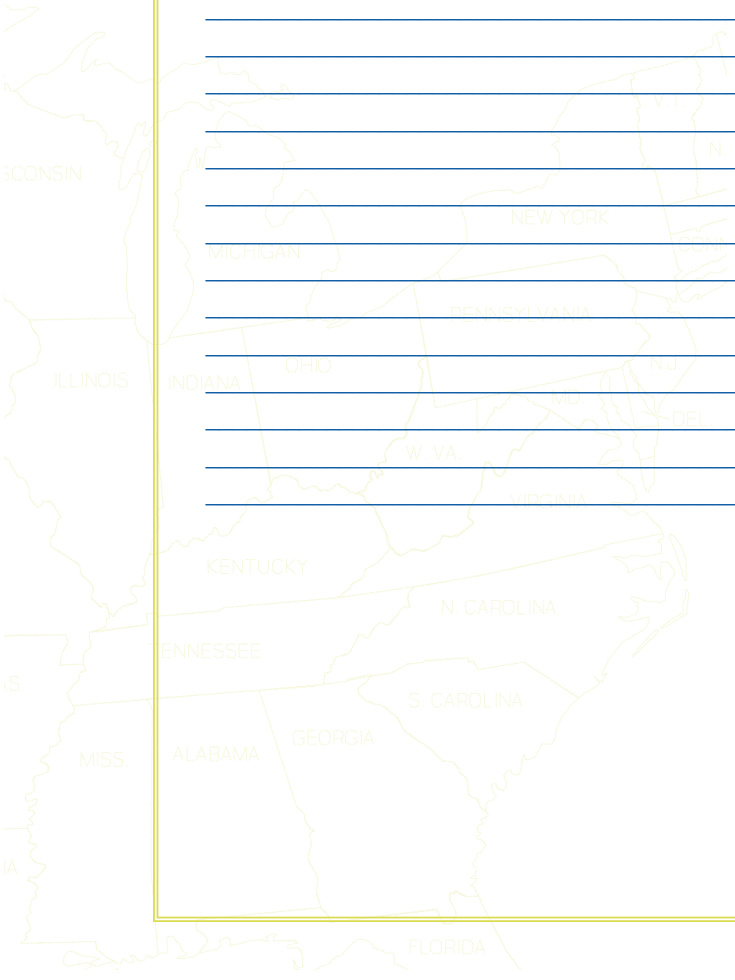

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