Medi-Cal Patient Satisfaction in Watts

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THE California Medical Assistance Program, popularly known as Medi-Cal, is the State's implementation of Title XIX of the Social Security Act. In other parts of the country this program is called Medicaid. Its services are delivered through various organizational modes such as individual fee-for-service practice, private group practices, hospital outpatient departments, county hospitals, neighborhood health centers sponsored by the Office of Economic Opportunity (OEO), and several prepayment plans.

This paper is concerned with a household interview survey of a sample of Medi-Cal beneficiaries living in the target area of the South Central Multipurpose Health Services Center, an OEO neighborhood health center in Watts, a district in south central Los Angeles. Medical and related services provided to the beneficiaries by the neighborhood health center were paid for by the Medi-Cal program on a fee-for-service basis.

Our objective was to determine what proportion of the interviewees and their families used the center, the interviewees' other sources of care, and the nature of their satisfactions and dissatisfactions with the health care resources available to them. It was also possible to compare responses from a small sample of low income households in the target area not eligible for Medi-Cal benefits with the responses of the Medi-Cal beneficiaries.

The South Central Center

The August 1965 riots in the predominantly black community of Watts brought national attention to the economic and social problems in the area. Although some investigators did not perceive the lack of health facilities and personnel as a primary cause of the August riots, nevertheless, ". . . inadequacies and failures in meeting health needs in the Riot Area undoubtedly have added to the weight of frustration and misery which in Los Angeles, as elsewhere, has often led to violence" (*1*). This anomie engendered antipoverty programs and the establishment of a neighborhood health center in the Watts area.

Development of the South Central Multipurpose Health Services Center, Inc. (also referred to in this paper as the center, the neighborhood health center, the health services center, or SCMHSC) began on June 30, 1966, when the OEO granted $2.4 million to the University of Southern California (USC) for a 1-year planning period; subsequently, additional funding continued to be granted.

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This paper is a shortened version of Medi-Cal Project Report No. 4, "Medi-Cal Patient Satisfaction Under an OEO Neighborhood Health Center and Other Health Care Resources in South Central Los Angeles," March 1972. The project was supported by PHS grant HS 00140 from the National Center for Health Services Research and Development, Health Services and Mental Health Administration. The Office of Economic Opportunity obtained the data used in this study.

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Because the program's origin and emphasis were as an antipoverty measure, many community residents initially viewed the center as a remedy for unemployment instead of a source for health services. Eventually some friction grew between the community residents who worked at the center and those who did not. The primary goal of delivering health care services had to be strenuously emphasized in order to undo the misconception about priorities.

As the health services center was being organized, a professional advisory board and a community health council were formed. The professional advisory board included a physician, dentist, and pharmacist selected from Watts by their respective local professional organizations, plus representatives of the county health department and USC's dental and medical schools. The board made recommendations on professional matters to the community health council.

The community health council was chosen from among representatives of local agencies and area residents who volunteered. In February 1967 the council became the board of directors, providing consultation and advice to USC concerning the center's operations. On December 31, 1969, the board acquired control of the center with USC assuming the role of consultant.

The center opened in October 1967. An estimated 32,000 persons lived in the target area and had incomes low enough to be eligible for the health center's services. The eligible population lived in a target area of approximately 3.2 square miles bounded by 92d Street on the north, 120th Street on the south, Alameda Boulevard on the east, and Central Avenue on the west.

According to the SCMHSC brochure, "The aim of South Central Multipurpose Health Services Center is to provide health care that is both comprehensive and of high quality." To achieve this goal, physician staffing during the survey period, November 1970–February 1971, consisted of approximately 33 full-time equivalents (40-hour weeks) in general practice, internal medicine, gynecology and obstetrics, ophthalmology, orthopedics, pathology, pediatrics, psychiatry, radiology, surgery, urology, and personal and family health.

The health team approach, stressed at the center, provides that each family or person be serviced by a team that includes a family physician, registered nurse, social worker, and neighborhood health agent. The nursing staff coordinates the health team and, with the aid of the neighborhood health agents, extends health care into the home environment through home visits.

The center is open 8:30 a.m. to 5 p.m., Monday through Friday, and the emergency room is open 24 hours a day, 7 days a week. Except for emergencies, patients register at the center and are assigned to a family health team. No persons living within the service area are turned away because of inability to pay. Medi-Cal beneficiaries, like other residents of the area, may register at the health services center or may go elsewhere for care. Services provided to them by SCMHSC are paid for by the Medi-Cal program on a fee-for-service basis at the same rates paid to other providers of service.

The radiology department provides a 24-hour, 7 days a week X-ray examination service, and all routine laboratory tests are done in the center's laboratory. Patients are treated in the physical therapy department on written orders from the center's and the community's physicians. Prescriptions written by the center's physicians may, but need not be, filled at the center's pharmacy. Approval by a center's physician is required for the filling of prescriptions originating outside the SCMHSC. Regular dental services are provided as well as the following dental specialties: oral surgery, endodontics, orthodontics, prosthodontics, periodontics, pedodontics, and dental health education. The staff of dentists had an approximate average of 15 full-time equivalents.

The community services division was organized to be the major link between the health center and the community. Its main function is to try to determine what is relevant, effective, and needed for the Watts area residents. The environmental health section of the health center has staff lawyers to provide legal advice to the center and to its registrants. Education and job training are offered for community residents recruited and trained as neighborhood health agents and to other paramedical personnel. Other educational programs are conducted for the inservice staff to upgrade existing skills for better job opportunities.

Background and Method of the Study

Preliminary work for a survey of Medi-Cal beneficiaries in the SCMHSC target area had been done by UCLA research staff when we learned that the Office of Economic Opportunity was planning impact studies of all its major neighborhood health centers, including the SCMHSC, and that

the impact studies were to include household interview surveys of the target areas. The board of directors and the staff of SCMHSC, with whom we had been working closely in the development of our study, understandably were reluctant to have the Watts community subjected to two surveys so close in time and with many objectives and procedures which would obviously overlap. Consequently, OEO and UCLA agreed to participate in a joint research effort in the Watts area. A household survey was subcontracted to a survey research firm. The following discussion is based on the results of the survey.

The sample. An area probability sample was developed for the SCMHSC service area and for a second area to be compared with the service area. This comparison area was north of and adjacent to the service area. A sample of tracts was chosen at random from the 1960 census tracts within each of these two areas. For all tracts chosen, residence lists were made in the field, and then the residences from which a respondent was to be interviewed were drawn at random from the lists for each tract. The household was the primary sampling unit; only one respondent was interviewed in each household, but on some interview items information was asked about all household members. Approximately one prospective respondent in seven refused to be interviewed, and one in nine was still not found at home on a second callback. This gave an overall response rate of 75 percent. No attempt was made to take into account any possible differences between respondents and nonrespondents.

Residents of the comparison area were not eligible to use the SCMHSC because they lived outside the service area of the center. They were similar in socioeconomic characteristics, however, and were included in the analysis because they offered comparative information on low income persons who did not have access to a neighborhood health center.

Households were classified as Medi-Cal beneficiaries on the basis of the interviewees' answers to question 13: "Are any of your family's hospital or doctor bills paid for by the public welfare department or Medicaid (Medi-Cal)?" This question, unfortunately, was not sufficiently restrictive to insure that the individual household members were certified for Medi-Cal services, since some persons not under Medi-Cal are eligible for care by the county hospital and may have answered "yes." However, of 477 interviewees in the target area who responded to this question, 358 answered "yes," and their families were classified as Medi-Cal households.

After the general population was interviewed in November and December 1970, another sampling frame was prepared in the same manner as the first. The objective was to augment the number of Medi-Cal households to at least 400, the number which had been determined to be adequate for analysis of Medi-Cal households alone, that is, leaving out other clinic users. Supplemental interviewing took place in February 1971. Medi-Cal interviews from the first and supplemental sample were simply merged. This resulted in a total sample of 519 households, consisting of 2,146 persons classified as Medi-Cal beneficiaries.

Grouping of the households and their individual members was made according to their use of the neighborhood center in the following scale. In group 1, SCMHSC was reported as the household's usual source of care, group 2 stated that family members used the center on occasion and also used other sources of care, group 3 interviewees reported generally using other medical sources and only rarely did individual family members use the neighborhood health center, and group 4 consisted of the comparison area residents not living in the OEO-designated eligibility area for the health center in Watts.

Statistical treatment. Chi-square tests ($P < 0.01$) of homogeneity were applied to tables of answers intended to determine differences among the four groups of our sample. In the analysis section significant group differences elicited by the questions and chi-square test are discussed and compared. Results from all other questions answered by the four groups are pooled for discussion. More elaborate statistical treatment such as correction for nonrespondent bias and for within-household intraclass correlation was not deemed appropriate because of the many imperfections in the interview design and questions.

This survey presents difficult problems in analysis because (*a*) the four groups were poorly defined by the interview questions and not mutually exclusive, and (*b*) on some items the interviewee reported not only for himself but also for every member of his household. In the subsequent discussion, the reader should note when numbers refer to individuals and when to households.

Surveys have certain inherent problems of study design and validity. Interviews designed to obtain facts, for example, depend on willingness and abil-

ity of interviewees to remember and report their experiences. Consequently, the results must be read with caution. The data should be considered only as indications of how welfare families in a predominantly black, urban ghetto use their health care resources and view their health needs.

Results and Analysis

This section relates responses to questions pertaining to characteristics of the Medi-Cal beneficiaries, their use of health care resources, and expressions of satisfaction or dissatisfaction with the services used. Grouping of the households and their individual members is shown in table 1.

Group 1, consisting of usual users of SCMHSC, included 22.9 percent of the households. Another 31 percent (group 2) used the center on occasion but also used other sources. Thus SCMHSC was considered the main or auxiliary source of care for more than half the households (53.9 percent). When group 4 was excluded from the totals, the percent of usual and occasional users of SCMHSC increased to 63 percent of the households and 70 percent of the individuals.

Among all 519 households, the usual source of health care (irrespective of occasional use of other resources) was most frequently a private physician's office, as shown in table 2. Only 11.1 percent of the interviewees depended on hospital outpatient departments. Nearly 6 percent of the interviewees said the family had no usual source of care.

Demographic characteristics. Black persons (from 487 households out of 519) constituted 94 percent of the total interviewed. More women than men were interviewed, and 61 percent of all the interviewees had lived in the area 5 years or more. Twenty-two percent of those responding about adult education indicated an educational level of "some high school" or high school completion—6.1 percent stated fourth grade or less.

There were significant differences in the age distribution of those who used the health center (groups 1 and 2) and those who did not, as shown in table 3.

Table 1. Household and individual beneficiaries of Medi-Cal, by group

Group	Households		Individuals	
	Number	Percent	Number	Percent
Total	519	100.0	2,146	100.0
1	119	22.9	538	25.1
2	161	31.0	761	35.5
3	167	32.2	565	26.3
4	72	13.9	282	13.1

Table 2. Usual source of care, by percent

Sources	Households
SCMHSC	23.0
Physicians' offices	54.5
Hospital outpatient departments	11.1
Other	5.4
No usual place	5.6
No response	.4

Table 3. Percent in each group, by range in age

Range in age (years)	1 (N= 538)	2 (N= 761)	3 (N= 565)	4 (N= 282)
Under 5	16.2	13.8	16.6	15.6
5–17	50.7	51.5	41.1	46.9
18–44	24.0	24.7	21.9	22.3
45–64	6.3	6.4	11.0	7.8
65 or over	2.4	3.5	9.4	7.4
No response [1]	.4	.1	...	...

[1] Not included in χ^2 calculations.

Despite their differences, all four groups had more children than the general population of California, which in January 1969 had an estimated 8.9 percent under the age of 5 and 25.5 percent between the ages of 5 and 18 years (*2*). On the other hand, the general population's proportion of persons aged 45 and over, 29.6 percent (*2*), was considerably higher than any of the four study groups, which ranged from 8.7 percent in group 1 to 20.4 percent in group 3.

According to their responses, health center users had larger families than nonusers. Approximately 50 percent of group 1 reported five or more persons in the family in contrast to 28 percent of group 3 reporting the family size as five or more persons.

Health status. Interviewees were asked, "Would you say that your health (and each family member's) in general is very good, good, fair, or poor?" Perceptions for each group are given in table 4.

According to their replies, the respondents in each group rated the physical health status of more than 60 percent of their family members as good to very good, with a significant difference among the groups. Literature on health needs of the poor suggests, however, that low income persons tend

to enc e, adjust, and finally accept pain and poor health as a normal part of their lives (*3, 4*). As stated by Harris (*5*):

> For two out of every three people in the population, when they are "feeling fine" it means that nothing is the matter with them. But for nearly two out of every three ghetto blacks in the inner city or rural poverty whites in Appalachia, "feeling fine" means literally, "not as sick as usual."

If this generalization is applicable to the Watts ghetto residents, the respondents may not be in as good health as they judged themselves to be. An alternative explanation of the high level of good health could be that this is a relatively young population.

Felt needs for care. Seventeen percent of all respondents felt there were times when a family member should have seen a physician during the past 12 months but failed to do so. Results of questions in this category did not show significant chi-square results nor substantive differences among the groups.

Reasons most often given for not obtaining care were, in order of frequency of replies, (*a*) physician inaccessible, (*b*) tried own treatment, (*c*) condition improved, (*d*) physically unable to go, and (*e*) distrust of physician. When asked about family planning or birth control services, more than three-fourths of the household respondents using the health services center reported that neither they nor their family members had sought these services from the center.

Table 4. Perceived health status of each group, given in percentages

Perceived health status	1 (N= 538)	2 (N= 761)	3 (N= 565)	4 (N= 282)
Very good	21.9	20.2	15.4	23.4
Good	50.4	46.8	49.5	47.2
Fair	16.4	23.1	23.4	14.9
Poor	7.8	7.5	9.6	9.9
No response [1]	3.5	2.4	2.1	4.6

[1] Not included in χ^2 calculations.

Table 5. Most recent source of health care, by percent of each group

Sources of care	1 (N= 538)	2 (N= 761)	3 (N= 565)	4 (N= 282)
Health services center	66.0	9.9	1.1	5.3
School	1.9	2.1	.9	.7
Physician's office	21.4	68.1	68.8	57.3
Hospital (emergency room and outpatient department)	5.7	8.2	13.4	15.2
Hospital (inpatient)	1.7	1.8	4.5	8.1
Other	1.1	3.3	7.1	6.7
No response [1]	2.2	6.6	5.2	6.7

[1] Not included in χ^2 calculations.

Source of services. Questions regarding the most recent pursuits of health care evoked predictable replies from all groups. The physician's office was the major source for persons in groups 2, 3, and 4, while group 1 principally sought care from the South Central Multipurpose Health Services Center (table 5). Unfortunately, the actual location of the other sources was not determined.

Lesser accessibility to private physicians is implied by the pattern of group 4's experience compared with the experiences of groups 2 and 3. Group 4 had a lower proportion of persons whose last visit was to a physician's office (57.3 percent) and a higher proportion who had sought care from hospital emergency rooms or outpatient departments (15.2 percent). Some persons in group 4 reported using the center even though they were outside the target area and their household source was elsewhere. Group 3 also reported relatively high usage of hospital emergency room or outpatient department services. It is quite probable that groups 3 and 4 received emergency room and outpatient department services at the Los Angeles County General Hospital. To seek services at this facility would necessitate a trip, for Watts residents, of approximately 8–10 miles with very poor public transportation.

Sixty-six percent of the persons in group 1 last sought care from SCMHSC. At first glance this may seem incompatible with the fact that the center was supposed to be the usual source of care for all their households. It is possible that wording of the question was confusing, and that some of those reporting "doctor's office" may actually have been referring to their physician's office at the center. However, there are various reasons why the center's registrants would use other resources.

1. The center does not offer inpatient care, and aftercare of hospitalized patients might not be expected to be provided there.

2. Some patients requiring specialized treatment not available at the center are referred elsewhere for the appropriate medical service.

3. For various reasons some persons prefer to go to other than their family's regular source

of care. This was further borne out by responses to the question, "What is the usual place of medical care for (family member)?" The percentage using the four most likely sources of care is shown in table 6.

These replies indicate that (*a*) a greater percentage of family members of group 1 households sought care from the same source than those among the other three groups, (*b*) a small proportion of persons in groups 3 and 4 used the neighborhood health center although it was not the household's usual source, and (*c*) the private physician's office was the main source of care for persons not claiming the center as their source of care.

According to respondents in group 1, the main reason for using the neighborhood health center is its accessibility. Other explanations were good care and free care, although medical services also are available elsewhere without charge to Medi-Cal beneficiaries.

Groups 2, 3, and 4 preferred to see their usual physican primarily for good care. It has been suggested by center administrators that among ghetto residents there is an elevated status position in the community when one has a personal physician and that this sociological component may have operated to deter some from seeking care at the center even though it might have been more convenient.

Respondents who reported their usual source of care to be someplace other than the "doctor's office" were asked if it is "very important," "fairly important," or "not very important" for them to see the same person at each visit. The majority felt it was "very important" to see the same person. Most SCMHSC users (groups 1 and 2) reported that they saw the same physician, indicating that in this respect the center had been successful in promoting this aspect of continuity of care. This factor should enhance the physician-patient relationship. (Somers (*6*) points out that patients plead for a personal physician-patient relationship and that their complaints as to the inability to establish such a relationship are the most widely expressed criticism of medical care today.)

As might be expected, the majority of group 1 and group 2 households turned to the health center for their emergency care, but approximately 30–40 percent of groups 3 and 4 indicated they went to a hospital emergency room or outpatient department. Most group 3 and 4 respondents did not, according to these replies, turn to their private physicians for the unanticipated services—indicating some lack of continuity in their care.

Table 6. Usual sources of care, by percent of each group

Usual sources of care	1 (N= 538)	2 (N= 761)	3 (N= 565)	4 (N= 282)
Health services center	74.4	9.4	2.3	4.3
Physician	11.9	63.5	63.8	53.5
Hospital outpatient department	2.6	5.5	9.5	15.6
Other	2.2	3.8	7.4	12.8
No response	8.9	17.8	17.0	13.8

Accessibility. Household respondents were asked what transportation was most often used to get to their usual source of care. The replies indicated the nearness to the neighborhood health center is a highly influential factor in its selection as the usual source. Approximately 43 percent of the interviewees in group 1 indicated that their families walked to the health center for care, whereas 59 percent of group 3 and 64 percent of group 4 reported that they either used their personal auto or went to their usual source of care in another person's auto. More than 80 percent of all groups said it took 30 minutes or less to reach their source of medical care. Residents of the comparison area (group 4) spent more time reaching their destination than the other three groups.

Upon arrival at their source, more group 1 respondents reported spending more than 1 hour "just waiting" than did the other respondents. The majority of groups 2, 3, and 4 reported a wait of less than 30 minutes. Paradoxically, more center users reported "always," given the response choice of "always, sometimes, or never," making appointments for medical services than did the other respondents. (Previously the majority of groups 2, 3, and 4 specified "doctor's office" as their usual source of care.) From these responses, it appears that (*a*) individual practice physicians in this low income area have a patient behavioral problem stemming from large daily "walk-in" patient loads and (*b*) the neighborhood health center may embody a "clinic type" organizational pattern with long waiting times in spite of scheduled appointments.

It has been suggested that the differences in waiting times have a relationship to the type and extent of health care services being rendered. In

other words, more center users in group 1 may have sought nonemergency care involving a more comprehensive workup than the others seeking care for acute illness. Waiting at several departments for basic preventive services could necessitate longer waiting periods than an emergency or one-time visit.

Those who did not make appointments every time said, (*a*) "Don't have to," (*b*) "Don't know future need," (*c*) "Don't know when they will have time to go," or (*d*) "Don't like to make appointments." Most respondents reported they did not miss appointments; nevertheless, some appointments were acknowledged to be unkept and the reasons given were too sick to go, transportation problems, forgot, or too inconvenient.

Acceptability. Responses to questions in this category showed a high degree of satisfaction in obtaining health services, with no significant differences among the four groups. Approximately 95 percent of all respondents felt they were given a chance to tell what was wrong with them, and consequently most did not feel rushed through their health visit. A large majority replied affirmatively when asked if health matters were explained in understandable terms. More than 85 percent said they received the care or advice they had sought and felt their condition improved after treatment. When asked if their usual source of care was too crowded, 46 percent of all respondents replied "no" and 26 percent said "sometimes."

Eighty-five percent did not feel they had to answer too many questions before seeing a physician when they first went to their usual source of care. Of those who did, 50 percent said this first visit was made for emergency conditions.

Attitudes of medical staff. More than three-fourths of all household respondents felt the staff at their usual source of care took a personal interest in them. Combining all four groups, approximately 94 percent said their physicians always treated them with respect, and, correspondingly, 93 percent reported liking their physicians. Although a large majority of respondents expressed positive feelings regarding other staff members also, 21 percent of group 1 felt the staff members at the center did not always treat them with respect.

Recommendations of usual source. More group 1 neighborhood health center users (51.3 percent) had recommended their usual source of care to others seeking medical care than had the remaining three groups (41.3 percent collectively). This indicates a successful departure from the negative attitudes often found among users of public clinics.

Treatment during preceding 12 months. A series of questions was asked regarding examinations and specific tests received, within the preceding 12 months, by the respondents and household members. The following data summarize the results: 12 percent had hearing tests, 26 percent had eye examinations, and 39 percent saw a dentist in 1970–71. Patients of the health services center who had entered the system on a nonemergency basis would have had these eye examinations and tests as a result of extensive prescreening.

Group 3 contributed most to the significant differences; fewer of these respondents had a physical examination in the past 12 months than reported by the other interviewees (table 7).

No consistent pattern of differences showed up among the four groups. Of those respondents who replied affirmatively, 67 percent had a blood test, 68 percent had a urine test, 60 percent had a chest X-ray, 72 percent reported their blood pressure was taken, 64 percent said their bodies were examined, and 47 percent of the women had a Pap smear. The neighborhood health center was the primary source for these examinations and tests for group 1, as was the physician's office for the other three groups.

Approximately 30 percent of the persons were reported to have been sick enough to be in bed for more than 1 day at a time during the past 12 months. Home care service had been requested and received from a physician by 1.9 percent, from a nurse by 0.8 percent, or from another kind of health worker by 2.5 percent of all respondents.

Area residents without Medi-Cal benefits. The original area probability sample of the OEO target area, which was augmented to provide a

Table 7. Physical examinations in the past 12 months, by percent of households

Replies	1 (N= 119)	2 (N= 161)	3 (N= 167)	4 (N= 72)
Yes	74.8	82.0	63.5	76.4
No	21.9	14.9	29.9	19.4
No response [1]	4.2	3.1	6.6	4.2

[1] Not included in χ^2 calculations.

larger number of Medi-Cal beneficiaries, included 135 households with 470 individuals classified as not under Medi-Cal. They were, however, screened before interviewing to include only families whose incomes were at or below the OEO guidelines based on family size. Responses of interviewees not receiving Medi-Cal were compared with responses of the Medi-Cal beneficiaries.

SCMHSC was reported to be the usual source of care for 20 percent of the households not receiving Medi-Cal and 23 percent of the households of Medi-Cal beneficiaries. Families not receiving Medi-Cal used hospital outpatient departments nearly twice as often and physicians' offices nearly 8 percent less than Medi-Cal families (table 8).

Less use of private physicians' services by persons not receiving Medi-Cal reflected families' expectation to pay for health services whereas Medi-Cal paid for those of its beneficiaries. The greater use of hospital outpatient departments by persons who were not Medi-Cal beneficiaries suggests their lack of access to "mainstream" medicine. It also appears partly to have been the result of demographic differences: households without Medi-Cal beneficiaries were smaller and had larger proportions of older persons.

The neighborhood health center had its greatest appeal to large families of young children. Older people among the poor as well as others tend to have established patterns of getting health care, and perhaps these low income persons continued to use familiar facilities, such as hospital outpatient departments, rather than to seek newer resources. In a study of the use of a county general hospital's outpatient department by Medi-Cal beneficiaries, Kisch and Gartside (7) reached the following conclusion:

> "A sizable proportion of the indigent population will continue, at least in the short run, to use formerly used channels for obtaining health care, and will regard these channels as their primary source of care."

Approximately 41 percent of the Medi-Cal group had five persons or more in their families whereas 27 percent of those who were not beneficiaries of Medi-Cal reported five or more. Forty-six percent of the households with no Medi-Cal beneficiary consisted of single- or two-person families. As for the age distribution, children and youths under the age of 18 constituted 63 percent of the Medi-Cal group in contrast to 47 percent of the persons who were not beneficiaries, and 22 percent of this latter group were over 44 years of age—compared with 13 percent of Medi-Cal family members. The interviewees who were not Medi-Cal beneficiaries, like the Medi-Cal respondents, viewed their families' health status as good or very good (table 9).

Table 8. Comparison of usual sources of medical care of families of Medi-Cal beneficiaries and households not receiving Medi-Cal, by percent of households

Usual sources of care	All households (N=654)	Medi-Cal beneficiaries (N=519)	Not receiving Medi-Cal (N=135)
Health services center	22.5	23.0	20.0
School	.3	.2	.7
Physician's office	53.1	54.5	46.7
Hospital outpatient department	13.0	11.1	20.0
Hospital emergency room	1.1	1.3	.....
Hospital (other)	.9	.8	1.5
Somewhere else	3.7	3.1	5.9
No usual place	5.0	5.6	4.5
No response	.4	.4	.7

Table 9. Comparison of perceived health status of Medi-Cal beneficiaries and persons not receiving Medi-Cal, by percent

Perceived health status	All persons (N=2,616)	Medi-Cal beneficiaries (N=2,146)	Not receiving Medi-Cal (N=470)
Very good	20.3	19.8	22.8
Good	48.4	48.6	48.3
Fair	20.5	20.4	21.1
Poor	8.2	8.4	6.8
Don't know	.1	.....	.4
No response	2.5	2.8	.6

The following similar responses with respect to several other aspects of the neighborhood health center were reported by a majority of SCMHSC users in each group.

1. Access time to the center of less than 15 minutes
2. Access medium (the majority walked to the center.)
3. Lengthy waiting times
4. Care by the same physician each time
5. Importance of seeing same physician each time
6. Feelings of having been treated with respect by the physicians
7. Recommendation of the center to others

Although a majority of Medi-Cal respondents felt they were treated with respect by staff mem-

bers who were not physicians, a substantial number (21 percent) did not. This reaction was not nearly so evident among those center users not receiving Medi-Cal (4 percent). Whether this might be the result of some lack of sensitivity on the part of a few staff members, undue sensitiveness among welfare recipients, or continued friction between those in the community who found employment at the center and those who did not, is not clear.

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An area probability sample of 519 households containing one or more Medi-Cal beneficiaries was interviewed in the predominantly black area of Watts, located in south central Los Angeles. The 519 households, consisting of 2,146 individuals, were classified according to their use of an OEO neighborhood health center, the South Central Multipurpose Health Service Center (SCMHSC). Services provided by SCMHSC to Medi-Cal beneficiaries were paid for by the Medi-Cal program on a fee-for-service basis at the same rates paid to other providers of service.

The neighborhood health center was reported to be the usual source of health care for the families of 23 percent of the interviewees. Another 31 percent stated they or their families occasionally used it. Thirty-two percent said their family members rarely if ever went there for care, and 14 percent were living outside the target area and theoretically were ineligible to use the center. When the ineligible households were excluded, the number of usual and occasional users of the center amounted to 63 percent of the 447 eligible households. Among those not claiming the center as their usual source of care, the private physician was most frequently cited, with hospital outpatient departments second.

Medi-Cal users of the center were predominantly families with children: two-thirds of the persons were under the age of 18, and less than 3 percent were aged 65 or over. In contrast, those who used other services almost exclusively had a lower percentage under 18 (58 percent), and nearly 10 percent were aged 65 or over.

Reasons most frequently given for choice of the center as the usual source of care were, in order of frequency, "easy to get to," "offers good care," and "free or low in cost." The importance of nearness to the facility was underscored by the fact that 43 percent of all group respondents said they walk to the center.

In each of the four groups most respondents were satisfied with their choice of care, reporting that they were given a chance to tell what was wrong with them, were not rushed through their visits, had health matters explained to them understandably, and felt their conditions did improve after treatment.

On the whole, questions referring to likes and complaints about the health center brought a substantial majority of favorable replies. A greater proportion of center users reported having recommended their usual source of care to others than did those mainly using services of a private physician.

Results of this survey were also compared with findings from responses of a low income group of 135 households, also interviewed in Watts, who on the basis of their replies were classified as not receiving Medi-Cal.