"An assessment of health care in Long Beach, California: How healthy are we?"

A field research and ease study project.

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Introduction:

In starting our research, we feel it necessary to clearly define what we mean when we employ terms often used in (public) many different contexts. The main focus of our research is to assign a 'grade' to the health care system in Long Beach, California. The criteria we base this grade on is based on community (humanitarian) benefit, the success rate, access, the end result, and restrictions. We consider the practicality, and influence of free clinics, and corporate medical facilities. To do this, we will define what we mean by fair and affordable, available, grade, and scope.

By using the terms, "fair and affordable," (in reference to health care) we feel this means health care services that are readily available to all those who seek it; and at a reasonable price, and not based to a person's economic level. In that frame of thought "available," (to our paper) means a system of conveniently located health care facilities, close to all manners of transport, with a flexible of hours of transportation, and the enthusiasm of staff members to discuss the services preformed. The "Grade" to be assigned will be a traditional letter grade allocated on our facilitator's rubric, and corresponding to the criteria set forth. This is based on the ability of the Long Beach health care system to: prove functional; the level of cooperation; their goals (set and reached), and being of a benefit to the community. The scope will be an overview of the health care provided, the satisfaction of client base, cooperation, and future plans. The term "range" is the variety of services, and the amount of clients served as a whole versus the amount services being provided. "Alternative Medicine," will be discussed for its general purposes, and is defined as a rational alternative method of treatment, in comparison to "traditional care" of the established status quo of the medical community; a practice only utilized by one percent of licensed practitioners (doctors).
Origin(s) of Long Beach Health Care:

The history of Long Beach, before 1850 was somewhat difficult to find, at least accurate information was lacking without the help of the city. However, there is a vast amount of information of Long Beach in the early, and mid 1900's. The following examples illustrate how cultural norms and medical technology helped to move our community forward. Long Beach has a long history (from an anthropological viewpoint) of being on the cutting edge in moving frontward with our health care, and communities.

If we look at our city culturally, as well as medically we see our pattern of exploration and enculturation; the medical advancements are quite impressive:

- 1900, infant mortality, and maternal mortality had decreased 90-99%
- 1901, identified tie linking drinking water, and dental care
- 1931, research discovered fluoride, and dental care was identified
- 1940, introduction, and, use of antibiotics
- 1950, cardiovascular disease decreases
- 1977, small pox infection was irradiated

In 1900 information concerning contraception and contraceptive devices was illegal in U. S, and the realization of contraceptive practice increased the infant (and maternal) mortality rate over ninety percent (Stats book 23). Most of the above advances are documented in the department's Health Statistics report, a report put out by the city to the public. In the report, the director, Mr. Ronald R. Arias, states:

Since its inception in 1906, the health division has locally developed and implemented programs and services to reflect Long Beach's diversity, for 96 years, the Health Department has played a vital role in shaping the health of the community.

The Long Beach health department is top-rated, the department tries to help our community, and according to Mr. Arias, "We feel a strong commitment to work in partnership with our community members to improve the quality of life for all Long
Beach residents (Stats 8).” The statistic report (stat book) says a picture of the overall health of Long Beach, from designing programs of awareness of health risks, to meeting the needs of Long Beach's diverse, 'and dynamic' population is succeeding in their mission. The founder(s) of the department are not mentioned, but the Department of Health and Human Services 'Mission Statement' is:

The mission of the city of Long Beach department of Health and Human services is to improve the quality of life for the residents of Long Beach by addressing the public health and human services needs, ensuring that the conditions affecting the public's health afford a healthy environment in which to live, work, and play.

The city and citizens of Long Beach strive to move forward while honoring our culture from the past, and a prime example is the growing gay and lesbian community in our city. Long Beach welcomes our gay brothers and sisters, but it is unfortunate that some of the gay community practices risky sexual behavior. This, coupled with the overall lack of general health care makes the lack of safe sexual practices and direct contributor to the rise of Chlamydia, Gonorrhea, and Hepatitis C in the (male) gay community. You will notice in our media coverage section, we list a public service announcement for S.T.D's. The example we use, the add calls for young men, is a military parody to "do your duty", and it is reference to the rise (spread) of a Gonorrhea public service announcement.

**Clients:**

We found through formal, and (mostly) informal interviews--utilized by a questioner to get an opinion poll from a cross section of the insured demographic--in Long Beach the persons with insurance are happy with their level of coverage. Our subjects ranged from ninety-five, to nineteen, and the questioners were factored into the grade assignment. It was not possible to factor any spatial data from the uninsured
element of Long Beach, but we address them in a later section. We are unable to obtain very much data on these client interactions (insured), to consider the possible attention, and care of providers offered to clients. We did notice that even less than helpful staff members only became less than helpful when they found out we were not patients. Our subjects that we use as examples in our sample data (questioners) represent the wide diversity of our city; those polled all covered by various forms of insurance.

- Subject one, 61, white, upper-middle class, and in moderate health, and diagnosed obese, insurance is provided through a PRO, and the subject has prescription benefits.
- Subject two, 84, black, in stable health, covered by a PRO, with prescription drug benefits.
- Subject three; 39, white, living with hepatitis C, and mild depression, subject receives S.S.I (Social Security Insurance) otherwise are in fair to good health. Subject's insurance is provided by 'Medical, 'and be also has prescription drug benefits.

The opinion we encountered (from the sparse participation of potential subjects) was that people that have a health care provider, graded with high marks for both treatment and prescription drug benefits. The large gap was the clients of so-called free clinics, or state run health systems, as we did not easily locate these facilities. We had to wonder if two (motivated) college students had a hard time, what chance would an illiterate immigrant have. We tried tirelessly to interview non-English speaking persons, but found that these people would not answer our questioners, and were less than fourth coming. We feel these individuals are of a migratory faction, the migrant worker(s), illegal alien(s), and even the ignorant, are all not covered by insurance, and are all victims. Sadly, many working class people with families have no health coverage (like a homeless person). Due do the difficulties, and the problems exclusive to the poor; such as moving often, and a less healthy diet, it goes to say that this unstable lifestyle adds to health problems. These are the 'citizens' with no health care, people indigenous to an
area migrate for various reasons, most of these citizens fall under the classification of uninsured (along with lower middle class families, and single adults). This was partly the reason they were skeptical about any discussion. In contrast to the under insured Hispanic population, is the reality that between 1998 and 1999 the number of live births for the Latin population doubled that of any other group, with a live birth rate of 43,000 (Stats 39). Not all these births were that of migratory and illegal residents, but the number should be more reflective of the coverage these groups receive in relation to health care. The richer the medical community grows, there seems to be a mirror image of the impact on the poor, sinking deeper into poverty with fewer free clinics and means to find health care. The burden is not relieved by the reduction in health care workers, or facilities. In Long Beach, the number of medical facilities being opened in poor areas, in shrinking fast, in comparison to the medical facilities opening in middle-class areas.

The (anthropological) visions of the past are not relevant today, as the Medicine Men, Shaman, and Healers of old, being revered in the village with places of respect in the tribe. Today in western medicine, the doctors have a position of prestige, but in our society (and city) these healers are more concerned with money than people. The socio-economic status of a person, and their health concerns need to be on the person, not the 'profit to patient ratio." Instead of our overall health outside concerns drive the level of treatment, as doctors treat people with concerns of malpractice law suits and insurance rates. Every agency, and company we contacted, from the Mayor, to H.M.O's, ignored our repeated contact attempts. This is unfortunate, as the level of cooperation is a high ranking piece of the rubric, so the low marks should serve as motivation to cooperate with future studies. The rings true from the smallest single doctor (P.P.O) to the Mayor herself as redirecting e-mails, providing empty promises, and a lack of cooperation (and discussion) from the current administration are laughable. We had no luck in contacting
any representatives to discuss the health care system in Long Beach, and sadly, this is a
driving factor of our contemplation of a low grade, and we fear it is a current trend.

Follow the Money:

Follow the money; how much money is generated by co-pays, and insurance
premiums, and what is the profit ratio for the heads of the corporations involved? How
much do clients pay? Do clients pay reasonable fees for medical services rendered at so called "free"
facilities, in comparison to H.M.O / P.P.O's? One such facility is the Chestnut street clinic. Is it actually
free, or on a pay what you can basis? Is that more than co-pay? What do they get for payment, and are
treatments equal? Why the (if any)
difference? And are the services as bad as our limited access indicates at free or low
income clinics? Are there similar complaints from clients of P2.0's, H.M.O's, and "Free
clinics?" Are both sides corporate owned, and if so by what corporations? These are the
questions we were not able to answer. The money trail, was the most uncooperative of
all, and we hope the Mayor's office will look into this, and, or aid future researchers. We
were lucky to find several clients to discuss their personal experiences in relation to the
high cost of minimal coverage; as corporate revenues soar and dwindling individual
rights. The following three subjects were gracious enough to give us an interview:

- Subject one, spends $613 a month for her family's health insurance, 24%
of her income. Rather than go without coverage, she sacrifices other
needs; her heat has been shutoff, and recently dropped her car insurance.
- Subject two, 52, years old and is a dress store owner in East Los Angeles;
half her income on medical insurance. She has recently given up her cell
phone; clothing from garage sales; longer turns on her heat.
- Subject three, closed his company after 17 years in industry; stopped his
family insurance policy; citing rising cost.

These sacrifices for health insurance will increase as insurance costs rise, and
more people (even healthy ones) are making drastic changes to afford insurance.

numerous people are delaying homeownership, delay saving money for their children's
college funds, or sacrificing wealth to ensure low cost medical bills. Many people, especially lower and middle-class workers and the chronically ill, are spending an unimaginable amount of their income on medical insurance. Also, in many cases medical insurance has become the number one priority before purchasing houses, cars, etc. Between 2000 and 2004, the amount of people spending over twenty-five percent of their income (which is a figure normally tied to homeownership) went up nearly a twenty-five percent (Washington D.C. based families USA, 2000-2004). At the same time period, a nationally celebrated, Southern California based healthcare insurance rose their premiums at an avg. of fifty-nine percent, and the employees' incomes rose twelve point nine percent. This could be the growing trend of "house-rich, cash-poor", as those who spend most of their income on housing, and hold on to their medical insurance are known as the "insured poor."

Impact

Eventually, people will join the almost 45,000,000 Americans without medical insurance. Estimates show that in California, costs are rising faster than the rest of the nation, and will continue to rise four times as fast as salaries will. In 2003, California costs went up to fifteen point eight percent while the rest of the country lingers at thirteen point nine percent, with more employers capping their spending on health coverage.

In that case, the employees pay for all rate increases, and there are companies dropping insurance. There are so many providers that a rational person would think the high prices would bring a decreased demand of healthcare which would eventually bring down the prices, but the prices are stagnant and the corporate facilities even hesitate to staff hospitals properly. We found where nurses are needed to fill empty beds; some Long Beach health care facilities are making an effort to provide the best care to the community. For example, and according to an ABC news internet article, "California
hospitals are scrambling to meet first-in-nation nurse staffing ratio", a ratio of one on duty nurse to a five patient ratio (ABC.COM). The facilities are looking to private staffing sources to find the nurses, and closing beds, or holding people in emergency room longer to ease overcrowding. It is not going well, as another article states, "...even if money came down from heaven to pay for all the additional costs, you still can't find the nurses (Jablon, 1)"

The impact on the community provides us a good indicator to add into our grade; are the providers doing a good job (providing) by us (the people they serve) or are the patients a means for bank accounts to grow. Do the providers, and drug manufacturers, and sales people, have the best interest of the residents of Long Beach in mind. How are these corporations encouraged, or discouraged by our state and local governments. What are the consequences for maltreatment of the compact with the general public? There are a multitude of questions we need answers to: How is the impact helping, or hurting our community; Are the clients served; did Uncle Joe have a chance to live, or at least to die with dignity? We considered this fact: illness takes our lives, but does the city facilitate a sound, reasonable prognosis and (or) solutions that give a patient the equal time to die, as they do to live? Does the impact of more nurses, or less corporate profits, or even more so, intervention from the local and state government, 'impact' our citizens. If so, what fraction of the health needed to live a better life do we receive? When people live fuller lives, they contribute more to our society as a whole, and then we all benefit, but this is where the City also falls short.

**Risky Sexual Behavior:**

The sole problem does not lie with the doctor, pharmaceutical manufacturer, or health maintenance organization; as we must all accept personal responsibility. Take for example the sexually risky behavior of younger, homosexual age groups, risky sex without
protection, and the rise of sexually transmitted diseases. The sexual promiscuity of some types in the group is having unprotected sex, and this is contributing to the rise of Chlamydia, Hepatitis C, AIDS, and gonorrhea. The rise is mainly in the age groups 20-30, ethnicity was a factor, but all groups reflected higher numbers. However, the city has launched an awareness campaign to address the rise of sexually transmitted diseases in the gay community. The example of an awareness PSA commercial: "Syphilis is on the rise in Long Beach" a military parody commercial. The awareness commercial (aired; 10:55, 03/03/05) was a safe-sex advertisement called for all able bodied gay men to report for duty, "It's your duty to have protected sex."

The (UN) insured:

The uninsured, in contrast to the "insured" is the truly appalling, or dirty secret or our society. People that, for one reason or another has no (job related insurance) health care, period. It is unfortunately the biggest disparity in the health in Long Beach, and a very un-factorable element, as our consideration of the grade assignment for the (level of quality) health care in Long Beach. In America today, some of our fellow citizens matter less than others, even in the health insurance they have, or require. In the article from the web site find articles, titled, "Cutting to the heart of the theory the latest on charity care litigation", Frank Fedor writes:

The nation's not-for-profit hospitals, which represent 85 percent of the industry, are at the center of a growing debate. As of November 2004, 70 lawsuits had been filed in federal court, with the cases targeting nearly 300 facilities these people live in unpleasantness we can not imagine, and that lifestyle only adds the risk of health related problems.

The number of insured is, in fact, not an accurate measure of those indeed, living without accessible, affordable health care. With mountains of paperwork to fill out, just to join free systems like Medi-Cal, or welfare, discourages people from participating.
For people with the occasional flu, or blue collar-work related injury this is not appealing, especially when the process takes thrice as long as the aliment to run its course. This is also a big factor in the assignment of a grade; the treatment of the uninsured, or indigent, is at the center of a growing debate as the collection, and billing practices are out of control. These corporations are harassing, and treating the uninsured in a less than honorable manner for their billing and collection practices toward uninsured patients.

Summary and Conclusion:

Summary of Long Beach health care system; the level of coverage by insured residents of Long Beach is very favorable (to above average), until the potential corporate profitability versus (non-financial) community betterment is factored into the equation. The grade drops from the sexual risks, as a local health problem, but the city addressing the issue is in their favor. The lack of any (all) cooperation, the second highest factor pulling down the grade is the uninsured-factor versus corporate profitability. Overall, the grade that the health care system in Long Beach earns is a "C" (barley). We it important to note that the problem with the system in not only here in our city, but Nationwide it is a growing problem that deserves further research. In addition to our grade we recommend the following:

> The increased involvement of city officials, departments, and people.
> Larger research teams (with two-person teams to focus on a sub-category)
> More cooperation from health care providers.

So, in grading our city, in comparison to the national standard, the Long Beach system earns the "C" because it has problems, but is far better than impact on our community than other equal-sized systems. We are ahead of most of the nation, however this should not lead to the complacency, as the future (and its problems) will be here before we know it.


Appendix A (Media coverage)

A PSA commercial "Syphilis is on the rise in Long Beach" a military parody commercial, aired at 10:55, on Thursday the 31 of March."

questioners were factored into the grade assignment. It was not possible to factor any spatial data from the uninsured.


