

# Health in the Heartland: *The Crisis Continues*

A Report on Health Status and Access to Care in the San Joaquin Valley



## Executive Summary

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## Introduction

Central California’s San Joaquin Valley is one of the largest rural and agricultural areas in the nation and is also one of the most culturally diverse. Although the Valley enjoys agricultural riches, many of its residents endure very serious health problems.

The dire health conditions of the residents of the San Joaquin Valley were first documented in 1996 in *Hurting in the Heartland: Access to Care in the San Joaquin Valley*. Eight years later, this report, *Health in the Heartland: The Crisis Continues*, reviews the current health status of the residents of the Valley and reports the changes that have taken place since the publication of *Hurting in the Heartland*.

*Health in the Heartland* was written to provide an update on current conditions related to the health status of the residents of the San Joaquin Valley. Recent data on over 60 health related indicators are presented for the eight San Joaquin Valley counties (Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, and Tulare), comparing them to each other and to California as a whole. In addition, as in *Hurting in the Heartland*, the Valley has been divided into 61 “zip code community clusters” to provide for sub-county-level data analysis.

This report is divided into five major sections:

- I. A profile of the San Joaquin Valley – describing its people and its health services, including demographics, economic indicators, environmental issues, health services, health financing, and insurance coverage. At-risk populations receive a special focus in this report.
- II. An overview of the health of San Joaquin Valley residents, highlighting access to care, health status, diseases, maternal and infant health, and behavioral risks.
- III. An analysis of the use of health and social services in the San Joaquin Valley, including care-seeking behavior, hospitalization rates, use of public health and nutrition programs, and cancer screening.
- IV. Implications of policy decisions on the health of Valley residents, including discussions of health insurance coverage, provider shortages, hospital closures, air quality issues, language access, and fiscal resources.
- V. A summary and conclusions on the continuing health crisis facing the San Joaquin Valley.



# I. A Profile of the San Joaquin Valley

## A. Who Lives Here?

The San Joaquin Valley is located in the southern portion of the Central California Region and stretches almost 300 miles from just south of Sacramento to north of Los Angeles, bordered on the east and west by the Coastal and Sierra Nevada mountain ranges. The Valley comprises 17% of California's landmass. The San Joaquin Valley has grown faster than the rest of the state, and as of the 2000 U.S. Census was home to 3.3 million residents, approximately 10.3% of California's population. The Valley has become more ethnically and linguistically diverse in the 10 years between the 1990 and the 2000 U.S. Census. In comparison to statewide demographics, the residents of the Valley have remained younger and much poorer, with lower educational attainment. Unemployment has remained high and per capita income low. In contrast, since 1990, California as a whole has seen much greater improvements in areas such as income than has the Valley.

### Key Findings -- Demographics

- The population of the San Joaquin Valley has grown faster than has the rest of the state over the past 10 years. The Valley's 20.5% rate of population growth between 1990 and 2000 was much higher than was the state's population growth rate of 13.8%.
- San Joaquin Valley residents were also younger than were the residents of the state as a whole, with nearly a third (31.8%) of Valley residents being under age 18, compared to 27.3% in California.
- The Valley has a highly diverse population comprised of various ethnic groups, nationalities, and races. Latino and White residents made up the dominant populations in the Valley. In 2000, four in ten (39.8%) persons in the San Joaquin Valley were Latino; 46.0% were White; 6.1% were Asian/Pacific Islander; and 4.6% were African American. Statewide, the Latino population was 32.4%. The Latino population in the Valley experienced a 32.2% growth from 1990 to 2000, while the White population decreased by 20.5%.
- English-speaking households continued to predominate in the Valley in 2000, with 62.9% speaking English as the dominant household language. However, 28.3% of Valley families spoke Spanish at home, up from 21.0% in 1990. One in ten persons (10.0%) did not speak English "well or at all," similar to the statewide rate.
- Income remained low and poverty levels remained high in the San Joaquin Valley. In 2000, per capita income was \$15,798 and the median family income was \$38,841. In 2000, the Valley's per capita income was 31.6% lower than that of California (\$22,711) and the median family income was 26.7% lower than that of California (\$53,025). The Valley's 36.3% rate of growth in per capita income between 1990 and 2000 was below the statewide growth rate of 38.4%.
- In 2000, over half of San Joaquin Valley children (53.0%) lived in families with incomes below 185% of the federal poverty level (a common eligibility standard for federal health and social benefits programs). Over one in four (28.1%) Valley children lived at or below the federal poverty level, similar to the percentage of children living in poverty in 1990. However, the statewide child poverty rate in 2000 was only 19.5%.

- Immigrants comprised 19.8% of the Valley population in 2000, compared to 15.8% in 1990. Statewide, the percentage of immigrants was 26.2% in 2000.
- In 2002, the average annual unemployment rate in the Valley continued at 12.9%, nearly double the statewide rate of 6.7%.
- Educational attainment levels in the San Joaquin Valley have also remained low over the past 10 years. In 2000, one in three Valley adults (32.2%) lacked a high school diploma, compared to 23.2% in California.

## B. What is the Quality of the Environment?

Air quality continues to be one of the most serious issues in the San Joaquin Valley. The heat in the Valley, its topography, agricultural industry, motor vehicles, and population growth all contribute to the problem. According to the San Joaquin Valley Air Pollution Control District (APCD) approximately 60% of the Valley's smog problems come from cars, diesel trucks, and other internal combustion engines. The remaining 40% of pollutants come from business and industrial sources, lawn and garden equipment, outdoor burning, and wood burning fireplaces and stoves.

The Valley's air has been rated among the worst in the nation, with a significant number of days of poor quality air every year. In December 2003, the APCD requested that the Valley be downgraded from a "severe" to an "extreme" non-attainment area as a result of failing to meet national ambient air quality standards. Overall, air quality in the Valley in 2002 was in the unhealthy range one out of four (24%) days. In Fresno and Kern Counties, the percentage of unhealthy days was significantly higher, 47% and 45% respectively.

Pesticide use is also a problem in the San Joaquin Valley. Nearly half of the 150 million pounds of pesticides used statewide were applied in the Valley in 2000. Although the heaviest usage was for sulfur (30 million pounds), nearly five million pounds of metam-sodium, a highly toxic fumigant and carcinogen, were used in the Valley in 2000.

## C. What is the Status of the Health Care Delivery System?

Every society requires adequate health care services to screen for and prevent disease, manage chronic conditions, and treat injuries and illness. Access to services that provide primary care, mental health care, and oral health care are essential. The health care delivery system in the San Joaquin Valley remains inadequate to serve the growing population. Provider shortages, hospital closures, and low reimbursement rates for services continue to plague the Valley. Clinics remain indispensable to the system for providing health care for diverse Valley populations.

In the San Joaquin Valley, provider shortages are prevalent across the entire health care workforce, including physicians, dentists, nurses and mental health professionals. The San Joaquin Valley has one of the lowest ratios of physicians to population, whereas coastal, urban areas such as the San Francisco Bay Area have the highest ratios.

Hospitals are also facing severe challenges. Closures, bankruptcies, and the financial deterioration of rural hospitals have affected the acute care delivery system in the San Joaquin Valley. Low reimbursement rates from public and private payers; shortages of nurses, pharmacists, and other personnel; implementation of nurse staffing standards; the burden of updating substandard facilities; the cost of compliance with the 2008 seismic standards; and a lack of capital have all contributed to the declining viability of vulnerable rural hospital facilities.

### Key Findings -- Health Care Providers

- Recent data show that the San Joaquin Valley had approximately 24% fewer primary care physicians and approximately 50% fewer specialists serving Valley residents than the residents of California as a whole. In 2000, there were 51.2 primary care physicians per 100,000 persons in the Valley, compared to 67.4 in California. There were only 73.2 specialists per 100,000 persons in the Valley, compared to 122.2 for California.
- For registered nurses – the number of nurses per 100,000 persons in the Valley in 2000 was 15.2% less than the number of nurses in California (619 registered nurses for every 100,000 persons in the Valley as compared to 730 nurses for every 100,000 persons in California).
- The shortage of dentists was also severe in the San Joaquin Valley. In 2000 there were 80 dentists per 100,000 persons in California; in the San Joaquin Valley there were only 51 dentists, or 36.2% fewer.
- The most severe provider shortages in the Valley were in the mental health field. In 2001, there were approximately 104 mental health and behavioral health personnel per 100,000 persons in the San Joaquin Valley, compared to 327 per 100,000 persons in the San Francisco Bay Area.

### D. How Do We Pay for Health Care?

A stable health delivery system relies upon sufficient financing through insurance reimbursements and public and private funding. There are many sources of health insurance coverage, such as the Medicare program that covers nearly all of the elderly population. In 2000, the Medi-Cal program and the Healthy Families program provided coverage for approximately one-fourth (23.4%) of the nonelderly population in the San Joaquin Valley, while employment-based private insurance provided coverage for an additional 54.6% of the nonelderly population. However, 16.6% of the nonelderly residents of the Valley had no health insurance.

As the number of uninsured persons in the San Joaquin Valley rises, the burden on the existing safety net of health services also rises. Unfortunately, additional sources of coverage and funding remain untapped. For example, three out of four uninsured children in the Valley are potentially eligible for the Medi-Cal program or the

Healthy Families program. Other locally controlled funds are potentially available for health purposes, but are allocated for non-health related programs. One example of this allocation of funds for non-health purposes is the approximately \$30 million of tobacco litigation settlement monies that San Joaquin Valley counties receive annually. Also, money available through grants and other philanthropic efforts have traditionally been dispersed at a much lower rate in the Valley than they have been in the large urban areas of California. Active solicitation to increase philanthropy in the Valley could contribute significantly to providing additional health services to Valley residents.

San Joaquin Valley providers received approximately \$3.4 billion in reimbursements from the Medi-Cal and Medicare programs in 2001. However, Medicare reimbursement rates for providers are lower for Valley counties than they are for counties in other parts of the state. Additionally, proposed cuts to the Medi-Cal reimbursement rates could have a serious impact on health care services for Valley residents.



### Key Findings -- Health Care Funding

- In 2001, 16.6% of the San Joaquin Valley's nonelderly residents, or 478,000 persons, had no health insurance. This includes 10.3% of children, or 108,000 children, who had no health insurance.
- In 2001, only 54.6% of San Joaquin Valley nonelderly residents had insurance through their employers, compared to 62.0% of nonelderly Californians who had employment-based insurance. Rates of employment-based insurance varied widely in the Valley, from 48.3% in Tulare County to 62.8% in Stanislaus County.
- In 2001, a much higher percentage of San Joaquin Valley residents, compared to residents in the rest of the state, reported being enrolled in the Medi-Cal program. Over one in five (21.1%) nonelderly Valley residents received health services through the Medi-Cal program, a rate 50.7% higher than that for California (14.2%). One in three Valley children (34.9%) depended on the Medi-Cal program or the Healthy Families program for their health care needs.
- Approximately three out of four uninsured children in the Valley were potentially eligible for, but not enrolled in, the Medi-Cal program or the Healthy Families program.
- The Central Valley region received less than \$10 per capita in private foundation grant funds in 1999, compared to many San Francisco Bay Area counties that exceeded \$400 per capita. Statewide, philanthropic grants averaged \$3 million per 100,000 persons during the three year period between 1995 and 1998. However in the Central Valley, of which the San Joaquin Valley is a part, grants averaged only \$1.2 million per 100,000 persons or 40% of the state rate.

## II. How Healthy are San Joaquin Valley Residents?

The health of a community can be analyzed by examining a number of indicators, such as access to health care services, maternal and child health, the delivery of services to manage chronic conditions, and the prevalence of serious health conditions. In this report zip-code-level data were available on four health indicators that were used to analyze access to care in the San Joaquin Valley: 1) prenatal care, 2) birthweight, 3) births to teens, and 4) avoidable hospitalizations (hospital discharge data for ambulatory-care-sensitive conditions such as asthma, diabetes, hypertension, and congestive heart failure). To simplify reporting and ensure greater statistical stability, data were aggregated into 61 zip code community clusters.

To give a more localized view of health access, the Health Access Index (HAI), first developed in *Hurting in the Heartland*, was used. The HAI is a composite ranking of the community clusters. Each of the 61 zip code community clusters was ranked according to the four variables listed

above. These ranks were then averaged to give a final composite HAI ranking. The communities with higher HAI rankings had better access to care than did those with lower rankings.

The community level analysis showed that the community clusters with worse access to care tended to have residents who were poorer, had lower educational attainment, and more female householder families than did communities with better access to care. The communities with worse access to care also tended to have more Latino residents, fewer English-speaking households, and more immigrants than did those community clusters with better access to care.

The following tables show the rankings of Valley community clusters with the 10 highest and the 10 lowest HAI rankings. Although the lower rankings are indicative of health access problems, they do not address the magnitude of the problem in those community clusters.

The 10 Communities With the Highest Health Access Index Rankings		
County	Community Cluster	Rank (of 61 Community Clusters)
Kern	Frazier Park	1
Fresno	Herndon/Pinedale	2
Fresno	Clovis/Sanger	3
Madera	The Mountains	4
Stanislaus	Turlock	5
Kern	Buttonwillow/Elk Hills	6
San Joaquin	Woodbridge	7
Kern	Mojave	8
Kern	Arvin/Tehachapi	9
Fresno	N. Fresno	10



The 10 Communities With the Lowest Health Access Index Rankings		
County	Community Cluster	Rank (of 61 Community Clusters)
Kings	Corcoran	52
Tulare	Tulare	53
Kern	Taft	54
Fresno	Central Fresno	55
Kern	E. Bakersfield/Lamont	56
San Joaquin	S. Stockton/French Camp	57
Stanislaus	W. Modesto/Empire	58
Fresno	S. Fresno	59
San Joaquin	Central Stockton	60
Fresno	W. Fresno/Burrel	61

On a regional level, San Joaquin Valley residents scored nearly the same as did their state counterparts on most health indicators. In no area of study did the Valley score remarkably better than the rest of the state. For example, the percentage of low birthweight babies born in California was the same as the percentage born in the Valley in 1999-2001, at 6.2%. However, during the same period the rate of births per 1,000 females ages 15 to 19 was much higher in the Valley (67.8) than it was in California (47.7).

Valley residents rated themselves as being in poorer health than did other Californians. This is reflected in the rates of chronic disease, such as diabetes, asthma, and heart disease.

As poor as the health of the San Joaquin Valley residents is overall, particular populations and communities face even worse conditions. The 375,000 Valley farmworkers, approximately half of the state’s farmworkers, suffer some of the worst health access of any group in the Valley. Most have no health insurance, rarely seek medical care, and are at higher risk for chronic debilitating conditions. Southeast Asian refugee families continue to face language and cultural barriers to appropriate care. Western medical providers still struggle to meet the challenges of working with cultures that have different systems of belief and healing. Children in immigrant families are often in poorer health, with less access to care and health insurance.

**Key Findings -- Health Status**

- Overall, in 2001, San Joaquin Valley residents were more likely than were Californians to rate their health status as “fair/poor” or “good,” rather than “very good/excellent.” Half (50.9%) of Valley residents rated their health as “very good/excellent” compared to 55.8% of Californians.
- Measures of maternal and child health, were worse in the Valley than they were at the state level in every area except low birthweight.
  - In 2001, the Valley and California had the same percentage of low birthweight babies (6.2%).
  - From 1997-2000, the infant mortality was higher in the Valley than it was in California (6.8 infant deaths per 1,000 live births in the Valley, compared to 5.7 statewide).

- In 2001, more Valley women (20.8%) received late prenatal care (care after the first trimester of pregnancy) than did women statewide (15.5%).
- In 2001, the rate of births to adolescent mothers in the Valley was 67.8 per 1,000 young women ages 15 to 19, compared to 47.7 statewide. Although the rate of births to teens has improved in both the state and the Valley, the improvement at the state level was slightly better.
- During 1999-2001, rates of infectious disease in the San Joaquin Valley varied when compared with statewide rates.
  - In the Valley, the incidence of tuberculosis per 100,000 residents was 8.6, lower than the California rate of 9.9.
  - In the Valley, the rate of syphilis per 100,000 persons (1.0) was slightly lower than was the state rate of 1.1.
  - The Valley rate for chlamydia infections was 348.1 per 100,000 persons, much higher than was the state rate of 271.6.
  - The Valley rate of new AIDS infections, 11.1 new cases per 100,000 persons aged 13 and older, was much lower than was the state rate of 16.4.
- In 2001, the overall rates of chronic disease in the San Joaquin Valley were higher than were the state rates.
  - In the San Joaquin Valley, 7.3% of adults have been diagnosed with diabetes, compared to 5.8% statewide.
  - The percentage of Valley residents who reported that they had been diagnosed with asthma was 13.8%, slightly higher than the California rate of 12.1%. Fresno County had the second highest asthma rate in the state at 17.2%. Of those diagnosed with asthma, 79.0% had experienced symptoms within the year preceding the survey.
  - In the Valley, 7.6% of adults have been diagnosed with heart disease, compared to 6.9% in California.
- In 2001, the percentage of Valley children suffering from obesity, as a predictor of chronic disease, was 16.4% for children ages 2-5 and 20.2% for children ages 6-20. These percentages were similar to the California percentages of 16.6% and 20.0%, respectively.
- Behaviors that are known to lead to poor health outcomes were higher among San Joaquin Valley residents than they were among Californians statewide.
  - In 2001, over half of San Joaquin Valley adults (53.1%) said that they had drunk alcohol in the month preceding the survey, compared to 59.0% of all Californians. However, of Valley adults who drank alcohol, 30.0% reported that they had consumed five or more drinks at a single time at least once in the month preceding the survey, compared to 26.3% of California drinkers.
  - Similarly, 18.5% of Valley adults were current smokers, compared to 16.9% of California adults.
- One area of particular concern is the rate of motor-vehicle-related deaths per 100,000 persons, which was much higher in the Valley than it was statewide (18.8 in the Valley, compared to 10.3 in California).

### III. How Do Valley Residents Use Health Services and Programs?

Residents of the San Joaquin Valley have a wide range of health services and programs from which to choose. These include clinics for primary care, public health departments for preventive care such as immunizations, and nutrition programs such as WIC and National School Lunch and School Breakfast programs.

Despite the shortage of primary care physicians and the dependence on clinics, only 12.2% of San Joaquin Valley residents had no usual source of

primary care. Many residents did not avail themselves of life-saving cancer screening tests, similar to their counterparts statewide.

Immunization programs have been very effective in the San Joaquin Valley, reaching nearly 95% of children entering kindergarten. On the other hand, some childhood nutrition programs, particularly the School Breakfast program, fall far short of reaching their target populations.

#### Key Findings -- Health Care Utilization

- In 2001, nearly one in eight Valley residents (12.2%) had no usual source of primary health care, a rate similar to that for California residents (12.0%).
- The San Joaquin Valley rate of avoidable hospitalizations in 1999, measured by hospital discharges for ambulatory-care-sensitive (ACS) conditions per 10,000 persons, was 39.8, slightly lower than was the state rate of 40.2.
- In 2001, the use of common cancer screening tests by residents of the San Joaquin Valley was similar to the use of these tests by Californians statewide.
  - In the Valley, two out of three (64.6%) adult women over age 18 reported having a Pap smear within the year preceeding the survey, which is similar to the state rate of 65.3%.
  - The percentage of women receiving breast cancer screenings in the San Joaquin Valley was comparable with that of the state. In the Valley over one in four (29.1%) women age 30 years and over had never had a mammogram, which is similar to the state rate of 27.6%.
  - The rate of colorectal cancer screening for Valley adults over age 40 was similar to that of California. In the Valley, 62.5% had never had a colorectal exam, compared to 60.4% statewide.
  - Nearly six in ten men (60.2%) in the San Joaquin Valley had either not had a Prostate Specific Antigen test for prostate cancer or had not heard of one, compared to 57.1% statewide.
- In the San Joaquin Valley, 12.8% of adults had delayed or foregone care in 2001, compared to 13.7% statewide.
- Childhood immunization rates in the San Joaquin Valley exceeded those in California and were nearly at the Healthy People 2010 national objective of 95% of children in kindergarten and childcare being immunized. In 2002, 94.6% of incoming kindergarteners had their immunizations, as did 95.5% of children in licensed child care and 74.1% of seventh graders, which are comparable to the state rates.

- Nearly one in three San Joaquin Valley children received services from the Child Health and Disability Prevention (CHDP) Program in 1999-2000.
- Numerous nutrition programs, particularly for children, exist in the San Joaquin Valley. However, these programs have not been totally successful in enrolling their target populations.
  - WIC advocates have estimated that 12.7% of potentially eligible WIC recipients in the San Joaquin Valley are not currently served by the program, which is similar to California's nonparticipation rate of 12.6%.
  - In the San Joaquin Valley, approximately 318,000 persons (or approximately 10% of the population) received food stamps in 2002, adding \$275 million of federal funds to spending on food in the Valley. However, about half (51.4%) of the estimated eligible persons did not receive food stamps.
  - Although the National School Lunch Program reached over 300,000 children in the San Joaquin Valley, about one in five (19%) of the estimated eligible children were not served.
  - Only an estimated 33.1% of eligible children (129,589) participated in the School Breakfast Program, out of an estimated 391,478 children who were eligible to participate.



## IV. What are the Most Significant Health Policy Issues Affecting the San Joaquin Valley?

### A. Health Disparities

There are serious health disparities among Valley communities. Although some communities have adequate access to care, the 2001 Health Access Index demonstrates wide differences within counties or even cities. The communities with the worst health access and health status tend to have more Latino residents and more non-English speaking households. The residents of these communities tend to seek prenatal care after the first trimester of pregnancy and have higher hospitalization rates for chronic disease than do communities with better access to care.

While some of the differences in access and health status in these primarily Latino communities can potentially be explained by demographic differences such as income and educational attainment, there is a large body of research that suggests disparate health outcomes are related to how individuals of different races and from ethnic groups are treated by our health care system. A recent congressionally mandated report from the Institute on Medicine (IOM) *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, published in 2002, found that individuals who were White tended to receive a higher quality of care than did individuals from other racial and ethnic groups, even when insurance status, income, age, and severity of conditions were comparable. Evidence reviewed in the IOM report suggests that bias, prejudice, and stereotyping on the part of health care providers may contribute to differences in care.

The challenge for the San Joaquin Valley lies in overcoming persistent disparities in health access and outcomes. The first recommendation in the IOM's report was to increase awareness of these disparities among the general public, health care providers, insurance companies, and policy-makers. The report also suggested other recommendations to reduce and eliminate disparities. These

recommendations included patient education on how to access the health care system, interact with providers, and participate in treatment decisions; and increasing the number of minority health care providers, community health workers, and language interpreters. Lastly, eliminating the disparities in health plans could also reduce the disparities in treatment. For example, if patients enrolled in the Medi-Cal program were able to access the same scope and level of services as those with private insurance plans are able to, it could potentially eliminate some disparities in care.

### B. The Uninsured

With one in six San Joaquin Valley nonelderly adults, and one in ten Valley children without health insurance in 2001, expanded efforts are necessary to provide health insurance coverage to a larger portion of the population. The last few years have seen renewed efforts at the local, state, and federal level to continue to expand coverage for these uninsured individuals.

Each of the suggested approaches and pending proposals for coverage will have an impact on the San Joaquin Valley, which needs to be evaluated. With the Valley's agricultural economy, its unique demographics, and its heavy reliance on government-sponsored programs, careful analysis is required to understand the potential benefits and pitfalls of the different approaches to cover the uninsured.

The newly signed employer mandate "pay or play" health insurance legislation (Senate Bill 2) may provide only limited relief to San Joaquin Valley workers. Nearly two-thirds (64%) of uninsured San Joaquin Valley adults employed by private companies worked for businesses with 50 or fewer employees, a group that is exempt from mandated coverage unless the state provides additional funding to employers to cover the cost of coverage.

Those working for companies with fewer than 20 employees are not covered by the legislation, regardless of increased state funding. However, immigrants may gain under an expansion of employment-based insurance, since one benefit of employment-based coverage is that it provides coverage to all workers, regardless of their immigration status.

A “single payer” approach, which creates a single, government-based insurance entity, might benefit the state overall, but it would result in a massive systems change for both the privately and publicly insured. Although the Valley has low rates of employment-based insurance (54% in the Valley compared to 62% statewide), over one in five nonelderly Valley residents is covered by the Medi-Cal program. These insurance programs statewide would need to be reengineered to accommodate the new system.

The most promising local efforts at coverage are being pursued by several Valley counties to provide universal coverage for children. These programs are reaching out to families that are eligible for, but not enrolled in the Medi-Cal program and the Healthy Families program, while also creating a local coverage product for lower-income children who are not eligible for these programs. Spearheaded by First 5 Commissions, these programs have been effective in over half a dozen other counties in California. Other incremental reforms such as those to consolidate existing sources of public coverage (e.g. Medi-Cal and Healthy Families) would potentially increase the enrollment in these joint federal/state-funded programs.

### C. Health Care Provider Shortages

With approximately 30% fewer primary care physicians in the San Joaquin Valley compared to the statewide average, a number of efforts are under way to recruit and retain physicians for the Valley. Recent efforts to recruit more physicians have focused on international physicians who are more willing to serve Valley residents and who often speak the language of their patients.

Provider shortages continue to exist in the San Joaquin Valley in other health professions such as nursing and mental health. Various initiatives in the Valley are underway to fund nursing scholarships, expand nursing education programs, improve the cultural competence of the current workforce, and promote nursing as a career.

### D. Chronic Disease – Asthma and Diabetes

There is a growing recognition that rates of chronic diseases such as asthma and diabetes are at critical levels in the San Joaquin Valley. The increasing costs of chronic disease treatment and hospitalization, accounting for over 75% of health spending nationwide, result in an increasing need for funding for public health interventions. Even though we know prevention works, the focus in the health care system has been on treatment of short-term, acute health problems, not on prevention of chronic disease. Resources need to be allocated for continued surveillance, targeted prevention programs, screenings, and appropriate referrals for treatment to address these chronic diseases.



## E. Childhood Obesity

One in five Valley children ages 6-20 is considered obese. The increasing prevalence of obesity in children and adolescents places them at risk for future chronic diseases such as stroke, hypertension, and diabetes. The Strategic Alliance to Prevent Childhood Obesity has a policy agenda that focuses on schools and includes eliminating unhealthy foods and advertising, adopting new and enforceable nutrition standards, eliminating soda sales and contracts, increasing state reimbursement for school meal programs, making changes to the WIC food package to include more fresh fruits and vegetables and less high-fat cheese and high-calorie juice, enforcing current physical education (PE) requirements, and improving the quality of PE programs.

## F. Air Quality

The San Joaquin Valley is considered to be one of the worst air basins in the United States. Ozone pollution, small particulates, dust, and soot adversely affect the Valley's air. For years, political and bureaucratic problems have stalled improvement in the Valley's air, which has resulted in a request by the Governing Board of the San Joaquin Valley Air Pollution Control District to voluntarily downgrade the Valley's ozone status from "severe" to "extreme." This marks the first time nationwide that an air district has voluntarily sought a downgrade. This move prevents a federal takeover of smog reduction plans and averts \$36 million in penalties for Valley businesses and a loss of \$2.2 billion in federal highway funds. Although past local efforts have met with limited success, recently enacted legislation ends the historic exemption of the agricultural industry from air pollution controls and is an additional step to cleaning up the Valley's air.

## G. Language Barriers

In the Valley, 10.2% of the population does not speak English "well or at all." Much research has documented the adverse impact on access to health care imposed by language barriers.

Providers have difficulty communicating with patients, and patients have trouble understanding providers, following directions, and obtaining insurance. Policies need to be developed that enable compliance with standards for limited-English-proficient patients, such as provider training, certification of interpreters, and establishing an adequate reimbursement system for interpreter services.

## H. Public Spending on Health

The San Joaquin Valley is highly dependent on federal and state funding for health coverage to assist its lower income residents. Given the large and ever-increasing budget deficits at the federal and state level, the Valley should be aware of the potential impact of such dependence. In the Valley, the proportion of residents who receive Medi-Cal is one-third higher than that of California. In 2001, the Valley received over \$1.6 billion in revenues from Medi-Cal payments, a disproportionate share given its population. These funds, which are entirely state and federal in origin, bolster the local economy and any reduction in this funding will have a significant impact on the local economy. A recent report suggested that Medi-Cal spending has a large multiplier effect in local spending. For example, every \$10 million loss in Medi-Cal payments would translate into a \$23.8 million loss for the local economy, the loss of 208 jobs, and the loss of \$8.7 million in wages.

The Valley has yet to maximize available programs for health care. For example, three out of four uninsured children in the San Joaquin Valley are potentially eligible for the Medi-Cal program and the Healthy Families program. If substantially more of these 80,000 children were enrolled in these programs it would result in millions of additional dollars in the local health economy.

In addition, Valley counties have diverted other potential funds for non-health care needs. For example, much of the \$30 million received by Valley counties from the Tobacco Litigation Master Settlement Agreement goes into county general funds and is not used for either health care or smoking prevention programs.

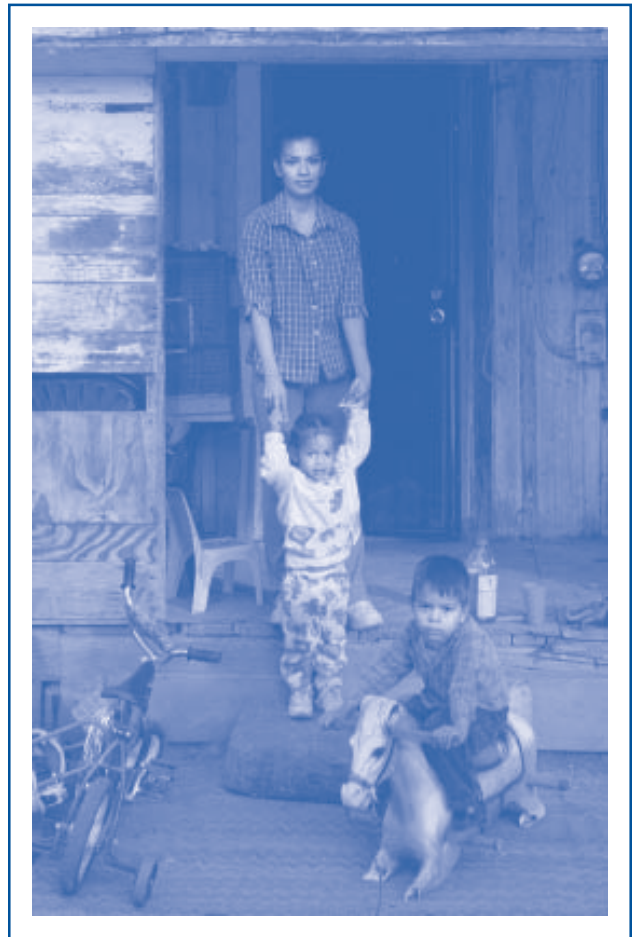
## V. Summary

This report paints a bleak picture of health status and access in San Joaquin Valley communities. Many programs have been instituted over the past eight years and many millions of dollars have been invested in health programs and care for Valley residents. However, the progress that has been made in the health status of Valley residents in the past eight years still falls short of statewide improvements in many cases.

The Valley continues to have high rates of disease, poor community health, and lacks an adequate provider network. The Valley still leads the state in infant mortality, teen births, and late access to prenatal care. Some residents have a harder time than do other Californians in finding care due to lack of health insurance, a scarcity of providers, and language and cultural barriers. Valley residents report binge drinking and smoking more frequently than do their statewide counterparts.

Perhaps the biggest challenge to Valley health is the quality of the air. The Valley has some of the worst air quality in the nation, which has severe impacts on the health of residents, the economy of the region, and the overall quality of life.

The data demonstrate that poor health access and health status in San Joaquin Valley exist in the context of communities with high rates of poverty, low educational attainment, a high number of female householder families, and a larger percentage of immigrants and non-English speakers. Although many of the San Joaquin Valley's health issues can potentially be explained by demographics, the economy also has an impact. The Valley's low-wage agricultural industry has left many Valley residents without health insurance and with fewer resources to improve their health. The demand for low-wage labor has fueled the immigration of new residents, mostly from Latin America, to work in the fields. Those who provide health services to these newly arriving workers struggle with limited public resources.



On a positive note, there is strong support for economic and educational solutions to existing Valley problems. Regional leaders recently strongly endorsed the Regional Jobs Initiative, a plan for creating 30,000 new jobs in the next five years and nurturing Valley industries that can compete nationally and internationally, in areas such as health care, manufacturing, and distribution. Similarly, recent discussions of bringing a University of California medical school to Fresno provide hope for potential solutions to the current health provider and delivery system crises.

The data clearly show the continuing crisis in the health of Valley communities since the publication of *Hurting in the Heartland* in 1996. If current trends continue, the Valley will be less and less able to adequately care for its needy resi-



dents. Despite advances in medical care across the state, many Valley residents lack the most basic of services. The rising costs of treatment for chronic disease and continued reliance on state and federal funding in a climate of budgetary deficits will lead to further erosion in the health care delivery system and further economic decline.

This report identifies the interdependence of demographic, economic, environmental, health status, and health system issues affecting the San Joaquin Valley. A coordinated approach, supported by a strong public health infrastructure, is necessary to improve conditions in the Valley. Environmental threats to health, such as air pollution, need to be eliminated. Re-deploying existing resources to provide services to those communities in highest need will increase the effective allocation of limited funds. Lastly, greater

efforts at reaching the Valley's culturally diverse populations are necessary to improve the health of residents in the Valley.

Although further research on understanding the underlying causes of the health conditions in Valley is clearly important, this should not deter immediate action on disparities already identified. Government, health institutions, and providers all have the charge to work with communities to devise and implement solutions that are affordable, practical, and effective. Collaborative efforts and more strategic allocation of funding are crucial to improve the health of San Joaquin Valley residents. Failing this, the crisis can only continue.



## Methodology

This report reviews the most recently available national, state, and regional data from secondary sources pertaining to over 60 demographic, economic, and health related indicators in the eight counties that comprise the San Joaquin Valley in Central California. The counties include Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, and Tulare.

When possible and appropriate, data were collected to show a five-year span that provides an opportunity to compare trends. In addition, some data were available on a zip-code level to allow for comparison of different communities within the Valley. The zip-code-level data have been aggregated into 61 community clusters composed of contiguous zip-codes. These community clusters are similar, but not identical to, Medical Service Study Areas (MSSA) used by the Office of Statewide Health Planning and Development (OSHPD). These community clusters were used in the original *Hurting in the Heartland* report, but have been updated here with the new zip-codes.

## Data Sources

This report utilizes 1990 and 2000 Census data for the demographic and economic indicator sections of the document. The *2001 California Health Interview Survey (CHIS)* was a major data source. The *CHIS* is a survey conducted every two years and is a random-digit-dial (RDD) telephone survey of over 55,000 households drawn from every county in California. The California Department of Health Services' *County Health Status Profiles* were used for several variables for diseases, morbidity, and mortality data. Where appropriate, the *2003 Health Status Profiles* report was compared with the *1998 Health Status Profiles* report to provide five-year trend data. The California Office of Statewide Health Planning and Development (OSHPD) reports provided data on California's licensed hospitals, long-term care facilities, and clinics. In addition, detailed hospital discharge data were obtained from OSHPD, which allowed for analysis of hospital discharges for ambulatory care sensitive conditions.

Specific references and citations are included in the full report available at

[www.csufresno.edu/ccchhs/pubs](http://www.csufresno.edu/ccchhs/pubs)

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