Office of Health Plan Policy and Research

Statewide Household Survey on Health Care

Summary Report

August 2001

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EXECUTIVE SUMMARY

The Statewide Household Survey on Health Care, conducted by Oregon Health Plan Policy and Research, and Portland State University's Survey Research Laboratory, produced the following findings.

ATTITUDES RELATED TO HEALTH CARE

Health care is a top issue for 65% of Oregon residents.

- Only 4% put health care at the bottom of the list among important issues facing Oregon today.

Few Oregon residents feel the health system is working well.

- Most feel fundamental change is necessary (56%) or so much is wrong that the entire system needs to be rebuilt (18%).

Most Oregon residents believe health care should be a basic right, but they are less certain about requiring people to have health insurance.

- 71% of respondents strongly agree and 18% somewhat agree that health care should be a basic right for all, just as education is a basic right.
- At the same time, a slight majority (54%) opposes mandatory health insurance.

Opinion is divided on whether the Oregon Health Plan (OHP) should be extended to Oregon residents who are not U.S. citizens.

- A slight majority of respondents favored inclusion of noncitizen residents (55%).

PRIMARY CONCERNS

Inequities in the healthcare system are the most common "number-one problem" for Oregon residents.

- About one-third of respondents mentioned the need for universal health care or more coverage assistance for disadvantaged groups, like low-income, children, seniors, working poor, self-employed, or middle class.

The problem of high costs is another common "number-one problem" for Oregon residents.

- In addition to those respondents who mentioned the problem of high costs in relation to extending access to more Oregonians, another 16% of respondents were concerned about costs in general.
- An additional 11% of respondents were most concerned about pharmacy costs.

The delivery of health care is a "number-one problem" for many Oregon residents.

- 13% of respondents were most concerned about the availability of treatments for specific conditions or specific groups, as well as better quality of care, better organization and integration of services, and in a few cases, better regional access to care.

Issues with insurance companies or health-maintenance organizations are the "number-one problem" for many Oregon residents.

- 6% of respondents were most concerned about unwelcome management of medical services by insurance companies.
- An additional 6% of respondents mentioned problems related to insurance administration, using words like "selectivity," "choice," and "coordination."

PREFERENCES FOR INSURING MORE OREGONIANS

Options for extending health coverage to more Oregonians by increasing public spending or regulations enjoy a high level of support among Oregon residents.

- Over 80% of respondents favored individual tax subsidies for the uninsured, expansion of programs like the Oregon Health Plan (OHP) for the low-income uninsured, expansion of community health clinics for underserved populations, and funding assistance for small employers to offer health insurance.

Options for extending health coverage to more Oregonians by benefit tradeoffs that reduce costs are generally opposed.

- Eliminating coverage for routine eye exams and glasses induced the most opposition among respondents (75%).
- About two-thirds opposed the proposals to eliminate outpatient coverage, reduce inpatient coverage, and reduce dental coverage.
- Respondents were evenly split over the proposal that OHP members pay a larger share of the costs of medical care, and only slightly in favor of charging individuals more for brand-name drugs.

WILLINGNESS TO PAY

A majority of Oregon residents are willing to pay extra, either in higher health-insurance premiums or higher taxes, in order to extend access to medical care to more Oregonians.

- 56% of respondents indicated they were willing to pay extra to extend access to more Oregonians. Nearly half of those willing to pay extra were willing to pay $50 per month, another quarter were willing to pay an extra $30 per month, and another quarter were willing to pay an extra $5 per month.
- The estimated $283 million in annual revenue that would be derived, although only a hypothetical commitment, demonstrates the importance Oregon residents attach to the issue of extending healthcare access.

Those willing to pay extra are much more likely than others to support public programs and regulations to extend health coverage to more Oregonians.

- Nearly all of those respondents willing to pay extra also favored expanding the OHP (98%). There also was strong support for helping the uninsured to buy insurance (92%), helping small employers to offer insurance (89%), expanding Medicare to cover those aged 55+ (82%), establishing a national health plan (80%), and requiring employers to offer insurance (78%).

ACCESS TO HEALTH CARE

A significant proportion of Oregon residents have problems in obtaining necessary medical care.

- Thirty percent of respondents reported some problems in obtaining necessary medical care (20% reported a small problem, and 10% a big problem).
- 35% of respondents had not had a routine medical exam, 13% had no regular provider, and 24% had received care in an emergency room.
- One-fourth of respondents reported access problems specifically due to cost, including having gone without a needed treatment, gone without filling a prescription, and having problems paying medical bills.

COVERAGE STATUS

About 11% of Oregon residents are currently without health insurance; about 25% have been without coverage sometime in the past 12 months.

- Excluding those aged 65 and over (98% of whom have coverage), the uninsurance rate for those aged 18-64 increases to nearly 13%.

Lower-income Oregon residents are more likely than those with higher incomes to be without health insurance.

- Respondents with incomes below $30,000 reported notably higher rates of uninsurance than those with higher incomes. The "gap group" just above the federal poverty level (FPL) showed the highest rate of uninsurance (22%).

SUMMARY OF GROUP DIFFERENCES

Hispanic residents are much more likely to favor help for small employers to offer health coverage to employees, and a national health plan for all.

- Hispanic respondents were 4.9 times as likely to favor help for small employers, and 6.2 times as likely to favor a national health plan for all.

Unlike other vulnerable groups, seniors are less likely to support expanding Medicare and other public programs to extend access.

- Respondents aged 65 and over were considerably less likely to favor expansion of Medicare to those aged 55+ (0.2 times as likely), to favor OHP expansion (0.6 times as likely), and to support a national health plan for all (0.6 times as likely).

Eastern Oregon residents have significant doubts about expanding public programs and regulations to extend health coverage to more Oregonians.

- Respondents in the Eastern Oregon region were much less likely than respondents in other parts of Oregon to favor help for small employers (0.3 times as likely), to favor OHP expansion (.3 times as likely), and to be willing to pay extra to extend access to more Oregonians (0.2 times as likely).

Most vulnerable groups (low income, uninsured, poorer health status, seniors, nonworking, nonwhite and Hispanic) are more likely to oppose increasing the co-payment for medical services under the Oregon Health Plan.

Except for seniors, all vulnerable groups have a greater likelihood of problems with access to at least one type of health care.

- Nonwhite respondents were 1.7 times as likely to receive care in an emergency room.
- Hispanic respondents were 2.4 times as likely to experience problems paying medical bills.

The uninsured report the greatest likelihood of problems with access.

- Respondents without health insurance were 13.5 times as likely to have no regular provider, and 6.0 times as likely to have gone without needed medical treatment due to cost. These represented the largest group differences found in the study.

While young adults (those aged 18-39) are less likely to rate health care as a top issue, they are a vulnerable group in terms of problems with access.

- Respondents aged 18-39 were 1.8 times more likely to have had no routine medical exam in the past 12 months, 3.7 times more likely to have no regular provider, 1.8 times more likely to have gone without a needed treatment due to cost, and 1.5 times more likely to have had problems paying medical bills.

Health status, education and race are all significant factors in above-average use of emergency care.

- Respondents with low health status were 2.1 times as likely to report receiving emergency care in the past year. Those with low education (no high-school diploma) were 2.5 times as likely, and nonwhite respondents were1.7 times as likely.

Residents in the Metro region are less likely to have problems with access due to cost.

- Metro respondents were 0.6 times as likely to report going without a prescription due to cost, and 0.5 times as likely to report problems paying medical bills.

BACKGROUND AND PURPOSE

In October 2000, the Office of Health Plan Policy and Research received a one-year planning grant from the U.S. Health Resources and Services Administration (HRSA) to perform an organized, collaborative and comprehensive study of universal health care options in Oregon.

As a part of this study, the Office of Health Plan Policy and Research HRSA team contracted with Portland State University's Survey Research Laboratory to conduct a statewide telephone survey of Oregon households. The survey was designed to gather information about:

- the relative importance of health care issues to Oregon households;
- household experience in seeking health care;
- core values about health care issues; and
- support for various health insurance expansion options and Oregon Health Plan cost-reduction options.

The Statewide Household Survey on Health Care was fielded in April 2001. Interviews were completed with 709 randomly selected households containing adults aged 18 and older. A complete description of the design, response rate calculation, data collection and data analysis methods is presented in Appendix 2, Technical Notes. Appendix 1 contains the survey instrument, along with the distribution of responses to each question.

The sections of this report present findings in the areas of interest addressed by the survey. Findings for the sample as a whole are presented, followed by a set of core subgroup comparisons. Included are grouped comparisons by income, health-coverage status, health status, age, education, employment status, gender, race, ethnicity, and geographic region. Because coverage status is such a central topic in discussions of the healthcare system, additional findings on this topic are reported in a separate substantive section. Group differences are summarized in the concluding section.

STUDY METHODS AND LIMITATIONS

For this study, telephone interviews with adults from 709 Oregon households were completed. The response rate achieved was 39% - 42%, depending on the method of calculation used (see Appendix 2, Technical Notes).

The study's design called for the collection of data by telephone; thus, households without telephones were excluded from participation. Because households with lower incomes are those most likely to not to have a telephone, low-income households likely are under-represented in the study. Similar problems would exist, however, with mailed surveys, which require a list of mailing addresses and literacy on the part of respondents.

Interviews were conducted during the day, as well as during evenings and on weekends. Due in large part to the greater likelihood of women and older adults being at home during the day, the achieved sample over-represented these groups. To adjust for this, the data presented here are weighted by age and gender, using the latest available U.S. Census data (see Appendix 2, Technical Notes).

Although low response rates generally are considered a major threat to the usefulness of a survey, two recent studies found only minor effects on survey results (Curtin, Presser, & Singer, 2000; Keeter, Miller, Kohut, Groves, & Presser, 2000). Nonetheless, this study's relatively low response rate and lack of representation of Oregon households without telephones dictate that caution be exercised when interpreting and generalizing from the findings.

SAMPLE CHARACTERISTICS

A total of 709 interviews were completed. Because the achieved sample over-represented women and older adults in comparison to the gender and age distribution of Oregon's population, the data were weighted. All analyses presented in this report apply these weights to adjust appropriately for age and gender. The weighted sample consists of 706 individuals. Appendix 2 describes the study's methods and details the weighting process.

Key characteristics of the sample are presented below. These characteristics are those used to differentiate groups in order to identify any subgroup differences. Additional details on these characteristics can be found in Appendix 1, which contains the survey instrument along with the distribution of responses to each question. The questions from which the data were derived are listed in parentheses.

	Percent of Respondents (excludes DK/REF)	Number of Respondents
• Household size (Q17): (used to compute federal poverty level)	Mean =2.7 (Max.=10)	705
• Income groups by federal poverty level (FPL)[1](Q41)		
	Up to 200% FPL = 24%	123
	Above 200% FPL = 76%	383
• Health insurance coverage (Q22):	No = 11%	77
	Yes = 89%	629
• Health status (Q16): (1 = Excellent, 2 = Very Good, 3 = Good, 4 = Fair, 5 = Poor)	Mean = 2.4	
	Health status groups	
	Poor or fair = 15%	105
	Good, very good, or excellent = 85%	601
• Age (Q30):	Mean = 45.8 (Max. = 92)	
	Age groups	
	18-39 = 41%	289
	40-64 = 42%	297
	65+ = 17%	120
• Education (Q31) (1 = less than 8 yrs, 5 = some college, no degree, 8 = grad degree)	Mean = 4.7	
	Education groups	
	Less than HS = 8%	57
	HS, less than BA = 58%	411
	BA, less than Grad = 25%	176
	Grad = 9%	63

[1] See Appendix 2 for a description of how this variable was computed. These data are missing for those respondents who refused to divulge their incomes.

	Percent of Respondents (excludes DK/REF)	Number of Respondents
• Employment status (Q20 & Q21)		
All ages		
No job	= 38%	268
Part-time/1-29 hours	= 11%	77
Full-time/ 30+ hours	= 51%	361
Employment groups by age		
Ages 18-64		
No job	= 28%	162
Part-time/1-29 hours	= 12%	72
Full-time/ 30+ hours	= 60%	352
Ages 65+		
No job	= 88%	106
Part-time/ 1-29 hours	= 4%	5
Full-time/ 30 + hours	= 8%	9
• Gender (Q33):	Male = 49%	346
	Female = 51%	360
• Race (Q35):	White = 88%	613
	Nonwhite = 12%	82
• Ethnicity (Q34):	Hispanic = 4%	25
	Other = 96%	679

• Geographic region of residence (derived from zip code)[2]:

Counties			
Clackamas, Multnomah, Washington	Metro:	41%	285
Benton, Lane, Lincoln, Linn	South Valley:	18%	121
Coos, Curry, Douglas, Jackson, Josephine	Southern:	14%	100
Marion, Polk, Yamhill	Mid-Valley:	10%	68
Baker, Grant, Harney, Malheur, Morrow, Umatilla, Union, Wallowa	Eastern Oregon:	6%	42
Crook, Deschutes, Jefferson	Central Oregon:	5%	31
Clatsop, Columbia, Tillamook	North Coast:	4%	25
Klamath, Lake	South Central:	2%	15
Gilliam, Hood River, Sherman, Wasco, Wheeler	Gorge:	1%	6

[2] See Appendix 2 for a description of how this variable was computed.

ATTITUDES RELATED TO HEALTH CARE

What Oregon residents feel about health care was measured in terms of the general importance of the issue, judgment of the current system, and beliefs about extending health coverage to more Oregonians.

Q1. Of all the issues facing Oregon today, would you say health care is near the top of the list in importance, in the middle, or near the bottom of the list in importance?

Q2. Which statement best summarizes your feelings about how the overall health care system is working today?

(1) The healthcare system is fine just the way it is, no changes are needed.

(2) The healthcare system works pretty well, and only minor changes are needed.

(3) There are good things about the healthcare system, but fundamental changes are needed.

(4) There is so much wrong with the healthcare system that it needs to be completely rebuilt.

Do you strongly disagree, somewhat disagree, somewhat agree, or strongly agree that:

Q12A. Access to health care should be a basic right for all, just as education is a basic right.

Q12B. People should be required to have health insurance, just as automobile drivers are required to have car insurance.

Q12C. The Oregon Health Plan should be open to all qualified low-income Oregon residents, even if they are not U.S. citizens.

Nearly two-thirds of respondents thought health care is near the top of the list in importance relative to other issues (Figure 1). Yet only about one-fourth thought the system is working well, requiring no change or only minor changes (Figure 2).

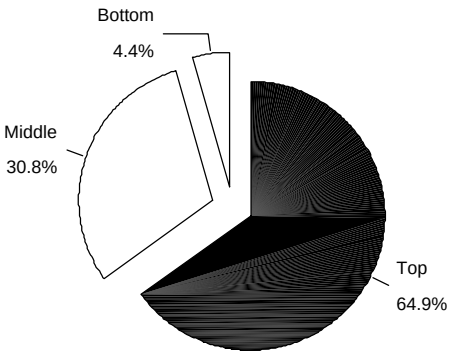

Figure 1. Of all the issues facing Oregon today . . . please think about where health care fits in relation to other important issues.

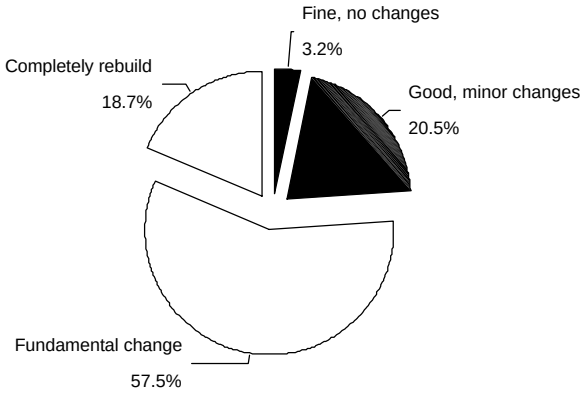

Figure 2. How well is the overall health care system working today?

Three-fourths felt fundamental change is necessary (56%) or so much is wrong that the entire system needs to be rebuilt (18%).

A large majority believed health care should be a basic right just as education is a basic right (87%) (Figure 3). At the same time, a slight majority (54%) opposed mandatory health insurance.

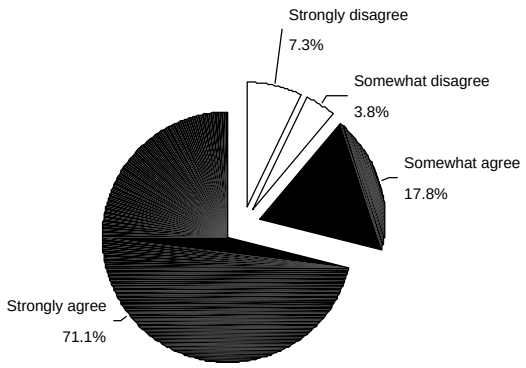

Figure 3. Access to health care should be a basic right for all.

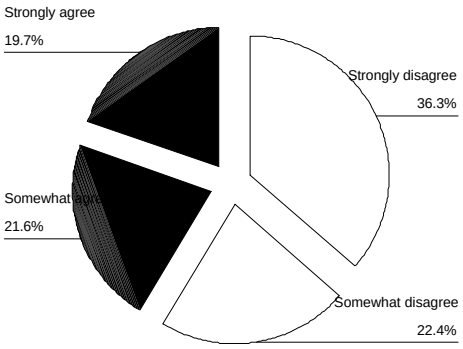

Figure 4. People should be required to have health insurance

Opinion was also divided on whether the Oregon Health Plan should be extended to Oregon residents who are not U.S. citizens (Figure 5). A slight majority favored inclusion of noncitizen residents (55%).

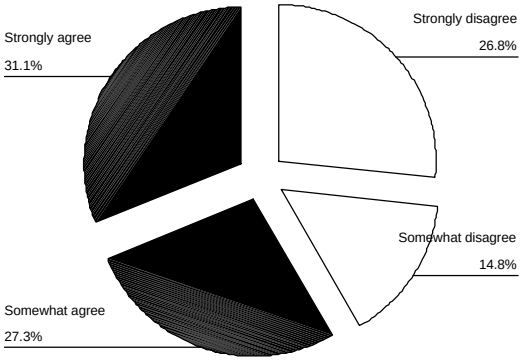

Figure 5. OHP should be open to all qualified low-income Oregon residents even if they are not U.S. citizens

Group differences

Groups of respondents exhibited the same level of agreement for the statement that health care should be a basic right, and were also equally uncertain about requiring individuals to purchase health insurance. For the statement that the Oregon Health Plan (OHP) should be open to all eligible residents even if they are not U.S. citizens, only Hispanic respondents exhibited a greater likelihood to agree with the idea.

For the items rating the importance of health care relative to other issues, and judging how well the current healthcare system is working, group differences did emerge. Even here, however, the general level of agreement was remarkable, unaffected by factors that might be assumed to be significant, including income level, coverage status, and region.

HEALTH STATUS

- Respondents with poor to fair health were more likely than those with good to excellent health to believe the healthcare system needs to be completely rebuilt (38% vs. 15%) [Q2].

AGE

- Respondents aged 65 and over were more likely to rate health care as a top issue compared to respondents under age 65 (77% vs. 62%) [Q1].

- Respondents aged 18-39 were less likely to rate health care as a top issue, compared to those aged 40 and over (53% vs. 73%) [Q1].

- Respondents aged 65 and over were less likely to take a negative view of the healthcare system (believing fundamental changes or a complete overhaul are needed), compared to respondents under age 65 (66% vs. 78%) [Q2].

EDUCATION

- Respondents with less than a high-school diploma, compared to those with higher education levels, were more likely to think the healthcare system is working fine (15% vs. 2%). At the same time, other respondents in this group were more likely to think the system needs to be completely rebuilt (29% vs. 18%) [Q2].

GENDER

- Women were a little more likely than men to rate health care as a top issue (68% vs. 61%) [Q1].

- Women were a little more likely than men to feel the healthcare system needed to be fundamentally changed or completely rebuilt (80% vs. 73%) [Q2].

RACE

- Nonwhite respondents were more likely than white respondents to view health care at the bottom of the list of important issues facing Oregon (9.9% vs. 3.6%) [Q1].

ETHNICITY

- Hispanic respondents were more likely than others to agree that OHP should be extended to all eligible residents, even noncitizens (83% vs. 58%) [Q12C].

PRIMARY CONCERNS

In order to get a broader view of opinions about the range of healthcare-related problems, respondents were asked to say in their own words what they think is the number-one problem that needs to be solved related to health care in Oregon today. Table 1 categorizes the responses and shows numbers and percentages for each category.

Among the different kinds of responses, inequities in the system comprised the category mentioned most frequently by respondents. The need for universal access to health care, or health coverage for disadvantaged or excluded groups, was mentioned by 32% of the respondents as the number-one problem to be solved. The issue of cost was often mentioned in this context, making it clear that many Oregonians equate cost and access. Sample responses included:

"All people should be able to access good health care."

"Unemployed people need healthcare coverage."

"Make it easier for self-employed people to get coverage."

"Not doing enough for low-income people."

"Poor children should get good health care."

High costs in general were another commonly listed "number-one problem," representing another way to express essentially the same issue as above, but without targeting a specific group in need. Specifically, 16% of respondents were most concerned about costs in general. An additional 11% of respondents were most concerned about pharmacy costs.

"Too expensive for diagnostics, and won't pay for needed therapy."

"My health insurance deductible is too high."

"Prescription drugs are too expensive."

"The cost of prescription drugs and the cost of treatment. I can't afford my prescriptions."

About 13% of the respondents noted problems with the health care delivery system. For example, they mentioned the need for better care for specific conditions or for specific groups, the need for better organization and integration of services, for better quality of care, or in a few cases, for better regional access.

"Getting doctors to listen more to their patients, give the patients what they need."

"The waiting lists are way too long."

"I think birth-defect prevention needs to be top priority."

"Lack of community resources in areas with smaller population bases."

Table 1. The number-one problem in Oregon health care: frequencies of open-ended responses

Number-one problem to be solved I	PERCENT OF RESPONSES (excludes DK/Ref.)	PERCENT OF TOTAL (includes entire sample)	NUMBER OF RESPONSES N = 706
COVERAGE, ACCESS, FAIRNESS - universal access, more assistance for disadvantaged, underinsurance	37	32	226
COSTS - In general and for seniors	16	14	100
PHARMACEUTICAL COSTS - Costs, coverage, and for seniors	11	10	70
DELIVERY SYSTEM - Specific programs or groups, medical organization, integration, quality of care	13	11	77
HMO & INSURANCE ORGANIZATION - Management of medical services, choice, selectivity, coordination	12	11	75
OTHER - Government administration, drug abuse, waste, lack of information, too many forms, need federal solution	11	11	65
NO PROBLEMS, DON'T KNOW, REFUSED	--	13	93

About 12% of the respondents considered issues with insurance companies or health-maintenance organizations (HMOs) to be the number-one problem to be solved. Half of this group referred to unwelcome management of medical services by insurance companies; the other half identified other problems related to insurance organization, using words like "selectivity," "choice," and "coordination."

"HMOs – get rid of them, or just so that they can't mandate or decide your health care. Have doctors have more control over what they can do and can't do as opposed to what the insurance company says you can do."

"Keep insurance companies from telling the doctors what to do."

"Finding and changing doctors without health insurance companies deciding for us – managing my own health care."

About 3% of the respondents found government, in various ways, to be the number-one problem to be solved in Oregon's healthcare system. Another 3% found the number-one

problem to be the need for various population-based health strategies, like vaccination or control of drug use.

"The abuse of drugs by too many people today, including those in dangerous work situations, such as heavy equipment, drivers, etc."

"Get rid of the chemicals in the prescriptions and foods."

"People need to be taught prevention more, taking care of their health instead of waiting 'til they are sick to go to the doctor."

"Need new governor."

Finally, 1% named waste as the number-one problem, and another 1% mentioned inadequate information and other transaction costs, such as complicated forms.

"Need more information about rules and regulations about health care."

"There are too many forms to fill out."

PREFERENCES FOR INSURING MORE OREGONIANS

Two sets of options measured the preferences of Oregonians for extending health insurance to more people in the state. The first set of options concerned public programs and regulations that could extend coverage. The second set of options addressed benefit tradeoffs that reduce costs and allow broader coverage. These options were among the policy ideas being reviewed at the time of the survey in May 2001.

A. Expand coverage by public programs and regulations

Favor or oppose:

Q13A. Use state funding to help small employers offer health insurance to their employees.

Q13B. Require all employers to offer health insurance to their employees.

Q13C. A national health plan, financed by taxpayers, that would cover everyone.

Q13D. Help uninsured people to buy health insurance on their own by offering them income tax deductions, tax credits, or other financial assistance.

Q13E. Expand Medicare to cover people aged 55 and older, not just those 65 and older.

Q13F. Expand public programs such as the Oregon Health Plan that provide insurance for low-income people without health insurance.

Q13G. Increase state funding to expand community health clinics that serve low-income people who do not have health insurance.

B. Extend coverage by benefit tradeoffs that reduce costs

Favor or oppose:

Q15A. Cover inpatient hospital care, but do not cover outpatient medical care.

Q15B. Cover outpatient medical care, but cover only a limited amount of inpatient hospital care.

Q15C. Ask Oregon Health Plan members to pay a larger share of the cost of their own medical care.

Q15D. Reduce dental coverage so that routine dental care, like check-ups and cleaning, is covered, but restorative dental services, such as fillings or crowns, are not covered.

Q15E. Eliminate coverage for routine eye exams and glasses.

Q15F. Change the pharmacy benefit so that Oregon Health Plan members would pay more for brand name drugs.

All of the proposed options for extending health coverage to more Oregonians by increasing public spending or regulations obtained a high level of support from respondents (see Figure 6, left side). The options endorsed most frequently were for individual tax subsidies for the uninsured (87%), expanding programs like the Oregon Health Plan for the low-income uninsured (86%), expanding community health clinics for underserved populations (84%), and funding assistance for small employers to offer health insurance (81%). Least favored, although still supported by a majority, was a national health plan for all (63%).

The proposals to reduce benefits in the Oregon Health Plan in order to extend coverage to more people were generally opposed (see Figure 6, right side); but respondents were evenly split over the proposal that OHP members pay a larger share of the costs of medical care, and were only slightly in favor of charging individuals more for brand-name drugs. Receiving the most opposition was the option to eliminate coverage for routine eye exams and glasses (opposed by 75%). About two-thirds opposed eliminating outpatient coverage, reducing inpatient coverage, and reducing dental coverage.

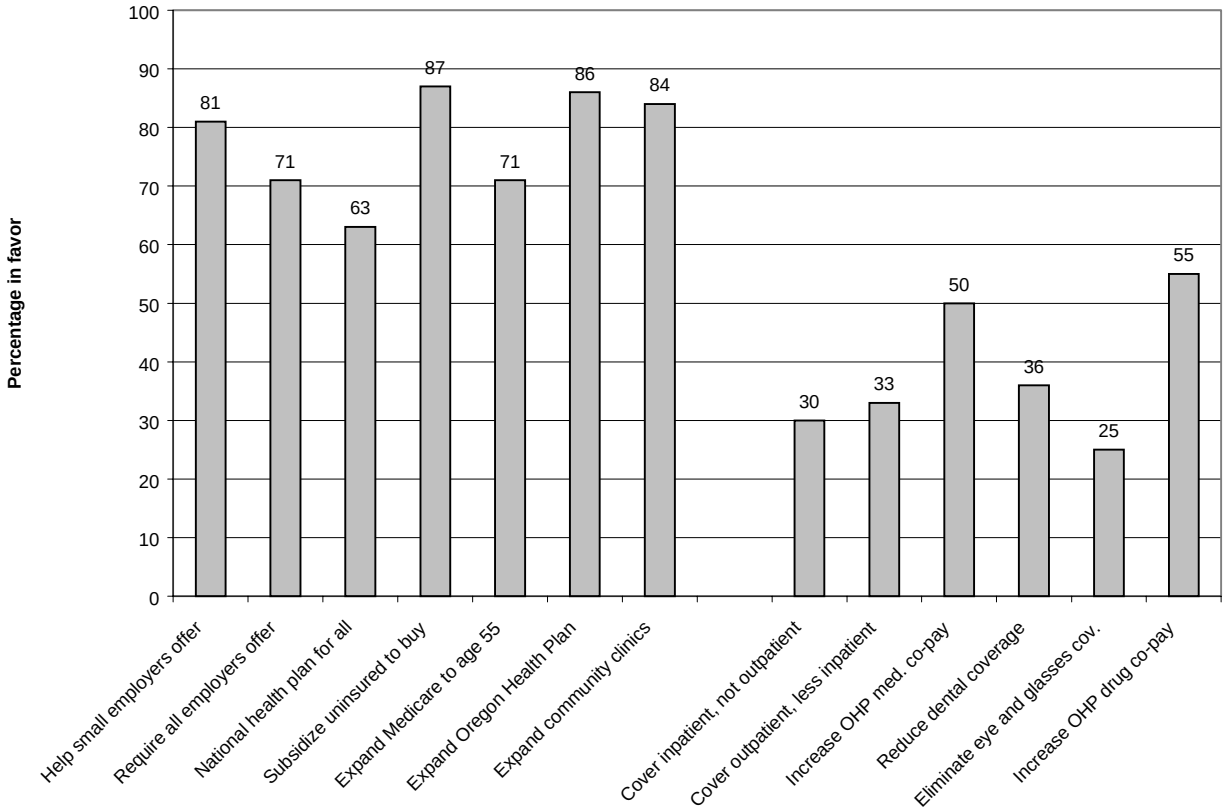

Figure 6. Percentage of respondents favoring options for extending coverage

Group differences

A large number of differences emerged among groups of respondents regarding their preferences for extending health insurance to more Oregonians. Support for the first set of options, involving expanding public programs and regulations, is substantially greater among several groups. Among the second set of options, that is for benefit tradeoffs to reduce costs, the option to increase the co-payment for OHP members showed the most

divergence of opinion among groups. For all of these specific options, no practical difference of opinion was evident for those with differing levels of education. Differences on at least one of the proposed options were evident for all other core variables.

A: Expand coverage by public programs and regulations

INCOME

- Respondents with incomes up to 200% FPL were more likely to favor expanding Medicare to include those aged 55 and over (83% vs. 69%) [Q13E].

- Respondents with incomes up to 200% FPL were more likely to favor expanding community clinics (92% vs. 80%) [Q13G].

COVERAGE

- Respondents without health insurance were more likely than those with coverage to favor a national health plan (80% vs. 61%) [Q13C].

- Respondents without health insurance were more likely than those with coverage to favor expanding Medicare to include those aged 55 and over (85% vs. 69%) [Q13E].

HEALTH STATUS

- Respondents with poor to fair health were a little more likely than those with good to excellent health to favor help for small employers to offer health insurance (89% vs. 80%) [Q13A].

- Respondents with poor to fair health were more likely than those with good to excellent health to favor expanding Medicare to include those aged 55 and over (81% vs. 69%) [Q13E].

AGE

- Respondents under age 65 were more likely than those aged 65 and over to favor a national health plan (65% vs. 51%) [Q13C].

- Respondents under age 65 were much more likely than those aged 65 and over to favor expanding Medicare to include those aged 55 and over (76% vs. 44%) [Q13E].

- Respondents under age 65 were a little more likely than those aged 65 and over to favor expanding OHP (87% vs. 80%) [Q13F].

RACE

- Nonwhite respondents were more likely than white respondents to favor most of the proposals for coverage expansion, including requiring employers to offer insurance (90% vs. 80%); establishing a national health plan (81% vs. 70%); expanding Medicare to include those aged 55 and over (83% vs. 69%); and expanding the OHP (94% vs. 85%) [Q13A, 13C, 13E, 13F].

ETHNICITY

- Hispanic respondents were more likely than others to favor requiring employers to offer insurance (92% vs. 70%), and more likely to favor a national health plan (91% vs. 62%) [Q13A, 13C].

REGION

- Eastern Oregon respondents were the least likely to favor help for small employers to offer health insurance, compared to all other regions combined (59% vs. 82%) [Q13A].

- Eastern Oregon respondents were the least likely to favor expanding OHP, compared to all other regions combined (67% vs. 88%) [Q13F].

B: Extend coverage by benefit tradeoffs that reduce costs

INCOME

- Respondents with incomes up to 200% FPL were less likely to favor OHP co-pay increases for drugs (45% vs. 59%) [Q15C].

COVERAGE

- Respondents without health insurance were less likely than those with coverage to favor OHP co-pay increases for medical care (36% vs. 52%) [Q15C].

HEALTH STATUS

- Respondents with poor to fair health were less likely than those with good to excellent health to favor OHP co-pay increases for medical care (39% vs. 53%) [Q15C].

- Respondents with poor to fair health were less likely than those with good to excellent health to favor OHP co-pay increases for drugs (40% vs. 58%) [Q15F].

AGE

- Respondents under age 65 were less likely than those aged 65 and over to prefer coverage for outpatient care, with reduced coverage for inpatient care (31 vs. 44%) [Q15B].

- Respondents aged 65 and over were less likely than those under age 65 to favor OHP co-pay increases for medical care (40% vs. 52%), and less likely to favor OHP co-pay increases for drugs (38% vs. 58%) [Q15C, 15F].

EMPLOYMENT (AGES 18-64)

- Nonworking respondents were less likely than working respondents to favor OHP co-pay increases for medical care (44% vs. 55%) [Q15C].

- Nonworking respondents were less likely than workers to favor reduced dental coverage (28% vs. 39%). Part-time workers were more likely than nonworking or full-time workers to favor reduced dental coverage (49% vs. 34%) [Q15D].

GENDER

- Men were more likely than women to favor coverage for inpatient care by eliminating coverage for outpatient care (36% vs. 26%) [Q15A].

RACE

- Nonwhite respondents were more likely than white respondents to favor coverage for inpatient care by eliminating coverage for outpatient care (49% vs. 29%) [Q15A].

- Nonwhite respondents were less likely than white respondents to favor OHP co-pay increases for medical care (34% vs. 53%) [Q15C].

ETHNICITY

- Hispanic respondents were more likely than others to favor coverage for inpatient care by eliminating coverage for outpatient care (60% vs. 30%) [Q15A].

- Hispanic respondents were less likely than others to favor OHP co-pay increases for medical care (29% vs. 52%) [Q15C].

REGION

- Mid-Valley respondents were more likely to favor reduced dental coverage, compared to all other regions combined (54% vs. 35%) [Q15D].

WILLINGNESS TO PAY

One section of the survey aimed to find out how many Oregon residents are willing to pay extra, and then how much extra, to extend health coverage to more Oregonians.

Q14. Would you be willing to pay any extra money – either in higher health insurance premiums or higher taxes – in order to increase the number of Oregon residents who have access to medical care?

Q14A. Would you be willing to pay an extra $50 more per month?

Q14B. Would you be willing to pay an extra $30 a month?

Q14C. Would you be willing to pay an extra $5 a month?

Over half of the respondents (56%) were willing to pay extra, either in higher health-insurance premiums or higher taxes. Of those willing to pay extra, 44% were willing to pay an extra $50 per month, 24% were willing to pay an extra $30 per month, and 28% were willing to pay an extra $5 per month. The remaining 4% would not specify an amount.

Table 2 provides an estimate of total revenue that could result, based on these respondents' expressed willingness to pay extra to expand healthcare access. The calculations in the table assume that each response represents a household; the numbers of Oregon households are drawn from the U.S. Census 2000. The results indicate potential annual revenue of about $283 million. Such a nonbinding commitment might be difficult to achieve in reality, but the size of the commitment, even as an abstraction, is one measure of the importance respondents attach to the issue of extending healthcare access to more Oregon residents.

Table 2. Potential revenue from Oregon households willing to pay extra to expand healthcare access

	WILLING TO PAY (Percent of all those willing to pay)	WILLING TO PAY (Percent of total sample)	HOUSEHOLDS WILLING TO PAY (Total = 1,333,723)	POTENTIAL REVENUE PER MONTH
In general	100%	56%	746,885	$23.6 million
$50/month	44%	25%	333,431	$16.7 million
$30/month	24%	14%	186,721	$5.6 million
$ 5/month	28%	19%	253,407	$1.3 million

Relative attitudes toward the healthcare system did not differ between those willing and unwilling to pay extra. Preferences for extending access through benefit tradeoffs differed on only one item:

- Those who were willing to pay extra were more likely to oppose coverage for inpatient care by eliminating coverage for outpatient care (71% vs. 62% of those unwilling to pay extra) [Q15A].

Regarding preferences for extending access through public programs and regulations, those willing to pay extra differed from those unwilling to pay on every item, displaying a greater likelihood to endorse public intervention. The differences are summarized below.

Those willing to pay extra were:

- much more likely to favor helping small employers to offer insurance (89% vs. 67%) [Q13A].
- more likely to favor requiring employers to offer insurance (78% vs. 64%) [Q13B].
- much more likely to favor a national health plan (80% vs. 41%) [Q13C].
- more likely to favor helping the uninsured to buy insurance (92% vs. 79%) [Q13D].
- much more likely to favor expanding Medicare to include those aged 55 and over (82% vs. 55%) [Q13E].
- much more likely to favor expanding OHP (98% vs. 69%) [Q13F].
- much more likely to favor expanding community clinics (95% vs. 66%) [Q13G].

Group differences

Very few group characteristics distinguished those willing to pay extra from those not willing to do so. Those willing to pay extra were similar to those unwilling to pay in terms of health status, employment, race and ethnicity. Even the factor of income level appeared to make no difference. The group differences that did emerge as statistically significant are summarized below.

Willingness to pay - in general

COVERAGE STATUS

- Respondents without health insurance were more likely than those with health insurance to be willing to pay extra (67% vs. 55%).

AGE

- Respondents aged 18-39 were more likely to be willing to pay extra (62%) than respondents aged 40-64 (56%) and respondents aged 65 and over (41%).

EDUCATION

- Respondents with a bachelor's degree, but less than a graduate degree, were more likely to be willing to pay extra, compared to all other education levels combined (65% vs. 53%).

GENDER

- Men were more likely than women to be willing to pay extra (60% vs. 52%).

REGION

- Eastern Oregon respondents, compared to all other regions combined, were much less likely to be willing to pay extra (23% vs. 59%).

Willing to pay $50 extra per month

AGE

- Among those willing to pay extra, respondents under age 65 were more likely than those aged 65 and over to be willing to pay $50 per month (46% vs. 27%).

Willing to pay $30 extra per month

GENDER

- Among those willing to pay extra, but less than $50 per month, men were more likely than women to be willing to pay an extra $30 per month (50% vs. 36%).

Willing to pay $5 extra per month

COVERAGE

- Among those willing to pay extra, but less than $30 per month, respondents without health insurance were less likely than those with health insurance to be willing to pay $5 per month (71% vs. 90%). This result somewhat offsets the earlier result showing that those without health insurance were more likely to be willing to pay extra in general.

ACCESS TO HEALTH CARE

This part of the study aimed to measure the conditions and problems Oregon residents may be experiencing with access to health care, including problems of access due to cost, all within the last 12 months.

Q4.	In the last 12 months how much of a problem, if any, was it to get the medical care you believed to be necessary? Was it a big problem, a small problem, not a problem, or did you not need any medical care?
Q5.	In the last 12 months have you received a routine physical examination or check up?
Q7.	In the last 12 months have you received care in an emergency room?
Q8.	Do you currently have a regular doctor or clinic to go to when you are sick or want medical advice?
Q9.	Because of cost, in the last 12 months have you or someone in your household gone without a needed medical test or treatment?
Q10.	Because of cost, in the last 12 months have you or someone in your household gone without filling a prescription for medicine?
Q11.	Because of cost, in the last 12 months did you have any problems paying medical bills, including doctor, hospital or prescription drug bills?

Thirty percent of the respondents reported problems getting necessary medical care, with 10% reporting a big problem. Similar results occurred in the other areas of access as well: 35% had not had a routine medical exam, 24% had obtained care in an emergency room, 13% had no regular provider, and roughly 25% had problems with access due to cost. For those having problems with access, group differences indicate some folks are having significantly more problems than others.

Group differences

Income

- Respondents with incomes up to 200% of the federal poverty level (FPL) were less likely to have received a routine physical exam (55% vs. 68%) [Q5].

- Respondents with incomes up to 200% FPL were more likely to have foregone a medical test or treatment due to cost (41% vs. 21%), more likely to have gone without filling a prescription due to cost (39% vs. 16%), and more likely to have had problems paying medical bills due to cost (40% vs. 21%) [Q9-11].

Coverage

- Respondents without health insurance were more likely than those with coverage to report a big problem obtaining necessary medical care (18% vs. 9%) [Q4].

- Respondents without health insurance were less likely than those with coverage to have received a routine physical exam in the past year (33% vs. 69%) [Q5].

- Respondents without health insurance were less likely than those with coverage to have a regular provider (46% vs. 92%) [Q8].

- Respondents without health insurance were more likely than those with coverage to have gone without a medical test or treatment due to cost (60% vs. 20%); more likely to have gone without filling a prescription due to cost (48% vs. 18%); and more likely to have had problems paying medical bills (51% vs. 22%) [Q9-11].

HEALTH STATUS

- Respondents with poor to fair health were more likely than those with good to excellent health to have experienced a big problem obtaining necessary medical care (16% vs. 9%) [Q4].

- Respondents with poor to fair health were more likely than those with good to excellent health to have received emergency care (37% vs. 22%) [Q7].

- Respondents with poor to fair health were more likely than those with good to excellent health to have gone without a needed medical treatment due to cost (35% vs. 23%), to have gone without filling a prescription due to cost (35% vs. 19%), and to have had problems paying medical bills (43% vs. 22%) [Q9-11].

AGE

- Respondents aged 18-39 were least likely to have had a routine physical exam (56%), compared to those aged 40-64 (69%), and those aged 65 and over (74%) [Q5].

- Respondents aged 18-39 were least likely to have a regular provider (78%), compared to those aged 40-64 (92%), and those aged 65 and over (96%) [Q8].

- Respondents aged 18-39 were more likely to have gone without a needed medical treatment due to cost (31%), compared to those aged 40-64 (23%), and those aged 65 and over (11%) [Q9].

- Respondents aged 18-39 were more likely to have had problems paying medical bills (30%), compared to those aged 40-64 (24%), and those aged 65 and over (17%) [Q11].

EDUCATION

- Respondents with less than a high-school diploma were more likely to have received care in an emergency room, compared to all those with higher levels of education (44% vs. 24%) [Q7].

- Respondents with less than a high-school diploma, compared to all those with higher levels of education, were more likely to have gone without a needed medical treatment due to cost, (38% vs. 23%), to have gone without filling a prescription due to cost (39% vs. 20%), and to have had problems paying medical bills (39% vs. 24%) [Q9-11].

EMPLOYMENT (AGES 18-64)

- Nonworking respondents were more likely than working respondents to have experienced a big problem obtaining necessary medical care (17% vs. 8%) [Q4].

- Nonworking respondents were more likely than working respondents to have gone without a needed medical treatment due to cost (37% vs. 24%), and to have gone without filling a prescription due to cost (31% vs. 19%) [Q9, 10].

GENDER

- Females were more likely than males to have had a routine physical exam (70% vs. 59%) [Q5].

- Females were somewhat more likely than males to have a regular provider (90% vs. 84%) [Q8].

- Females were more likely than males to have gone without filling a prescription due to cost (24% vs. 18%), and to have had problems paying medical bills (29% vs. 22%) [Q10, 11].

RACE

- Nonwhite respondents were more likely than white respondents to have received care in an emergency room (33% vs. 22%) [Q7].

ETHNICITY

- Hispanic respondents were more likely than others to have had problems (big or small) paying medical bills (44% vs. 25%) [Q11].

REGION

- Central Oregon respondents were more likely to have received care in an emergency room, compared to all those from other regions combined (44% vs. 23%) [Q7].

- Metro respondents, compared to those from other regions combined, were less likely to have gone without filling a prescription due to cost (17% vs. 25%), and less likely to have had problems paying medical bills (19% vs. 30%) [Q10, 11].

- Southern Oregon respondents, compared to those from other regions combined, were more likely to have gone without filling a prescription due to cost (31% vs. 20%), and more likely to have had problems paying medical bills (34% vs. 24%) [Q10, 11].

COVERAGE STATUS

This study found that 11% of respondents were without health insurance at the time of the survey. This figure corresponds to the generally agreed-upon level of uninsurance in Oregon today. The percentage of respondents without coverage at any time in the past 12 months was 25%. Excluding those aged 65 and over, of whom 98% had insurance coverage, the uninsurance rate for those aged 18-64 rose to nearly 13%.

Medicare, Medicaid and "other" sources of insurance cover 55% of the insured with incomes up to 200% of the federal poverty level (FPL). Among this low-income group of respondents, 33% obtained insurance through an employer or family member's employer. Among those with incomes over 200% FPL, 72% obtained insurance through employment. Similar percentages of the two income groups purchased insurance privately: 11% of those with incomes below 200% FPL, and 15% of those with incomes above 200% FPL.

The uninsured are much more likely to be single, compared to the insured (46% vs. 20%), or living together with a partner (15% vs. 5%). Those separated, widowed or divorced had similar levels of coverage. The majority of the insured are married (59%).

Coverage and Income

Figure 7 illustrates the significant relationship between income level and coverage status. Those with incomes below $30,000 are clearly having relatively more problems with health coverage. The rate of uninsurance is highest among those with incomes of about $20,000 (22%). This is the group just above the federal poverty level, which ranges from $8,590 for an individual to $17,650 for a family of four.

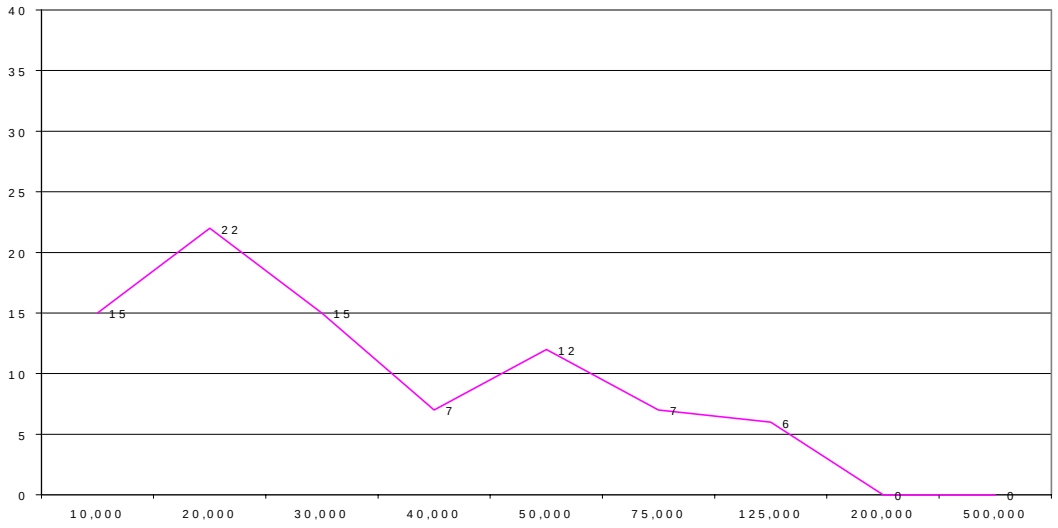

Figure 7. Percentage of respondents without health insurance, by income level

In spite of the difference that income level makes in the likelihood of uninsurance, Figure 8 illustrates that respondents with higher incomes are not exempt from problems with health coverage. Of the uninsured in this study, over half had incomes between 200% and 500% of the FPL. Nearly two-thirds had incomes above 200% of the FPL. The commonly acknowledged group in need of assistance, those at 100-200% FPL, represented 26% of the uninsured in this study.

It should be noted that these figures differ considerably from those of other recent studies in the state and may be the result of two factors, both related to the likely under-representation of low-income households in the study. First, the collection of data by telephone excluded households without telephones, which mostly are low-income households. Second, as described in Appendix 2, Technical Notes, there was considerable item nonresponse on the income question. A comparison of nonrespondents and respondents to this question revealed that nonrespondents were less likely to be employed, which suggests that a proportionately greater number of nonrespondents to the income question were probably people at lower income levels.

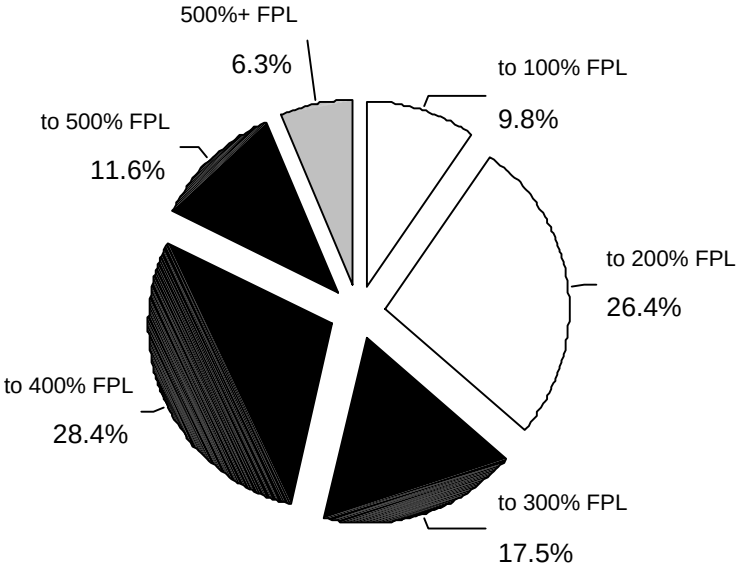

Figure 8. Currently without health insurance, by federal poverty level (FPL)

Group differences

INCOME

- Respondents with incomes up to 200% FPL were more likely to be without health insurance, compared to those with incomes above 200% FPL (17% vs. 9%).

HEALTH STATUS

- Respondents with fair or poor health were more likely to be without health insurance compared to those in good to excellent health (17% vs. 10%).

AGE

- Respondents aged 18-39 were more likely to be without health insurance (18%), compared to those aged 40-64 (8%) and those aged 65 and over (2%).

EDUCATION

- Respondents with less than a high-school diploma were more likely to be without health insurance, compared to respondents with higher levels of education, combined (21% vs. 10%).

EMPLOYMENT (AGES 18-64)

- Nonworking respondents were more likely than working respondents to be without health insurance (21% vs. 10%).

ETHNICITY

- Hispanic respondents were more likely than others to be without health insurance (32% vs. 10%).

SUMMARY OF GROUP DIFFERENCES

Numerous group differences discovered in this study are presented in the previous sections. All of the differences are plotted here in four tables, crossing each of the comparisons made against each survey item. Together, the tables represent the basic areas of interest in this study, including attitudes, preferences, willingness to pay, access, and coverage status. Each of the core group comparisons, except for gender and region, allow examination of potentially vulnerable populations: low income, uninsured, low health status, young adults, seniors, low education, unemployed, nonwhite and Hispanic.

The magnitude of the group differences is calculated with an odds ratio – commonly used in epidemiology – to provide one figure for the likelihood of a certain response within the "exposed" (or vulnerable) group relative to the likelihood of the same response in the "unexposed" group. The odds ratios here summarize the relative rates reported as percentages in the previous sections for significant group differences. Odds ratios greater than 1.0 represent a proportionately greater likelihood for the particular response. Fractions less than 1.0 represent a proportionately reduced likelihood in comparison to the rest of the sample. See Appendix 2 for the formula used to compute the odds ratios.

Table 3. Group differences in attitudes related to health care - odds ratios

	Q1 HC most important issue	Q2 HC system negative judgment	Q12A HC access as a basic right	Q12B Require health insurance	Q12C Extend OHP to non-citizens
INCOME (UP TO 200% FPL)					
COVERAGE (UNINSURED)					
HEALTH (POOR TO FAIR)	3.5				
AGE (18-39)	0.3				
AGE (65+)	2.1	1.8			
EDUCATION (NO HS DIPLOMA)		1.9			
EMPLOYMENT (NONWORKING)					
GENDER (MALE)					
RACE (NONWHITE)	0.4				
ETHNICITY (HISPANIC)					3.5
REGION					

As shown in Table 3, there are few group differences in attitudes related to health care. The largest differences are for respondents with poorer health, who were 3.5 times more likely to rate health care as a top issue; for Hispanics, who were 3.5 times more likely to favor extending the Oregon Health Plan to noncitizens; and for young adults, who were considerably less likely (0.3 times as likely) to rate health care as a top issue.

Table 4 includes willingness to pay along with the items pertaining to the area of preferences for public programs and regulations to extend health coverage to more Oregonians. This is because those who were willing to pay extra also showed much greater support for every option in this category, as described earlier. For this set of options, the greatest number of differences was for nonwhite respondents. The largest differences were for Hispanic respondents versus nonHispanic respondents on two options: favoring help for small employers to offer health insurance to employees, and a national health plan for all. Seniors were clearly less interested in supporting a few of the options, particularly for expanding Medicare to include those aged 55 and over, which most other vulnerable groups were more likely to favor.

Also of interest here is the relative lack of support from respondents in Eastern Oregon, relative to those from the remainder of the state, for two of the expansion options. Eastern Oregonians were 0.3 times as likely to favor help for small employers to offer health insurance to their employees, and 0.3 times as likely to favor expansion of the Oregon Health Plan. Respondents in Eastern Oregon were even less likely to be willing to pay for expanded access.

Table 4. Group differences in support for expanding public programs and regulations to extend health coverage to more Oregonians, plus willingness to pay – odds ratios

	Q13A Help small employers offer HC insurance	Q13B Require employers to offer HC insurance	Q13C National health plan for all	Q13D Help uninsured to buy	Q13E Expand Medicare to age 55	Q13F Expand OHP	Q13G Expand community clinics	Q14 Willing to pay extra to expand access
INCOME (UP TO 200% FPL)					2.2		2.9	
COVERAGE (UNINSURED)			2.6		2.5			1.7
HEALTH (POOR TO FAIR)	2.0				1.9			
AGE (18-39)								1.5
AGE (65+)			0.6		0.2	0.6		
EDUCATION (NO HS DIPLOMA)								
EMPLOYMENT (NONWORKING)								
GENDER (MALE)								1.4
RACE (NONWHITE)	2.3		1.8		2.2	2.8		
ETHNICITY (HISPANIC)	4.9		6.2					
REGION	0.3					0.3		0.2

Table 5 clearly shows that nearly every vulnerable group was more likely to oppose increasing the co-pay for medical services under the Oregon Health Plan. Also of interest is the significantly greater likelihood of nonwhite and Hispanic respondents (and men) to support coverage for inpatient care at the expense of outpatient care. The region showing a 2.2 times greater likelihood of favoring reduced dental coverage is Mid-Valley, representing a unique source of support for this option.

Table 5. Group differences in support for benefit tradeoffs to reduce costs in order to extend health coverage to more Oregonians – odds ratios

	Q15A Cover inpatient, not cover outpatient	Q15B Cover outpatient, reduce inpatient	Q15C Increase OHP copay for medical	Q15D Reduce dental coverage	Q15E Eliminate routine eye coverage	Q15F Increase OHP copay for drugs
INCOME (UP TO 200% FPL)			0.6			
COVERAGE (UNINSURED)			0.5			
HEALTH (POOR TO FAIR)			0.6			0.5
AGE (18-39)						
AGE (65+)		1.7	0.6			0.4
EDUCATION (NO HS DIPLOMA)						
EMPLOYMENT (NONWORKING)			0.6	0.6		
GENDER (MALE)	1.6					
RACE (NONWHITE)	2.4		0.5			
ETHNICITY (HISPANIC)	3.5		0.4			
REGION				2.2		

In Table 6, coverage status (no health insurance) is included along with the items pertaining to problems with access, since coverage is the most salient factor in this area, with larger differences on more items than those experienced by any other vulnerable group. The most remarkable aspect of this table is the profusion of differences, with nearly every vulnerable group expressing a greater likelihood of problems on a number of items.

The largest differences of any found in the study appear here for the uninsured, who were 13.5 times as likely to have no regular provider and 6 times as likely to have gone without needed medical treatment due to cost, compared to respondents with health insurance. Seniors, who showed relatively stronger opinions than did younger respondents, do not stand out in terms of access problems. Young adults, however, whose only previous

differences were a reduced likelihood to rate health care as a top issue, and a slightly greater likelihood of willingness to pay extra to extend access to more Oregonians, now appear as a vulnerable group with a greater likelihood of access problems. Similarly, respondents without a high school diploma, whose only previous difference was an increased likelihood to have a negative view of the healthcare system, now appear with a greater likelihood of access problems due to cost, and a greater likelihood of receiving care in an emergency room.

For regional differences, the greater likelihood of receiving care in an emergency room refers to Central Oregon. Metro is the region with a reduced likelihood of problems with access due to cost, while Southern is the region with a somewhat greater likelihood of problems with access due to cost.

Table 6. Group differences in problems with access to medical care, plus coverage status (no health insurance) – odds ratios

	Q4 Big problem getting care	Q5 (reverse) No exam in 12 mos	Q7 Received care in ER	Q8 (reverse) No regular provider	Q9 Gone w/o treatment due to $	Q10 Gone w/o prescription due to $	Q11 Problems paying medical bills	Q22 No health insurance
INCOME (UP TO 200% FPL)		1.7			2.6	3.4	2.5	2.1
COVERAGE (UNINSURED)	2.2	4.5		13.5	6.0	4.2	3.7	
HEALTH (POOR TO FAIR)	1.9		2.1		1.8	2.3	2.7	1.8
AGE (18-39)		1.8		3.7	1.8		1.5	3.4
AGE (65+)								
EDUCATION (NO HS DIPLOMA)			2.5		2.1	2.6	2.0	2.4
EMPLOYMENT (NONWORKING)	2.4				1.9	1.9		2.4
GENDER (MALE)		1.6		1.7		0.7	0.7	
RACE (NONWHITE)			1.7					
ETHNICITY (HISPANIC)							2.4	4.2
REGION			2.6			0.6	0.5	
REGION						1.8	1.6	

APPENDIX 1: SURVEY INSTRUMENT AND AGGREGATE RESPONSES

Total Number of Respondents = 706 (sample weighted by age and gender)	PERCENT OF RESPONSES (excludes DK/Ref)	PERCENT OF TOTAL (includes DK/Ref)	NUMBER OF RESPONSES

Questions

Q1. Of all the issues facing Oregon today, including education, the economy, the environment, crime, taxes and other issues, please think about where health care fits in relation to other important issues.

In terms of importance, would you say health care is near the top of the list in importance, in the middle, or near the bottom of the list in importance?

1	Top	64.9	64.6	456
2	Middle	30.8	30.6	216
3	Bottom	4.4	4.3	31
8	Don't know/no opinion	-	.5	3
9	Refused	-	0	0

Q2. Now, I am going to read you four statements. Please tell me which one best summarizes your feelings about how the overall health care system is working today.

1	The health care system is fine just the way it is, no changes are needed.	3.2	3.2	22
2	The health care system works pretty well and only minor changes are needed.	20.5	20.2	142
3	There are good things about the health care system, but fundamental changes are needed.	57.5	56.4	398
4	There is so much wrong with the health care system that it needs to be completely rebuilt.	18.7	18.4	130
8	Don't know	-	1.9	13
9	Refused	-	0	0

Q3. In general, when you think about health care in Oregon, what do you think is the number one problem that needs to be solved? *[Interviewer records verbatim response.]*

Response categories:

Coverage/Access & Fairness	36.9	32.0	226
High Costs (general & for seniors)	16.3	14.2	100
High Costs (pharmaceuticals)	11.4	9.9	70
Delivery System	12.6	10.9	77
HMO & Insurance Organization	12.2	10.6	75
Transaction Costs/Information	1.0	.8	6
Waste	.8	.7	5
Government Administration (too much, bad)	3.3	2.8	20
Population-based Health Management	2.9	2.5	18
Miscellaneous & Ambiguous	2.6	2.3	16
No problem, Don't Know, Refused	-	13.2	93

Now, I'd like to ask you about your experiences with getting health care in the last year, that is, since March of 2000.

Q4. In the last 12 months how much of a problem, if any, was it to get the medical care you believed to be necessary? Was it a big problem, a small problem, not a problem, or did you not need any medical care?

		PERCENT OF RESPONSES (excludes DK/Ref)	PERCENT OF TOTAL (includes DK/Ref)	NUMBER OF RESPONSES
1	A big problem	10.2	10.2	72
2	A small problem	20.0	19.9	141
3	Not a problem	56.7	56.6	399
7.	Does not apply; have not needed	13.2	13.1	93
8.	Don't know	-	.1	1
9.	Refused	-	0	0

Q5. In the last 12 months have you received a routine physical examination or check up? By routine, we mean a check-up when you are not sick or injured.

0	No	35.4	35.4	250
1	Yes	64.6	64.6	456
8	Don't know	-	0	0
9	Refused	-	0	0

Q6. In the past 12 months have you visited a doctor or health clinic for an illness or injury?

0	No	32.7	32.7	231
1	Yes	67.3	67.3	475
8	Don't know	-	0	0
9	Refused	-	0	0

Q7. In the last 12 months have you received care in an emergency room?

0	No	76.2	76.0	537
1	Yes	23.8	23.8	168
8	Don't know	-	.2	1
9	Refused	-	0	0

Q8. Do you currently have a regular doctor or clinic to go to when you are sick or want medical advice?

0	No	12.9	12..8	91
1	Yes	87.1	87.0	614
8	Don't know	-	.2	1
9	Refused	-	0	0

Q9. Because of cost, in the last 12 months have you or someone in your household gone without a needed medical test or treatment?

0	No	75.8	75.7	534
1	Yes	24.2	24.2	171
7	Does not apply; have not needed	0	0	0
8	Don't know	-	.1	1
9	Refused	-	0	0

		PERCENT OF RESPONSES (excludes DK/Ref)	PERCENT OF TOTAL (includes DK/Ref)	NUMBER OF RESPONSES
Q10. Because of cost, in the last 12 months have you or someone in your household gone without filling a prescription for medicine?				
0	No	78.7	78.7	555
1	Yes	20.9	20.9	147
7	Does not apply; have not needed	.4	.4	3
8	Don't know	-	0	0
9	Refused	-	0	0
Q11. Because of cost, in the last 12 months did you have any problems paying medical bills, including doctor, hospital or prescription drug bills?				
0	No	74.8	74.4	525
1	Yes	25.1	25.0	177
7	Does not apply; have not needed	.1	.1	1
8	Don't know	-	.3	2
9	Refused	-	.1	1

Now, I would like to read a series of statements about health care values. Please tell me if you agree or disagree with each one. If you have no opinion about a statement, please just say so.

Q12A. Do you strongly disagree, somewhat disagree, somewhat agree, or strongly agree that: Access to health care should be a basic right for all just as education is a basic right.				
1	Strongly disagree	7.3	7.1	80
2	Somewhat disagree	3.8	3.7	26
3	Somewhat agree	17.8	17.5	123
4	Strongly agree	71.1	69.6	491
8	Don't know/no opinion	-	2.1	15
9	Refused	-	0	0
Q12B. Do you strongly disagree, somewhat disagree, somewhat agree, or strongly agree that: People should be required to have health insurance, just as automobile drivers are required to have car insurance.				
1	Strongly disagree	36.3	33.4	236
2	Somewhat disagree	22.4	20.7	146
3	Somewhat agree	21.6	19.9	141
4	Strongly agree	19.7	18.2	128
8	Don't know/no opinion	-	7.7	54
9	Refused	-	.1	1

		PERCENT OF RESPONSES (excludes DK/Ref)	PERCENT OF TOTAL (includes DK/Ref)	NUMBER OF RESPONSES

Q12C. The Oregon Health Plan is a publicly funded health insurance program for low-income residents of Oregon. Do you strongly disagree, somewhat disagree, somewhat agree, or strongly agree that: The Oregon Health Plan should be open to all qualified low-income Oregon residents, even if they are not U.S. citizens.

1	Strongly disagree	26.8	25.3	179
2	Somewhat disagree	14.8	14.0	99
3	Somewhat agree	27.3	25.8	182
4	Strongly agree	31.1	29.4	207
8	Don't know/no opinion	-	5.3	38
9	Refused	-	.1	1

Because many Oregon residents do not have health insurance, state officials are considering ways to expand coverage to more people. Now, I'm going to ask you about several options for doing this. As I read each one, please tell me whether you favor or oppose it. If you have no opinion, please just say so.

Q13A. Would you favor or oppose using state funding to help small employers offer health insurance to their employees?

1	Favor	80.9	74.9	529
2	Oppose	19.1	17.7	125
8	No opinion/don't know	-	7.4	52
9	Refused	-	0	0

Q13B. What about this option — would you favor or oppose requiring all employers to offer health insurance to their employees?

1	Favor	70.7	66.0	465
2	Oppose	29.3	27.4	193
8	No opinion/don't know	-	6.7	47
9	Refused	-	0	0

Q13C. Would you favor or oppose a national health plan, financed by taxpayers, that would cover everyone?

1	Favor	62.8	54.9	387
2	Oppose	37.2	32.5	230
8	No opinion/don't know	-	12.4	88
9	Refused	-	.1	1

Q13D. Would you favor or oppose helping uninsured people to buy health insurance on their own by offering them income tax deductions, tax credits, or other financial assistance?

1	Favor	86.9	78.6	555
2	Oppose	13.1	11.9	84
8	No opinion/don't know	-	9.4	66
9	Refused	-	.2	1

		PERCENT OF RESPONSES (excludes DK/Ref)	PERCENT OF TOTAL (includes DK/Ref)	NUMBER OF RESPONSES
Q13E. What about expanding Medicare to cover people aged 55 and older, not just those 65 and older — would you favor or oppose this?				
1	Favor	70.5	64.9	458
2	Oppose	29.5	27.1	191
8	No opinion/don't know	-	8.0	57
9	Refused	-	0	0
Q13F. Would you favor or oppose expanding public programs such as the Oregon Health Plan that provide insurance for low-income people without health insurance?				
1	Favor	86.2	79.0	558
2	Oppose	13.8	12.6	89
8	No opinion/don't know	-	8.3	59
9	Refused	-	0	0
Q13G. Would you favor or oppose increasing state funding to expand community health clinics that serve low-income people who do not have health insurance?				
1	Favor	83.7	77.0	543
2	Oppose	16.3	14.9	105
8	No opinion/don't know	-	8.0	56
9	Refused	-	.1	1
Q14. Would you be willing to pay any extra money — either in higher health insurance premiums or higher taxes — in order to increase the number of Oregon residents who have access to medical care?				
0	No *[Skip to Q15.]*	43.9	39.7	280
1	Yes	56.1	50.6	357
8	Don't know	-	9.6	68
9	Refused	-	.1	1
Q14A. Would you be willing to pay an extra $50 more per month to increase the number of Oregon residents who have access to medical care?				
0	No	56.2	30.8	216
1	Yes *[Skip to Q15.]*	*43.8*	*23.8*	*168*
8	Don't know	-	5.4	38
9	Refused	-	.5	3
[Ineligible]		-	39.7	280
Q14B. Would you be willing to pay an extra $30 a month?				
0	No	56.6	17.9	126
1	Yes *[Skip to Q15.]*	*43.4*	*13.7*	*97*
8	Don't know	-	4.4	31
9	Refused	-	.5	3
[Ineligible]		-	63.5	448

		PERCENT OF RESPONSES (excludes DK/Ref)	PERCENT OF TOTAL (includes DK/Ref)	NUMBER OF RESPONSES

Q14C. Would you be willing to pay an extra $5 a month to increase the number of Oregon residents who have access to medical care?

0	No	12.3	2.3	17
1	Yes	87.7	16.6	117
8	Don't know	-	3.6	25
9	Refused	-	.2	2
[Ineligible]		-	77.2	545

Next, I'd like to ask you some questions about choices the Oregon Health Plan needs to make. As I mentioned earlier, the Oregon Health Plan provides medical coverage for many low-income residents of Oregon. In order to cover more people, Oregon officials are considering reductions to the medical benefits provided to some adults in the program. I would like to read a few possible options. These options would not affect children, pregnant women, blind, disabled or elderly people. As I read each strategy please tell me if you favor or oppose it as a way to expand coverage to more low-income adults.

Q15A. Cover inpatient hospital care but do not cover outpatient medical care. Do you favor or oppose that?

0	Oppose	69.2	61.4	433
1	Favor	30.8	27.3	192
8	Don't know	-	10.7	76
9	Refused	-	.6	4

Q15B. The next strategy is almost the opposite of the first one: Cover outpatient medical care but cover only a limited amount of inpatient hospital care. Would you favor or oppose this strategy as a way to offer coverage to more low-income adults?

0	Oppose	66.6	57.9	408
1	Favor	33.4	29.0	205
8	Don't know	-	12.6	89
9	Refused	-	.6	4

Q15C. How about the strategy of asking Oregon Health Plan members to pay a larger share of the cost of their own medical care. Would you favor or oppose this strategy?

0	Oppose	49.5	43.4	307
1	Favor	50.5	44.4	313
8	Don't know	-	11.9	84
9	Refused	-	.2	2

Q15D. How about this strategy: Reduce dental coverage so that routine dental care like check-ups and cleaning are covered but restorative dental services such as fillings or crowns are not covered.

0	Oppose	63.9	58.5	413
1	Favor	36.1	33.0	233
8	Don't know	-	8.2	58
9	Refused	-	.3	2

		PERCENT OF RESPONSES (excludes DK/Ref)	PERCENT OF TOTAL (includes DK/Ref)	NUMBER OF RESPONSES
Q15E. How about this strategy: Eliminate coverage for routine eye exams and glasses.				
0	Oppose	74.9	71.3	503
1	Favor	25.1	23.8	168
8	Don't know	-	4.7	33
9	Refused	-	.2	2
Q15F. Finally, this strategy: Change the pharmacy benefit so that Oregon Health Plan members would pay more for brand name drugs.				
0	Oppose	45.1	42.4	299
1	Favor	54.9	51.5	364
8	Don't know	-	5.9	41
9	Refused	-	.2	2

My final questions are about you and your household.

Q16. In general, would you say your health is:				
1	Excellent	24.5	24.5	173
2	Very good	30.0	30.0	211
3	Good	30.7	30.7	217
4	Fair	10.9	10.9	77
5	Poor	4.0	4.0	28
8	Don't know	-	0	0
9	Refused	-	0	0

Q17. How many children and adults, including yourself, are living in your household? Please include anyone who normally lives in your household but who is now in the hospital for a short time, is in a nursing home or is away at school.

Q18. Of the people in your household, how many are 18 years of age or younger?				
0	No children 18 or under	59.8	59.7	421
1-7	# children 18 or under	40.2	40.2	284
99	Refused	-	.1	1
Q19. How would you describe your marital status?				
1	Single, never married	23.0	23.0	162
2	Married	55.3	55.3	390
3	Living with a partner	5.7	5.7	40
4	Separated	1.2	1.2	9
5	Divorced	7.7	7.7	55
6	Widowed	7.0	7.0	49
8	Don't know	-	0	0
9	Refused	-	.1	1

		PERCENT OF RESPONSES (excludes DK/Ref)	PERCENT OF TOTAL (includes DK/Ref)	NUMBER OF RESPONSES
Q20. Are you currently either employed or self-employed?				
0	No	37.0	36.9	261
1	Yes	63.0	62.9	444
8	Don't know	-	.1	1
9	Refused	-	0	0

Q21. About how many hours a week, on average, do you work?

Q22. Are you currently covered by some type of health insurance?				
0	No	10.9	10.9	77
1	Yes *[Skip to Q25.]*	89.1	89.1	629
8	Don't know	-	0	0
9	Refused	-	0	0

Q23. How long have you been uninsured?

Q24. There are many reasons why people do not have health insurance. Could you tell me why you do not currently have health insurance?

01	Can't afford/too expensive	49.5	5.4	38
02	Unemployed or between jobs	20.0	2.2	15
03	Employer doesn't offer to any employees	8.6	.9	7
04	Not eligible through employer	7.8	.8	6
05	Can't get coverage or refused insurance	1.9	.2	1
06	Too difficult/too much paper work	1.0	.1	1
07	Don't need it	2.3	.2	2
08	Other *[Record response.]*_____	*8.9*	*1.0*	*7*
88	Don't know	-	.1	1
99	Refused	-	0	0
[Ineligible]		-	89.1	629

Q25. Is your primary health insurance plan obtained through:

1	Your employer	36.4	32.2	228
2	A family member's employer	22.2	19.7	139
3	Insurance you purchased privately	13.0	11.5	81
4	Medicare	11.0	9.7	69
5	Medicaid, including Oregon Health Plan	4.8	4.2	30
6	Other *[Record response.]*_____	*12.7*	*11.2*	*79*
8	Don't know	-	.4	3
9	Refused	-	.1	0
[Ineligible]		-	10.9	77

		PERCENT OF RESPONSES (excludes DK/Ref)	PERCENT OF TOTAL (includes DK/Ref)	NUMBER OF RESPONSES

Q26. In the past 12 months, has there been any period of time in which you have been completely without any health insurance coverage?

0	No	76.4	75.6	534
1	Yes	23.6	23.3	165
8	Don't know	-	0	0
9	Refused	-	0	0
[Ineligible]		-	1.1	8

Q27. Thinking only about the children in your household who are 18 or younger, do they currently have health insurance coverage?

0	No	12.1	4.8	34
1	Yes	87.1	34.5	244
2	Some do, some don't	.8	.3	2
8	Don't know	-	.5	3
9	Refused	-	.2	2
[Ineligible]		-	59.7	421

Q28. In the past 12 months, has there been any period of time in which the children who are 18 or younger and living with you were completely without any health insurance coverage?

0	No	80.4	31.8	224
1	Yes	19.6	7.8	55
8	Don't know	-	.5	4
9	Refused	-	.2	2
[Ineligible]		-	59.7	421

Q29. In summary, of all the people in your household, how many are currently covered by some type of health insurance? Please include yourself in this count.

Q30. In what year were you born?

Q31. What is the highest grade or level of school you have completed?

01	Less than 8 years	1.4	1.4	10
02	Some high school (9–12 years), without a diploma	6.7	6.7	47
03	High school diploma or GED	24.0	24.0	170
04	Associate Degree (for example: AA, AS)	7.7	7.7	54
05	Some college, but no degree	26.4	26.4	187
06	Bachelor's degree	21.8	21.8	154
07	Some graduate or professional study but no degree	3.1	3.1	22
08	Graduate or professional degree	8.9	8.9	63
88	Don't know	-	0	0
99	Refused	-	0	0

		PERCENT OF RESPONSES (excludes DK/Ref)	PERCENT OF TOTAL (includes DK/Ref)	NUMBER OF RESPONSES
Q32.	What language do you usually speak at home?			
1	English	96.5	96.5	681
2	Spanish	.2	.2	2
3	Other *[Record response.]*_____	*3.2*	*3.2*	*23*
8	Don't know	-	0	0
9	Refused	-	0	0
Q33.	Are you male or female? *[Only ask if interviewer is unsure; otherwise record it.]*			
0	Male	49.0	49.0	346
1	Female	51.0	51.0	360
8	Don't know	-	0	0
9	Refused	-	0	0
Q34.	Would you describe yourself as any of the following: Spanish, Hispanic or Latino?			
0	No	96.5	96.2	679
1	Yes	3.5	3.5	25
8	Don't know	-	0	0
9	Refused	-	.3	2
Q35.	How would you describe your race? Indicate only one:			
1	American Indian or Alaskan Native	1.3	1.3	9
2	Asian	1.5	1.4	10
3	Black or African-American	1.3	1.3	9
4	White	88.2	86.8	613
5	Bi- or multi-racial	3.1	3.1	22
6	Other *[Record response.]*_____	*4.5*	*4.4*	*31*
8	Don't know	-	.4	3
9	Refused	-	1.1	8

Q36. Could you please tell me your zip code?

Q37. Which of the following four statements best describes your ability to get along on your household income:

1	You can't make ends meet	8.3	8.1	57
2	You have just enough, no more	22.8	22.3	157
3	You have enough, with a little extra sometimes	48.7	47.6	336
4	You always have money left over	20.2	19.8	140
8	Don't know	-	.8	5
9	Refused	-	1.5	10

Q38. Finally, my last question: Adding together the income of all the people in your household, approximately what was your total household income last year, from all sources, before taxes?

APPENDIX 2: TECHNICAL NOTES

Sample

The design for this study called for telephone interviews to be conducted with a minimum of 600 Oregon households. To obtain this minimum, a total of 3,311 telephone numbers were randomly selected using ASDE Survey Sampler software. Of these numbers, 3000 were directory-listed numbers, and 311 were directory not listed (i.e., the final four digits were randomly generated based on the exchanges in use in the state).

The original design called for numbers in the sample to be called up to five times, if necessary on different days of the week and weekend, and at different times of the day and evening. Up to five attempts were to be made to reach a household, or until it was determined that the number was not working, did not belong to a residence, belonged to a respondent who did not speak English, or belonged to a respondent who refused to participate. In an attempt to improve the response rate for the study, 10 or more attempts were made to the remaining unresolved numbers.

Upon achievement of the required number of 600 completed interviews, it was determined that older adults and females were over-represented. Thus, the fieldwork was extended, in an attempt to achieve a more representative sample. Also, the screening criteria were modified, such that when someone answered the telephone, the interviewer requested first to speak with an adult male, and then with the male who had the most recent birthday. When no male lived in the household, the interview was conducted with the adult female who had the most recent birthday. If an adult male resided in the household but was not available, a time to call back was scheduled. Another 109 interviews were completed, for a total number of 709 completed interviews. (As noted below, however (see Sample Weighting, next page), the additional interviews did not fully correct the over-representation of women and older adults, so the data were weighted for presentation here.)

To obtain the 709 completed interviews, a total of 11,376 calls were made to the 3,311 telephone numbers drawn as the sample. Of these 3,311 numbers, 660 remained active at the time the study was concluded[1], leaving 2,651 numbers. Of these, 809 were not valid numbers for the study (621 were nonworking, 166 were nonresidential, 22 did not speak English or had some other language/hearing problem), leaving a total potential eligible household N of 1,842. Of these, 171 were persistently unavailable (i.e., the required number of attempts had been made without reaching anyone), leaving a total of 1,671 households with whom contact was made. Of these, 709 completed the interview, while 962 refused to be interviewed, either hanging up immediately or once the questions had begun.

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[1] "Active" numbers are those numbers that had not been called the required minimum number of attempts designated at the start of the study (five, in this case), or numbers that had callbacks scheduled for a date beyond the end date for the study. In the present study, most of these "active" numbers (660) had callbacks scheduled; many belonged to households who had refused once to complete the screening interview, and so another attempt had been rescheduled.

Response rate

To calculate response rate, typically the number of completed interviews is divided by the number of eligible units in the sample. There are various definitions, however, of "eligible units" (CASRO, 1982). In general, when a "quota" for the completed sample has been established, such as in the present study, numbers that have not been called the required number of times are excluded from the denominator (660, in this case). In addition, numbers determined to be nonvalid (809, in this case) are excluded. At issue is whether those households with which contact could not be established even after five attempts should be considered "eligible." A conservative approach is to assume that all such numbers (171, in this case) would have been eligible, if only contact could have been made by extending indefinitely the number of attempts made to reach them. Calculating the response rate using this assumption yields a rate of 38.5% (709/(3311-660-809)).

A less conservative approach is to exclude from the denominator not only the still active numbers (n=660) and the nonvalid numbers (n=809), but also the numbers that were persistently unavailable (n=171). This method, which follows the lead of marketing studies, uses the Politz-Simmons technique, in which the population sampled is defined as the population of persons eligible and at home (either on the first attempt or within the number of attempts set as the minimum) when the interviewer calls; those who were never at home or available when the interviewer called are not considered part of the nonresponse group (CASRO, 1982). In this approach, households who refuse to be interviewed are assumed to have been eligible, but all others are not. Using this approach in this study would yield a response rate of 42.4% (709/(3311-660-809-171), or 709/1671).

A middle-ground approach is to estimate the number of households that would likely have been ineligible had all of the persistently unavailable numbers been reached. This estimate is derived from dividing the number of numbers known to be ineligible by the total number of numbers, or 809/3311, for a 24.4% ineligibility rate. Using this percentage to determine the likely number of ineligible numbers among the 171 yields 42 ineligibles. To calculate the response rate using this estimate involves dividing the number of completed interviews by the number of (estimated) eligible reporting units in the sample. In this case, that would yield a response rate of 39.4% (709/(3311-660-809-42), or 709/1800).

Although low response rates generally are considered a major threat to the usefulness of a survey, two recent studies found only minor effects on survey results (Curtin, Presser, & Singer, 2000; Keeter, Miller, Kohut, Groves, & Presser, 2000). Nonetheless, this study's relatively low response rate, and the lack of representation of Oregon households without telephones given the mode of data collection, dictate that caution be exercised when interpreting and generalizing from the findings.

Sample Weighting

Even with the additional 109 interviews beyond the 600 originally called for, the achieved sample continued to over-represent women and persons aged 65 and over. This is because although calls were made during the evenings and weekends, as well as during the day, too many daytime calls had already been made, when those not working (e.g., older adults and women not working outside the home) are those most likely to be reached.

Thus, using data from the Center for Population Research and Census at Portland State University, a weighting variable was created, and weights were applied to the responses of each survey participant based on age and gender. The values of the weighting variable indicate the number of observations represented by single cases in the data file. A working-age male, for example, would have a weight of greater than 1, while an older female would have a weight of less than 1. The procedure used was the "weight cases" command syntax in SPSS-PC. "Weight Cases" gives cases different weights (by simulated replication) for statistical analysis.

All analyses presented in this report apply these weights to adjust appropriately for age and gender. In the Crosstabs procedure, when weights are applied, cell counts based on fractional weights are rounded to the nearest integer. For example, a cell count of 4.2 based on fractional weights is rounded to 4. Cases with zero, negative, or missing values for the weighting variable are excluded from analysis. Because age and/or gender were not available for three (3) respondents, no value for the weighting variable "wgt" could be computed. **Thus, the weighted sample consists of 706 individuals.**

It should be noted that although the average age of respondents (45.8 years; see Sample Characteristics) may appear high, weights were applied based only on the adult population of Oregon; residents under age 18 were excluded.

Instrumentation and Measures

The data for the study were collected using a survey instrument developed by the Office for Oregon Health Policy and Research project team, in consultation with Dr. Margaret Neal and Mr. Terry Hammond at Portland State University. Dr. Neal is the Director of PSU's Survey Research Laboratory (SRL), and Mr. Hammond is a student in the Urban Studies doctoral program as well as the Master of Public Health program. The instrument is presented in Appendix 1. In brief, topical areas included:

- the relative importance of health care issues to Oregon households and core values concerning health care (Questions 1, 2, 3, 12A-C);
- support for various means for extending health insurance to more Oregon residents (Questions 13A-G, 15A-F)
- willingness to pay in order to expand the number of Oregon residents with access to medical care (Questions 14, 14A-C);
- household experience in seeking health care (Questions 4-11);
- household health coverage (Questions 22, 24-29); and
- demographic characteristics.

Data Collection Process

Training

The director and the manager of the SRL trained all interviewers and supervisors. Question-by-question training on the study's survey instrument was provided, and interviewers made several practice calls to each other and to supervisors before beginning to make calls formally. The SRL manager and supervisors provided additional one-on-one training of interviewers, as needed.

Use of CATI

All calls were made from the supervised, centralized 20-station interviewing facility at the SRL. This facility uses a Computer-Assisted Telephone Interviewing (CATI) system. Use of a CATI system eliminates the inadvertent missing of questions by interviewers. Also, in a CATI system the respondent's answers are entered into the database directly by the interviewer at the time the response is given; thus, the need for second-level data entry and the additional error associated with having to record responses twice is eliminated. In addition, the CATI software can prohibit entry of out-of-range or invalid values by the interviewer. Finally, by having all calls made in a centralized and supervised facility, it is possible to visually monitor interviewers' presence and activities. The CATI system allows calls to be randomly monitored to make sure that questions are being asked as written and data are being entered appropriately.
In sum, use of CATI enhances data quality and provides the ability to produce a clean data file almost immediately.

Respondent Selection

In each household, the adult Oregon resident to be interviewed was selected randomly, using the "last birthday" approach. In this approach, after introducing the study, the interviewer requests to speak with the adult who had the most recent birthday (Salant & Dillman, 1994). Screening questions were asked to assure that the respondent was at least 18 years of age and an Oregon resident.

Data Analysis

For all analyses in this report, weights have been applied to adjust appropriately for age and gender (see Sample Weighting, above). Frequency distributions and descriptive statistics were computed for the study variables. Percentages and sample sizes are reported in Appendix 1 for each question on the survey. The results are described by topic area in the report itself.

Reported Percentages

All percentages reported in this study represent the percent of responses provided, excluding the "Don't Know" (DK) responses and refusals to respond (Ref) to each particular question. This procedure is standard practice for the U.S. Census Bureau and for academic reporting of survey results (cf., Shryock & Siegel, 1971). This reporting convention assumes that the missing cases are a random sample of the cases with observed values. Appendix 1 reproduces the survey instrument and a tabulation of the results, with the percentage of responses (excluding "DK/Ref") and the corresponding percentage of the total sample (including "DK/Ref") for each item. In general, the amount of missing data is extremely small, with the exception of the income question (see below).

Group Differences

In addition to aggregate frequencies on key items, results were also compared for various subgroups using crosstabulations or analyses of variance, as appropriate. The set of standard subgroup comparisons included:

- income (up to 200% of the federal poverty level (FPL) vs. above 200% FPL);
- health coverage status (uninsured vs. insured);
- health status (poor or fair health vs. good to excellent health);

- age (18-39, 40-64 and 65+);
- education (less than high-school diploma, high-school diploma but less than Bachelor's degree, Bachelor's degree but less than Graduate degree, and Graduate degree);
- employment status (not employed, working 1-29 hours, working 30+ hours);
- gender;
- race (white respondents versus others);
- ethnicity (Hispanic versus others);
- region of residence (nine standard Oregon regions).

In this report, only differences that are statistically significant at the .05 level of significance are presented. Differences that are statistically, but not practically, significant (e.g., where groups differ by 2% or less), are not reported.

Income: Missing Data

It should be noted that there was a fairly large amount of missing data concerning respondents' incomes, reflecting their reluctance to report such information, at least in the open-ended way in which the question was asked. Asking respondents about their incomes in two steps (e.g., first asking "Is your total household income below $30,000 per year or is it $30,000 or above?" and then reading a list of applicable categories) may have yielded more responses.

Of the 706 respondents, 26% were missing data on income. In order to be aware of possible bias due to nonresponse on this item, a dummy variable was used to compare the answers of respondents and nonrespondents to the income question on each other survey item. No significant differences existed between respondents and nonrespondents to the income question in the areas of attitudes, preferences or coverage. Significant differences were found only on the following items:

- Nonrespondents were less likely to be employed (48% vs. 68%).
- Nonrespondents were a little older on average (age 50 vs. 44.2).
- Nonrespondents were somewhat less likely to report problems obtaining needed medical care (2.66 vs. 2.49 – on 3-point scale where 1 = big problem, and 3 = not a problem).
- Nonrespondents were less likely to be willing to pay extra to expand access to medical care for more Oregon residents (48% v. 59%).
- Nonrespondents reported fewer children, aged 18 or younger, in the household, on average (.56 vs. .84)

The most likely source of bias in the above list is the fairly large difference in employment status, which suggests a proportionately greater number of nonrespondents to the income question were probably people at lower income levels. In the analyses of group differences in this study that rely on the distinction between two income categories up to or above 200% FPL, the lower income group is probably somewhat underrepresented.

Income: Calculating Federal Poverty Level

In light of current health-policy deliberations for extending health coverage to more Oregonians at lower incomes, a distinction was made between those with incomes up to and including 200% of the federal poverty level and those with incomes above 200% FPL. Calculating FPL from income levels was accomplished by dividing reported income

by the U.S. FPL, which varies according to household size. Each additional person in the household adds $3020 to the FPL, meaning higher income households remain closer to poverty level as household size increases. The following formula was used to transform income levels into FPL levels: Reported Income / 5570 + (household size*3020).

Region

To examine the possibility of regional differences in responses, respondents were classified as residing in one of nine standard geographic regions in Oregon, based on their zip codes. Smaller populations in several of these regions reduced the power of the analyses, making it difficult to detect differences that might otherwise exist. Respondents in the Gorge region, for example, were too few in number to consider separately in any analyses.

*O*dds Ratio

Using an odds ratio to compare risk has an advantage over direct computation of relative risk from one positive percentage. This latter approach can be misleading, because the value may change depending on how it is expressed. For example, one may report that 46% of the uninsured have a regular provider compared to 92% of the insured, giving the impression of a two-fold difference, whereas one could also say that 54% of the uninsured do not have a regular provider compared to 8% of the insured, giving the impression of a nearly seven-fold difference.

Alternatively, an odds ratio accounts for all the probabilities and remains the same no matter how one expresses it. In the example above, the odds ratio is 13.5. The odds ratio is applied to a 2x2 table, with columns representing case vs. control, and rows representing an outcome. The conceptual formula is pi(1)/(1-pi(1)) / pi(0)/(1-pi(0)), where pi(1) is the probability of a positive outcome for all cases in one column, and pi(0) is the probability of a positive outcome for all controls in the second column. The result compares the one probability to the other.

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