Chapter 3. Access to Health Care

Many Americans have good access to health care that enables them to benefit fully from the Nation's health care system. However, others face barriers that make the acquisition of basic health services difficult. As demonstrated by extensive research and confirmed in previous National Healthcare Disparities Reports, racial and ethnic minorities and persons of low socioeconomic status[i] are disproportionately represented among those with access problems. Poor access to health care comes at both a personal and societal cost: for example, if persons do not receive vaccinations they may become ill and spread disease to others, increasing the burden of disease for society overall, in addition to the burden borne individually.

Components of Health Care Access

Access to health care means having "the timely use of personal health services to achieve the best health outcomes."[1] Attaining good access to care requires three discrete steps:

- Gaining entry into the health care system.
- Getting access to sites of care where patients can receive needed services.
- Finding providers who meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust.[2]

Health care access is measured in several ways including:

- Structural measures of the presence or absence of specific resources that facilitate health care, such as having health insurance or a usual source of care.
- Assessments by patients of how easily they are able to gain access to health care.
- Utilization measures of the ultimate outcome of good access to care—i.e., the successful receipt of needed services.

How This Chapter Is Organized

This chapter presents new information about disparities in access to health care in America. It is divided into two sections:

- **Facilitators and barriers to health care**—such as measures of health insurance coverage, having a usual source of care and primary care provider, and patient perceptions of need.
- **Health care utilization**—such as measures of receipt of dental care, emergency care, potentially avoidable admissions, mental health care, and substance abuse treatment.

Information about patient-provider communication is found in the section on patient centeredness in Chapter 2, Quality of Health Care. As in previous NHDRs, this chapter focuses on disparities in access to care related to race, ethnicity, and SES in the general U.S. population. Disparities in access to care and patient-provider communication within specific priority populations are discussed in Chapter 4, Priority Populations. Analyses of changes over time and stratified analyses are also presented within this chapter.

[i] As described in Chapter 1, Introduction and Methods, income and educational attainment are used to measure socioeconomic status in the NHDR.

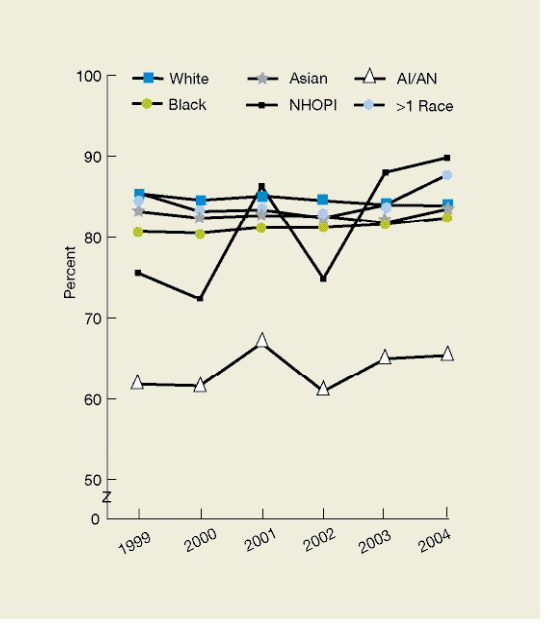
Facilitators and Barriers to Health Care

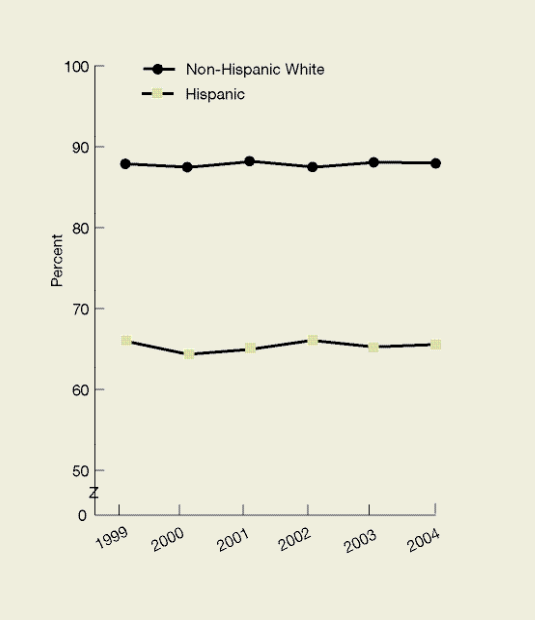
Facilitators and barriers to health care discussed in this section include health insurance, having a usual source of care (including having a usual source of ongoing care and a usual primary care provider), and patient perceptions of need. (See Tables 3.1a and 3.1b for a summary of findings related to all core measures on facilitators and barriers to health care.)

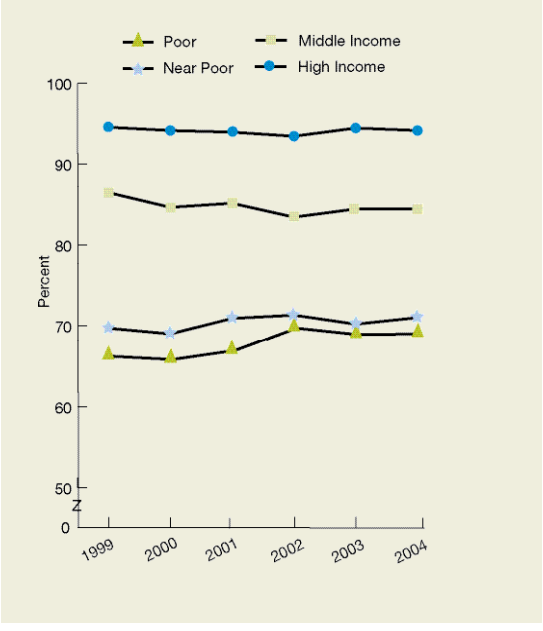
Health Insurance

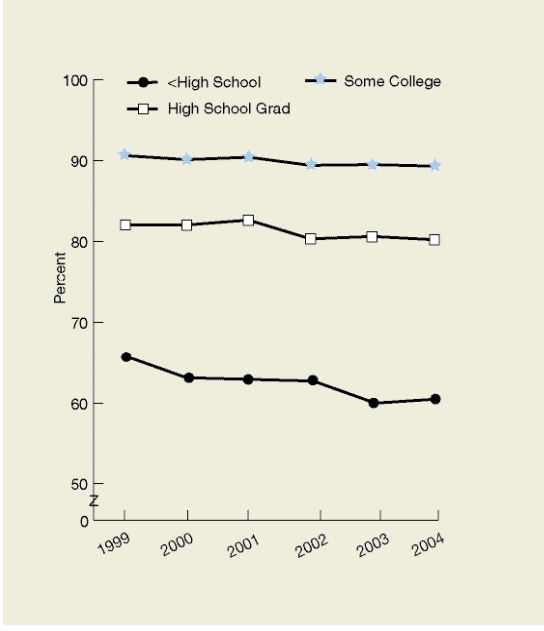
Health insurance facilitates entry into the health care system. The uninsured are more likely to die early[3] and have poor health status[4]; the costs of early death and poor health among the uninsured total $65 billion to $130 billion.[3] The financial burden of uninsurance is also great for uninsured individuals; almost 50% of personal bankruptcy filings are due to medical expenses.[5] The uninsured report more problems getting care, are diagnosed at later disease stages, and get less therapeutic care.[5, 6] They are sicker when hospitalized and more likely to die during their stay.[6]

Figure 3.1. Persons under age 65 with health insurance, by race (this page, left), ethnicity (this page, right), income (next page, left), and education (next page, right), 1999-2004









Key: AI/AN=American Indian or Alaska Native; NHOPI=Native Hawaiian or Other Pacific Islander.

Source: National Heath Interview Survey, 1999-2004.

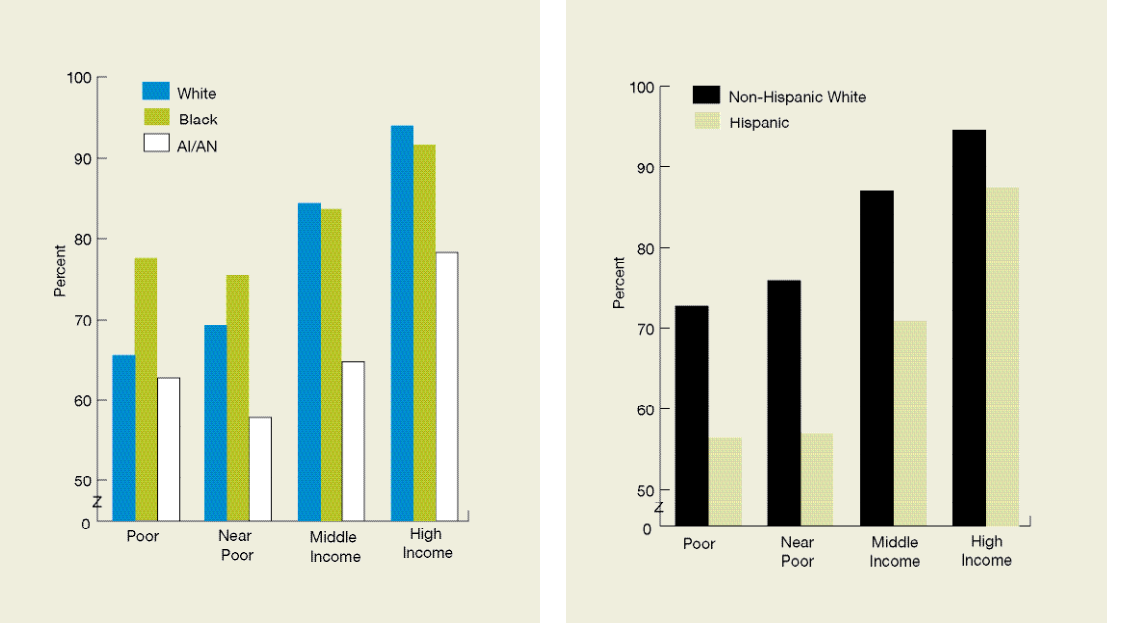
Reference population: Analyses by race, ethnicity, and income performed for civilian noninstitutionalized persons under age 65. Analyses by education performed for civilian noninstitutionalized persons age 25-64.

Note: NHIS respondents are asked about health insurance coverage at the time of interview; respondents are considered uninsured if they lack private health insurance, public assistance, Medicare, Medicaid, a State-sponsored health plan, other government-sponsored programs, a military health plan, or if their only coverage is through the Indian Health Service.

- In all 6 years, the proportion of persons with insurance was significantly lower among AI/ANs compared with Whites; among Hispanics compared with non-Hispanic Whites; among poor, near poor, and middle income persons compared with high income persons; and among persons with a high school education or less compared with persons with some college (Figure 3.1).
- From 1999 to 2003, the proportion of persons with insurance was significantly lower among Blacks compared with Whites, but in 2004 this disparity had been eliminated.
- From 1999 to 2004, rates of insurance decreased significantly for Whites, middle income persons, and persons of every education level, while rates increased significantly for Blacks and the poor.

Racial and ethnic minorities are disproportionately of lower socioeconomic status.[7] To distinguish the effects of race, ethnicity, income, and education on health insurance coverage, this measure is stratified by income and education level.

Figure 3.2. Persons under age 65 with health insurance by race (left) and ethnicity (right), stratified by income, 2004



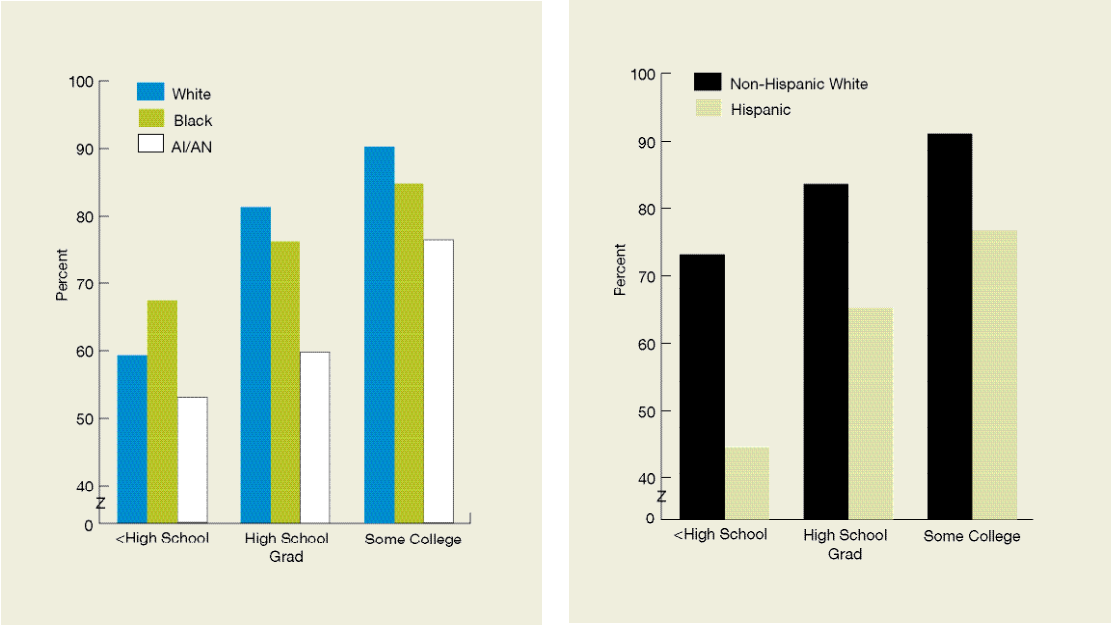
Key: AI/AN=American Indian or Alaska Native.

Source: National Heath Interview Survey, 2004.

Reference population: Civilian noninstitutionalized persons under age 65.

Note: NHIS respondents are asked about health insurance coverage at the time of interview; respondents are considered uninsured if they lack private health insurance, public assistance, Medicare, Medicaid, a State-sponsored health plan, other government-sponsored programs, a military health plan, or if their only coverage is through the Indian Health Service.

Figure 3.3. Persons under age 65 with health insurance by race (left) and ethnicity (right), stratified by education, 2004



Key: AI/AN=American Indian or Alaska Native.

Source: National Heath Interview Survey, 2004.

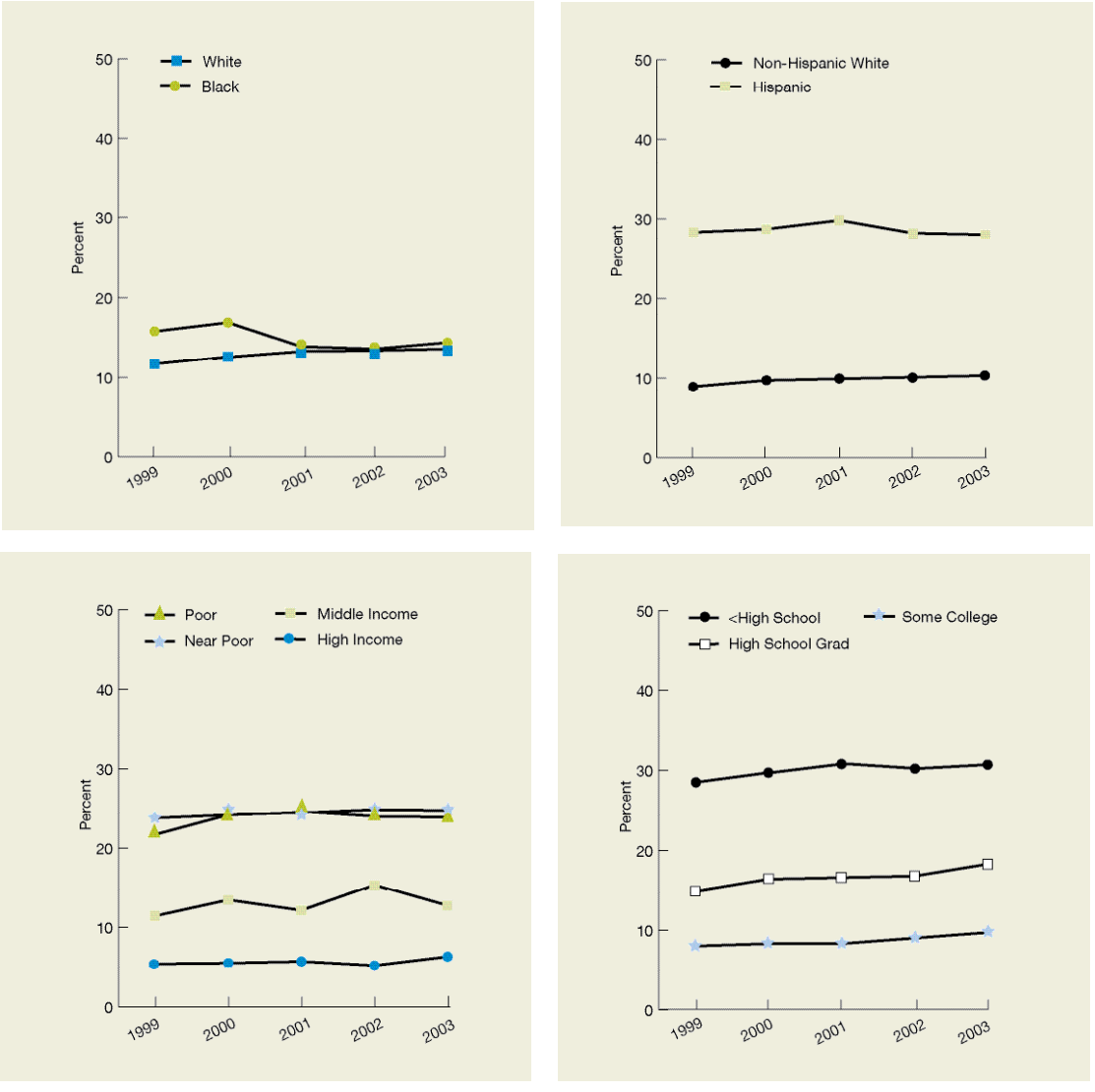
Reference population: Civilian noninstitutionalized persons age 25-64.

Note: NHIS respondents are asked about health insurance coverage at the time of interview; respondents are considered uninsured if they lack private health insurance, public assistance, Medicare, Medicaid, a State-sponsored health plan, other government-sponsored programs, a military health plan, or if their only coverage is through the Indian Health Service.

- Socioeconomic status explains some but not all of the differences in rates of insurance among persons under age 65 by race and ethnicity (Figures 3.2 and 3.3).
- Hispanics of every income and education level were significantly less likely than respective non-Hispanic Whites to have health insurance.
- Poor and near poor Blacks were significantly more likely than respective Whites to have health insurance, while middle income AI/ANs and high income Blacks and AI/ANs were significantly less likely to have health insurance.
- Blacks with less than a high school education were significantly more likely than respective Whites to have health insurance while Blacks and AI/ANs with a high school education or any college education were significantly less likely to have health insurance.
- No group achieved the Healthy People 2010 target of 100% of Americans with health insurance.

Because uninsured persons often postpone seeking care, have difficulty obtaining care when they ultimately seek it, and must bear the full brunt of health care costs, prolonged periods of uninsurance can have a particularly serious impact on a person's health and stability. Over time, the cumulative consequences of being uninsured compound, resulting in a population at particular risk for suboptimal health care and health status.

Figure 3.4. Persons under age 65 uninsured all year by race (top left), ethnicity (top right), income (bottom left), and education (bottom right), 1999-2003



Source: Medical Expenditure Panel Survey, 1999-2003.

Reference population: Analyses by race, ethnicity, and income performed for civilian noninstitutionalized persons under age 65. Analyses by education performed for civilian noninstitutionalized persons age 18-64.

Note: In 2002 and 2003, survey respondents could report more than one race. Racial categories shown here for 2002 and 2003 exclude multiple race individuals and hence are not directly comparable to earlier years. Estimates for racial groups other than Whites and Blacks are significantly affected by this change and are not shown here.

- In all 5 years, the proportion of persons uninsured all year was significantly higher among Hispanics compared with non-Hispanic Whites; among poor, near poor, and middle income persons compared with high income persons; and among persons with a high school education or less compared with persons with some college (Figure 3.4).
- The proportion of persons uninsured all year was significantly higher among Blacks compared with Whites in 1999 and 2000. In 2001, 2002, and 2003 this disparity was eliminated.
- From 1999 to 2003, rates of uninsurance for the whole year rose significantly among Whites, high school graduates, and persons with at least some college education.

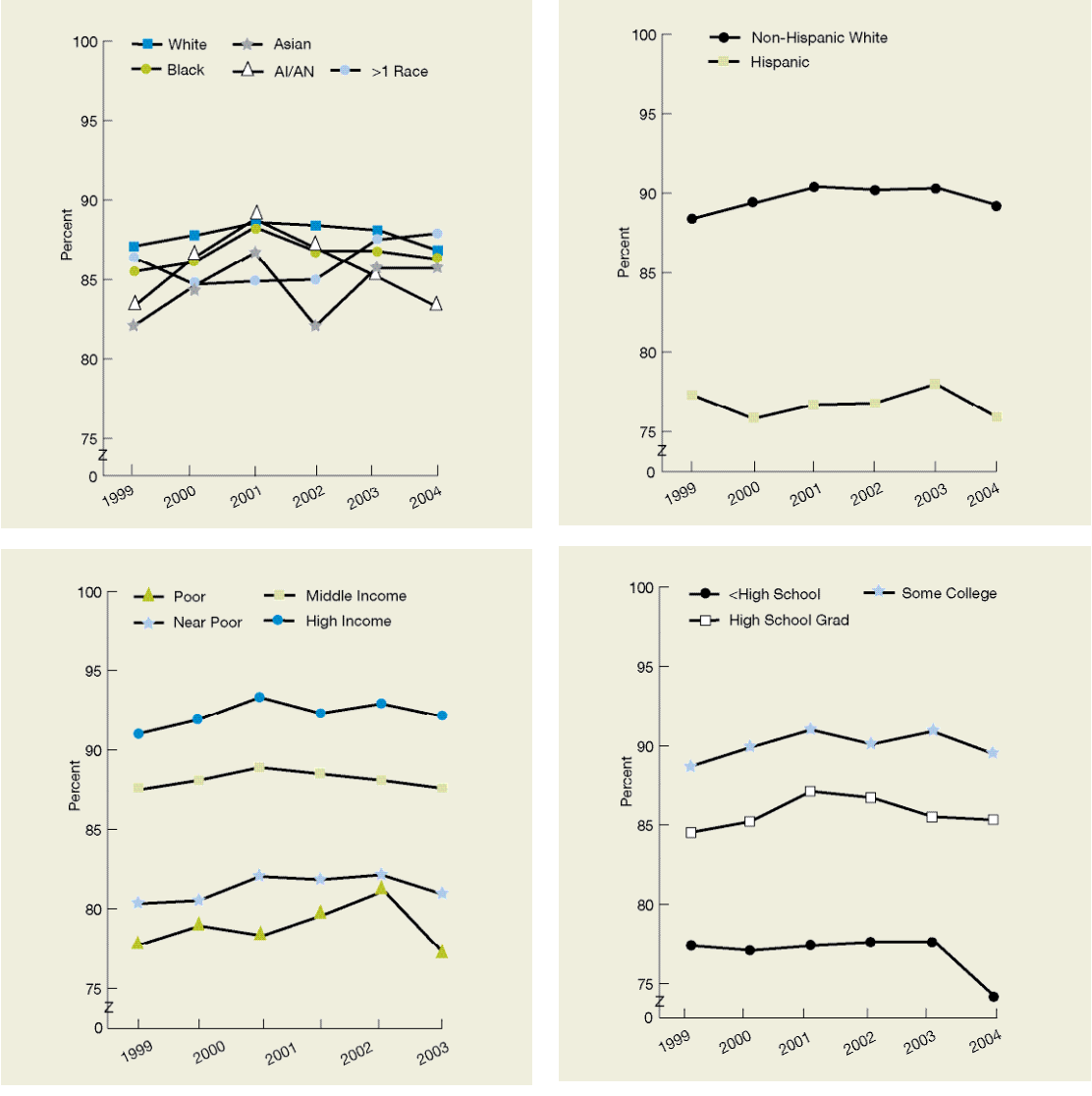
Usual Source of Care

Persons with a usual source of care (a facility where one regularly receives care) experience improved health outcomes and reduced disparities[8] and costs,[9] yet over 40 million Americans do not have a specific source of ongoing care.[10]

Specific Source of Ongoing Care

Higher costs, poorer outcomes, and greater disparities are observed among individuals without a usual source of care.[11]

Figure 3.5. Persons with a specific source of ongoing care by race (top left), ethnicity (top right), income (bottom left), and education (bottom right), 1999-2004



Key: AI/AN=American Indian or Alaska Native.

Source: National Heath Interview Survey, 1999-2004.

Reference population: Analyses by race, ethnicity, and income performed for civilian noninstitutionalized persons of all ages. Analyses by education performed for civilian noninstitutionalized persons age 25 and over.

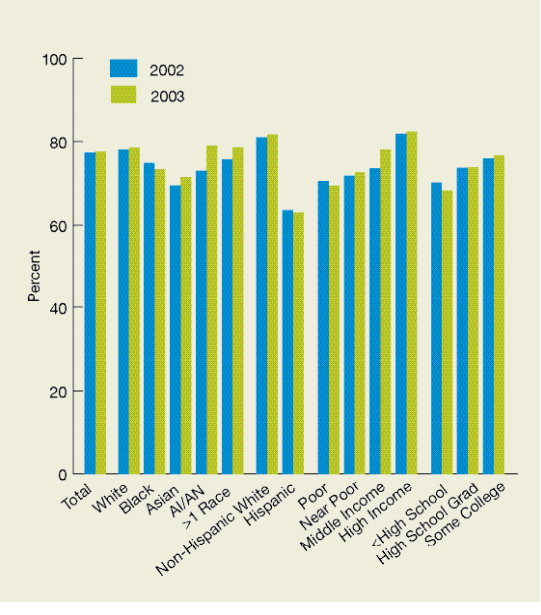
Note: Measure is age adjusted.

- In all 6 years, the proportion of persons with a specific source of ongoing care was significantly lower among Hispanics compared with non-Hispanic Whites; among poor, near poor, and middle income persons compared with high income persons; and among persons with a high school education or less compared with persons with at least some college (Figure 3.5).
- In all years except 2001 and 2004, the proportion of persons with a specific source of ongoing care was significantly lower among Asians and Blacks compared with Whites.
- From 1999 to 2004, the proportion of persons with a source of ongoing care improved significantly among non-Hispanic Whites and high income persons while it fell significantly among persons with less than a high school education.
- No group achieved the Healthy People 2010 target of 96% of Americans with a specific source of ongoing care.

Usual Primary Care Provider

Having a usual primary care provider (a doctor or nurse from whom one regularly receives care) is associated with patients' greater trust in their provider[12] and with good patient-provider communication which, in turn, increases the likelihood that patients receive appropriate care.[13] By learning about patients' diverse health care needs over time, a usual primary care provider can coordinate care (e.g., visits to specialists) that best meets patient needs.[14] Indeed, having a usual primary care provider correlates with receipt of higher quality care.[15, 16]

Figure 3.6. Persons who have a usual primary care provider by race, ethnicity, income, and education, 2002 and 2003



Key: AI/AN=American Indian or Alaska Native.

Source: Medical Expenditure Panel Survey, 2002 and 2003.

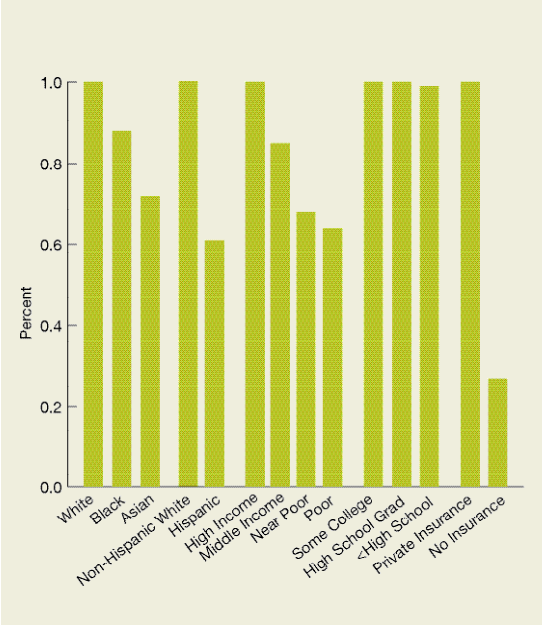
Reference population: Analyses by race, ethnicity, and income performed for civilian noninstitutionalized persons of all ages. Analyses by education performed for civilian noninstitutionalized persons age 18 and over.

Note: A usual primary care provider is defined as the source of care that a person usually goes to for new health problems, preventive health care, and referrals to other health professionals. Data are age adjusted.

- In both years, the proportion of persons with a usual primary care provider was significantly lower among Blacks and Asians compared with Whites; among Hispanics compared with non-Hispanic Whites; among poor, near poor, and middle income persons compared with high income persons; and among persons with less than a high school education compared with persons with some college education (Figure 3.6).
- No group achieved the Healthy People 2010 target of 85% of Americans with a usual primary care provider.

Each year, multivariate analyses are conducted in support of the NHDR to identify the independent effects of race, ethnicity, and socioeconomic status on access to health care. Past reports have listed some of these findings. This year, the NHDR presents the results of a multivariate model for one measure: persons who have a usual primary care provider. Adjusted odds ratios are shown to quantify the relative magnitude of disparities after controlling for a number of confounding factors.

Figure 3.7. Persons who have a usual primary care provider: Adjusted odds ratios, 2002 and 2003



Source: Medical Expenditure Panel Survey, 2002 and 2003.

Reference population: Civilian noninstitutionalized population ages 18-64.

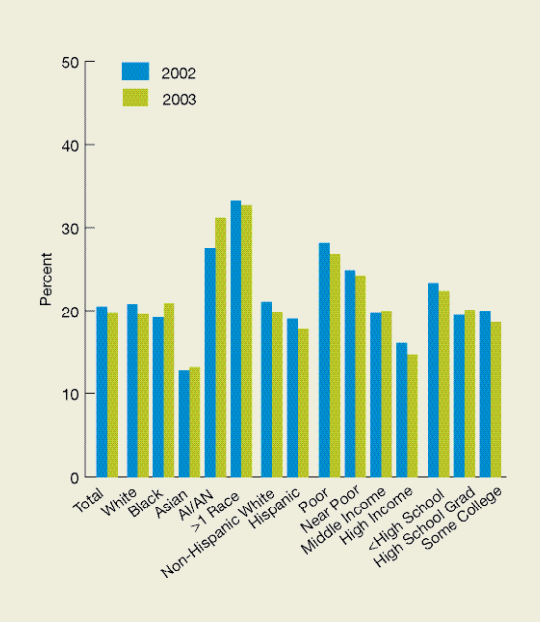
Note: Adjusted odds ratios are calculated from logistic regression models controlling for race, ethnicity, income, education, age, gender, insurance, and residence location. White, non-Hispanic White, high income, and some college are reference groups with odds ratio=1; odds ratios <1 indicate that group is less likely to receive service than the reference group. For example, compared with individuals with private insurance, the chances that an individual with no insurance has a usual primary care provider is 0.27 after controlling for other factors. Another way to state this is that individuals with no insurance are 73% less likely than individuals with private insurance to have a usual primary care provider.

- In multivariate models controlling for race, ethnicity, income, education, age, gender, insurance, and residence location, Blacks were 12% and Asians were 28% less likely than Whites, Hispanics were 39% less likely than non-Hispanic Whites, poor individuals were 36% less likely than high income individuals, and individuals with no health insurance were 73% less likely than individuals with private insurance to have a usual primary care provider (Figure 3.7).

Patient Perceptions of Need

Patient perceptions of need include perceived difficulties or delays in obtaining care and problems getting care as soon as it is wanted. Although patients may not always be able to assess their need for care, problems getting care when patients perceive that they are ill or injured likely reflect significant barriers to care.

Figure 3.8. Families in which a member was unable to receive or delayed in receiving needed medical care, dental care, or prescription medicines, by race, ethnicity, income, and education, 2002 and 2003



Key: AI/AN=American Indian or Alaska Native.

Source: Medical Expenditure Panel Survey, 2002 and 2003.

Denominator: Analyses by race, ethnicity, and income performed for civilian noninstitutionalized persons, all ages. Analyses by education performed for civilian noninstitutionalized persons age 18 and over.

- In both years, the proportion of families in which a member was unable to receive or delayed in receiving needed medical care, dental care, or prescription medicines was significantly higher among families headed by multiple race individuals compared with White individuals; among poor, near poor, and middle income families compared with high income families; and among families headed by individuals with less than a high school education compared with individuals with some college education. In both years, the proportion was significantly lower among families headed by Asians than among families headed by Whites (Figure 3.8).
- From 2002 to 2003, significant changes were not observed for any group.

Health Care Utilization

Measures of health care utilization complement patient reports of barriers to care and permit a fuller understanding of access to care. Barriers to care that are associated with differences in health care utilization may be more significant than barriers that do not affect utilization. Landmark reports on disparities have relied on measures of heath care utilization,[17, 18] and these data demonstrate some of the largest differences in care among diverse groups. More recent efforts to inform health care delivery continue to include measures of health care utilization.[19]

Interpreting health care utilization data is more complex than analyzing data on patient perceptions of access to care. Along with access to care, health care utilization is strongly affected by health care need and patient preferences and values. In addition, greater use of services does not necessarily indicate better care. In fact, high use of some inpatient services may reflect impaired access to outpatient services. Therefore, the key to symbols used in Tables 3.2a and 3.2b, which summarize findings on all core measures related to health care utilization, is different from that used for Tables 3.1a and 3.1b. Rather than indicating better or worse access compared with the comparison group, symbols on the utilization tables simply identify the amount of care received by racial or ethnic minority and socioeconomic groups relative to their comparison groups.

Each year, the Nation's 12 million health services workers provide about 820 million office visits and 590 million hospital outpatient visits and treat 35 million hospitalized patients, 2.5 million nursing home residents, 1.4 million home health care patients, and 100,000 persons in hospice settings.[20] About 70% of the civilian noninstitutionalized population visit a medical provider's office or outpatient department, about 60% receive a prescription medicine, and about 40% visit a dental provider each year.[21]

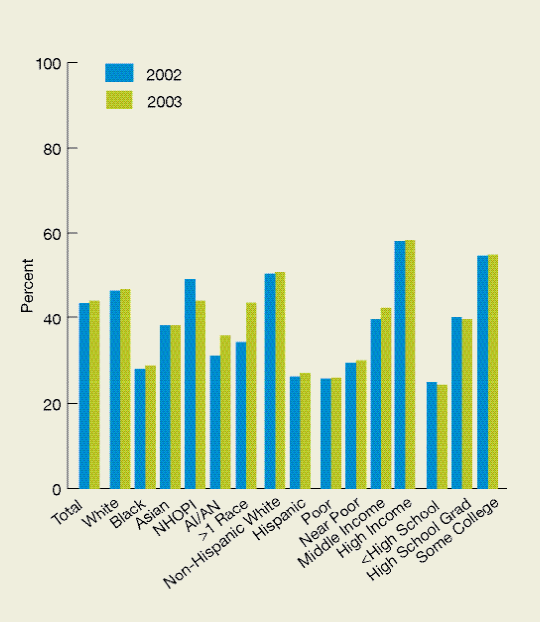
National health expenditures totaled $1.8 trillion in fiscal year 2004, nearly doubling those of a decade earlier, in 1994.[22] Health expenditures among the civilian noninstitutionalized population in America are extremely concentrated, with 5% of the population accounting for 55% of outlays.[23] In addition, it has been estimated that as much as $390 billion a year—almost a third of all health care expenditures—are the result of poor quality care, including overuse, misuse, and waste.[24]

Previous NHDRs reported that different racial, ethnic, and socioeconomic groups had different patterns of health care utilization. Asians and Hispanics tended to have lower use of most health care services including routine care, emergency department visits, avoidable admissions, and mental health care. Blacks tended to have lower use of routine care, outpatient mental health care, and outpatient HIV care but higher use of emergency departments and hospitals, including higher rates of avoidable admissions, inpatient mental health care, and inpatient HIV care. Lower socioeconomic status individuals tended to have lower use of routine care and outpatient mental health care and higher use of emergency departments, hospitals, and home heath care. This year, findings related to dental care, emergency department visits, potentially avoidable admissions, and mental health care and substance abuse treatment are highlighted.

Dental Visits

Regular dental visits promote prevention, early diagnosis, and optimal treatment of oral diseases and conditions. Failure to visit the dentist can result in delayed diagnosis, overall compromised health, and, occasionally, even death.[25]

Figure 3.9. Persons with a dental visit in the past year by race, ethnicity, income, and education, 2002 and 2003



Key: NHOPI=Native Hawaiian or Other Pacific Islander; AI/AN=American Indian or Alaska Native.

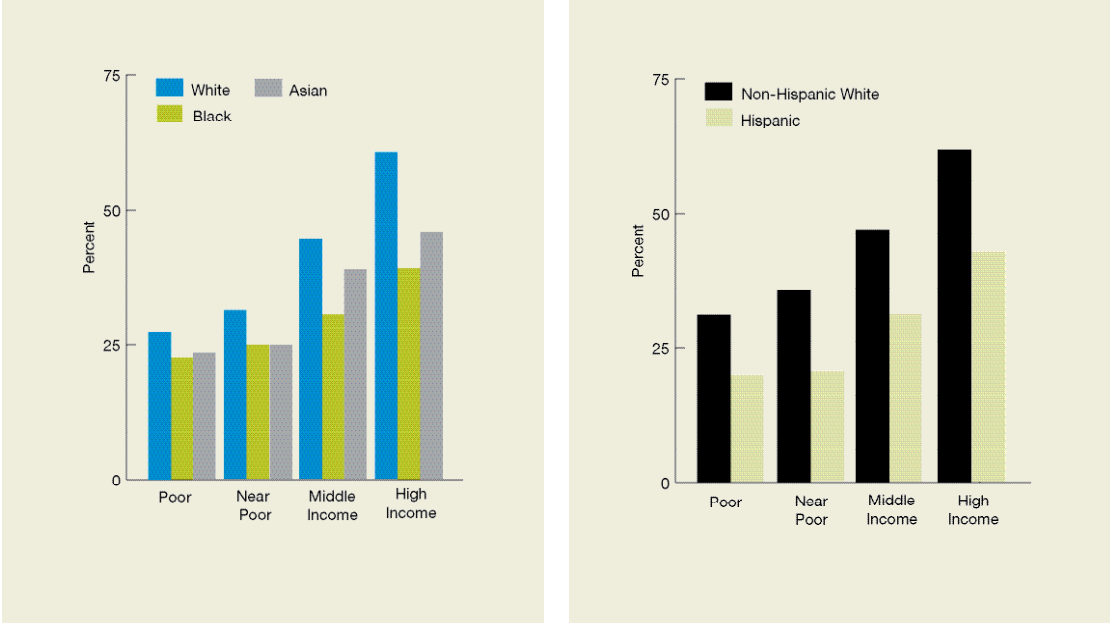
Source: Medical Expenditure Panel Survey, 2002 and 2003.

Reference population: Analyses by race, ethnicity, and income performed for civilian noninstitutionalized persons, all ages. Analyses by education performed for civilian noninstitutionalized persons age 18 and over.

- In both years, the proportion of persons with a dental visit in the past year was significantly lower among Blacks, Asians, and AI/ANs compared with Whites; among Hispanics compared with non-Hispanic Whites; among poor, near poor, and middle income persons compared with high income persons; and among persons with a high school education or less compared with persons with at least some college. In 2002, the proportion was also significantly lower among persons of multiple races compared with Whites, but in 2003 this difference was eliminated (Figure 3.9).
- From 2002 to 2003, the proportion of persons with a dental visit in the past year increased significantly for persons of multiple races.
- Only high income persons met the Healthy People 2010 target of 56% of persons with a dental visit in the past year.

To distinguish the effects of race, ethnicity, and socioeconomic status on health care utilization and to identify populations at greatest risk for barriers to health care utilization, this measure is stratified by income and education level.

Figure 3.10. Persons with a dental visit in the past year by race (left) and ethnicity (right), stratified by income, 2003

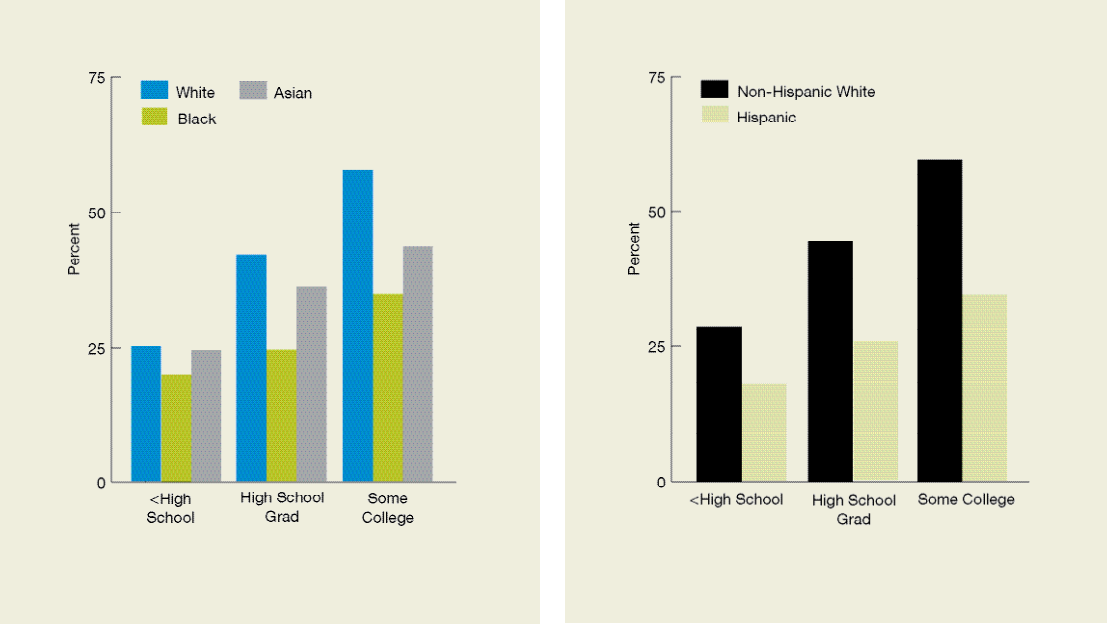


Key: AI/AN=American Indian or Alaska Native.

Source: Medical Expenditure Panel Survey, 2003.

Reference population: Civilian noninstitutionalized population, all ages.

Figure 3.11. Persons with a dental visit in the past year by race (left) and ethnicity (right), stratified by education, 2003



Key: AI/AN=American Indian or Alaska Native.

Source: Medical Expenditure Panel Survey, 2003.

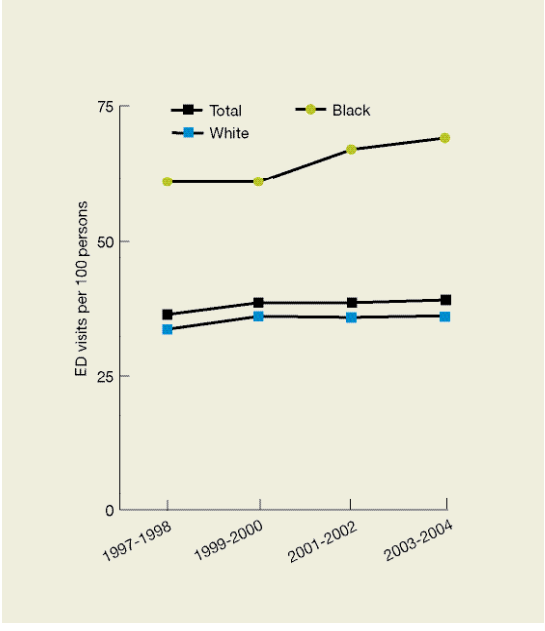
Reference population: Civilian noninstitutionalized persons age 18 and over.

- Socioeconomic status explains some but not all of the racial and ethnic differences in rates of dental visits (Figures 3.10 and 3.11).
- Hispanics of every income and education level are significantly less likely than respective non-Hispanic Whites to have had a dental visit.
- Blacks of every income and education level and high income Asians and Asians with at least some college are significantly less likely than respective Whites to have had a dental visit.

Emergency Department Visits

Without good access to health care, persons sometimes resort to using the emergency department when care is needed. A high rate of emergency department visits may suggest that a population lacks access to preventive and routine care and other avenues of treatment. Delaying care until care is urgent often results in poorer health outcomes and increased health care costs.

Figure 3.12. Emergency department visits per 100 population by race, 1997-2004



Source: National Hospital Ambulatory Medical Care Survey, 1997-2004.
Denominator: Civilian noninstitutionalized population, all ages.

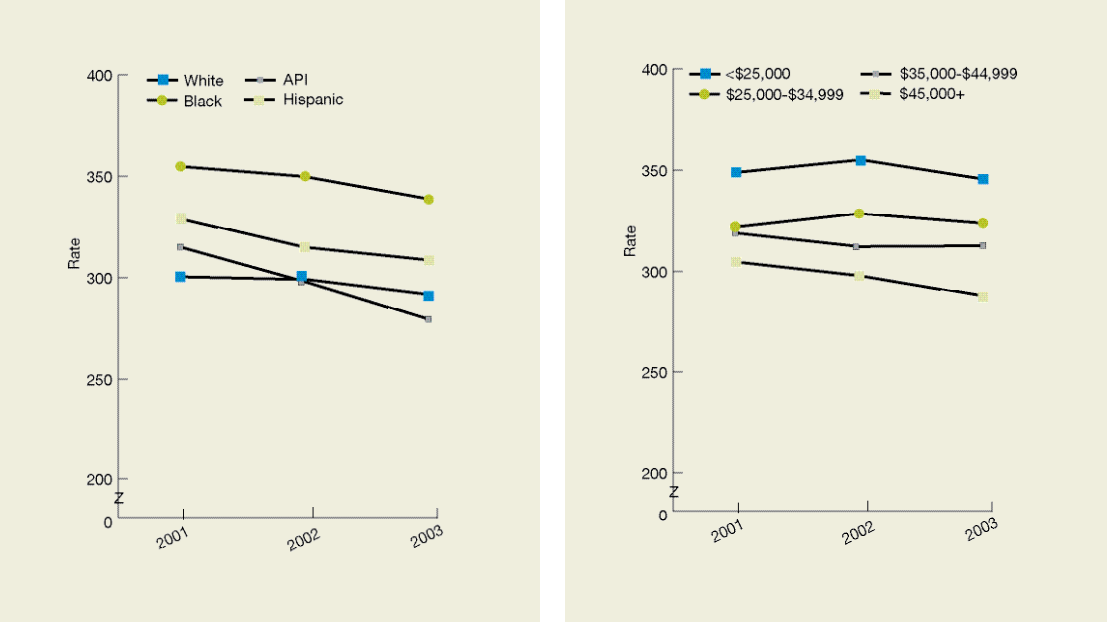
- In all years, rates of emergency department visits were significantly higher among Blacks compared with Whites (Figure 3.12).
- Over the 1997-1998 to 2003-2004 time periods, the rate of emergency department visits did not change significantly overall or for Blacks or Whites.

Potentially Avoidable Admissions

Potentially avoidable admissions are hospitalizations that might have been averted by good quality outpatient care. They relate to conditions for which good outpatient care can prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. Though not all admissions for these conditions can be avoided, rates in populations tend to vary with access to primary care.[26] For example, better access to care should facilitate the diagnosis of appendicitis before rupture occurs.

Data for perforated appendix presented here come from AHRQ's Healthcare Cost and Utilization Project State Inpatient Databases disparities analysis file. This file is designed to provide national estimates using weighted records from a sample of hospitals from 23 States that have 64% of U.S. hospital discharges. These 23 States participate in HCUP and have relatively complete race and ethnicity data.

Figure 3.13. Perforated appendix per 1,000 admissions with appendicitis by race/ethnicity (left) and area income (median income of ZIP Code of residence) (right), 2001-2003



Key: API=Asian or Pacific Islander.

Source: HCUP State Inpatient Databases disparities analysis file, 2001-2003.

Denominator: Patients hospitalized with appendicitis, all ages.

Note: White, Black, and API are non-Hispanic groups. Numerical income categories are used instead of the NHDR's usual descriptive categories because that is how data are collected for this measure.

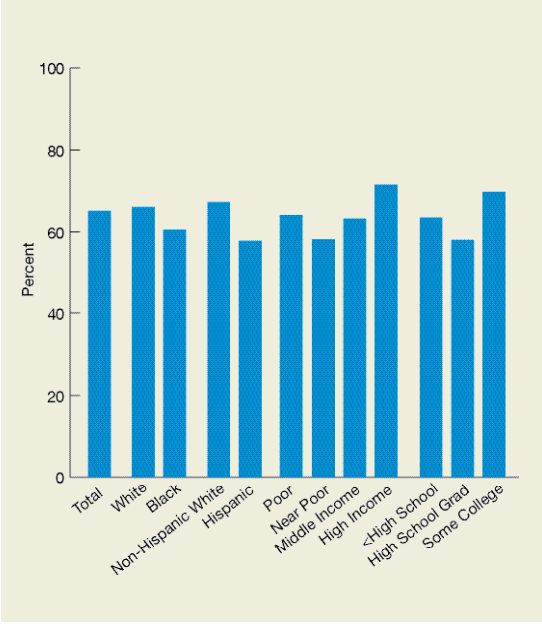
- In all 3 years, the rate of perforated appendix was significantly higher among Blacks compared with Whites and among residents of ZIP Codes with median income <$25,000 compared with residents of ZIP Codes with income $45,000 and over (Figure 3.13).
- From 2001 to 2003, the rate of perforated appendix decreased significantly for Whites, APIs, Hispanics, and residents of high income ZIP Codes, but did not change significantly for Blacks and residents of lower income ZIP Codes.

Mental Health Care and Substance Abuse Treatment

Mental Health Care

In 2004, 8% of adults, or about 17 million persons, reported having experienced at least one major depressive episode during the past year.[27] Although the prevalence of mental disorders for racial and ethnic minorities in the United States is similar to that for Whites,[28] minorities have less access to mental health care and are less likely to receive needed services.[29] These differences may reflect, in part, variation in preferences and cultural attitudes toward mental health.

Figure 3.14. Adults who received mental health treatment/counseling in the past year by race, ethnicity, income, and education, 2003 and 2004



Key: AI/AN=American Indian or Alaska Native.

Source: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health, 2003 and 2004.

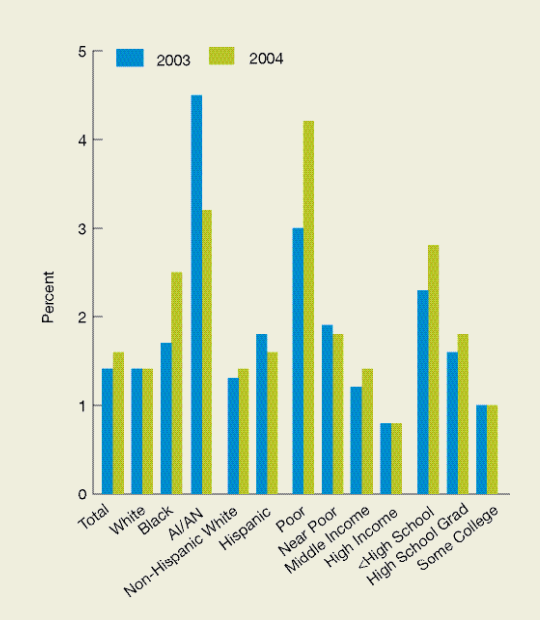
Reference population: U.S. population age 18 and older.

- In both years, the proportion of persons who received mental health treatment/counseling was lower among Blacks and Asians compared with Whites; among Hispanics compared with non-Hispanic Whites; and among persons with a high school education or less compared with persons with at least some college (Figure 3.14).
- In both years, the proportion of persons who received mental health treatment was higher among poor persons compared with high income persons.
- In 2003, the proportion of persons who received mental health treatment was lower among AI/ANs compared with Whites and among middle income persons compared with high income persons, but these differences were not statistically significant in 2004.
- From 2003 to 2004, the proportion of persons who received mental health treatment did not change significantly for any group.

Substance Abuse Treatment

In 2004, about 16.7 million Americans age 12 and older acknowledged being heavy alcohol drinkers and about 55 million acknowledged having had a recent binge drinking episode.[30] About 19.1 million persons age 12 and older were illicit drug users and about 70.3 million reported recent use of a tobacco product.[30] The direct costs of mental disorders and substance abuse amounted to $99 billion in 1996; lost productivity and premature death accounted for an additional $75 billion.[30] Racial, ethnic, and socioeconomic differences in substance abuse treatment[30] are observed which may, in part, reflect variation in preferences and cultural attitudes toward mental health and substance abuse.

Figure 3.15. Persons age 12 or older who received any illicit drug or alcohol abuse treatment in the past year, by race, ethnicity, income, and education, 2003 and 2004



Key: AI/AN=American Indian or Alaska Native.

Source: SAMHSA National Survey on Drug Use and Health, 2003 and 2004.

Reference population: U.S. population age 12 and older.

Note: The figure reflects both prevalence and treatment; prevalence likely has an effect on racial/ethnic differences in treatment.

- In both years, the proportion of persons age 12 or older who received any illicit drug or alcohol abuse treatment was significantly greater among poor, near poor, and middle income persons compared with high income persons and among persons with a high school education or less compared with persons with any college education (Figure 3.15).
- In 2003 the proportion was also significantly greater among AI/ANs compared with Whites, but this difference was not statistically significant in 2004. In 2004 the proportion was significantly greater among Blacks compared with Whites, although in 2003 this disparity was not observed.
- From 2003 to 2004, the proportion of persons age 12 or older who received any illicit drug or alcohol abuse treatment increased significantly among Blacks and poor persons and did not change significantly for any other group.

Table 3.1a. Racial and Ethnic Differences in Facilitators and Barriers to Health Care

Core Report Measure	Racial Difference[i]					Ethnic Difference[ii]
	Black	Asian	NHOPI	AI/AN	>1 Race	Hispanic
Health Insurance Coverage						
Persons under 65 with health insurance[iii]	=	=	=	↓	=	↓
Persons uninsured all year[iv]	=	=		=	=	↓
Usual Source of Care						
Persons who have a specific source of ongoing care[iii]	=	=	=	=	=	↓
Persons who have a usual primary care provider[iv]	↓	↓	=	=	=	↓
Patient Perceptions of Need						
Families that experience difficulties or delays in obtaining health care or do not receive needed care[iv]	=	↑		=	↓	=
Families that experience difficulties or delays in obtaining health care due to financial or insurance reasons[iv]	↓					↓

[i] Compared with Whites.

[ii] Compared with non-Hispanic Whites.

[iii] Source: National Health Interview Survey, 2004.

[iv] Source: Medical Expenditure Panel Survey, 2003.

Key: NHOPI=Native Hawaiian or Other Pacific Islander; AI/AN=American Indian or Alaska Native.

Key to Symbols Used in Access to Health Care Tables:

= Group and comparison group have about same access to health care.
↑ Group has better access to health care than the comparison group.
↓ Group has worse access to health care than the comparison group.
Blank cell: Reliable estimate for group could not be made.

Table 3.1b. Socioeconomic Differences in Facilitators and Barriers to Health Care

Core Report Measure	Income Difference[i]			Educational Difference[ii]		Insurance Difference[iii]
	<100%	100-199%	200-399%	<HS	HS Grad	Uninsured
Health Insurance Coverage						
Persons under 65 with health insurance[iv]	↓	↓	↓	↓	↓	
Persons uninsured all year[v]	↓	↓	↓	↓	↓	
Usual Source of Care						
Persons who have a specific source of ongoing care[iv]	↓	↓	↓	↓	↓	↓
Persons who have a usual primary care provider[v]	↓	↓	↓	↓	=	↓
Patient Perceptions of Need						
Families that experience difficulties or delays in obtaining health care or do not receive needed care [v]	↓	↓	↓	↓	=	↓
Families that experience difficulties or delays due to financial or insurance reasons[v]	↓	↓	↓	↓	↓	↓

[i] Compared with persons with family incomes 400% of Federal poverty thresholds or above.
[ii] Compared with persons with any college education.
[iii] Compared with persons under 65 with any private health insurance.
[iv] Source: National Health Interview Survey, 2004.
[v] Source: Medical Expenditure Panel Survey, 2003.
Key: HS=High school.

Key to Symbols Used in Access to Health Care Tables:

= Group and comparison group have about same access to health care.
↑ Group has better access to health care than the comparison group.
↓ Group has worse access to health care than the comparison group.
Blank cell: Reliable estimate for group could not be made.

Table 3.2a. Racial and Ethnic Differences in Health Care Utilization

Core Report Measure	Racial Difference[i]					Ethnic Difference[ii]
	Black	Asian	NHOPI	AI/AN	>1 Race	Hispanic
General Medical Care						
Persons with a dental visit in the past year[iii]	↓	↓	=	↓	=	↓
Emergency department visits per 100 population[iv]	↑	↓	=	↓	↓	
Avoidable Admissions						
Admissions for perforated appendix per 1,000 admissions with appendicitis[v]	↑	=				=
Mental Health Care and Substance Abuse Treatment						
Adults who received mental health treatment or counseling in the past year[vi]	=					=
People age 12 and older who received illicit drug or alcohol abuse treatment in the past year[vi]	↑			=		=

i Compared with Whites.

ii Compared with non-Hispanic Whites.

iii Source: Medical Expenditure Panel Survey, 2003.

iv Source: National Hospital Ambulatory Medical Care Survey – Emergency Department, 2003-2004. Missing rates preclude analysis by ethnicity.

v Source: HCUP SID disparities analysis file, 2003. This source categorizes race/ethnicity very differently from other sources. Race/ethnicity information is categorized as a single item: Non-Hispanic White, Non-Hispanic Black, Hispanic, Asian or Pacific Islander. These contrasts compare each group with non-Hispanic Whites.

vi Source: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health, 2004.

Key: NHOPI=Native Hawaiian or Other Pacific Islander; AI/AN=American Indian or Alaska Native.

Key to Symbols Used in Health Care Utilization Tables:

= Group and comparison group receive about same amount of health care.
↑ Group receives more health care than the comparison group.
↓ Group receives less health care than the comparison group.
Blank cell: Reliable estimate for group could not be made.

Table 3.2b. Socioeconomic Differences in Health Care Utilization

Core Report Measure	Income Difference[i]			Educational Difference[ii]		Insurance Difference[iii]
	<100%	100-199%	200-399%	<HS	HS Grad	Uninsured
General Medical Care						
Persons with a dental visit in the past year[iv]	↓	↓	↓	↓	↓	↓
Mental Health Care and Substance Abuse Treatment						
Adults who received mental health treatment or counseling in the past year[v]	=	↓	=	=	↓	
Persons age 12 and older who received illicit drug or alcohol abuse treatment in the past year[v]	↑	↑	↑	↑	↑	

[i] Compared with persons with family incomes 400% of Federal poverty threshold or above.

[ii] Compared with persons with any college education.

[iii] Compared with persons under 65 with any private health insurance.

[iv] Source: Medical Expenditure Panel Survey, 2003.

[v] Source: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health, 2004. Insurance disparities were not analyzed.

Key: HS=high school.

Key to Symbols Used in Health Care Utilization Tables:

= Group and comparison group receive about same amount of health care.
↑ Group receives more health care than the comparison group.
↓ Group receives less health care than the comparison group.
Blank cell: Reliable estimate for group could not be made.

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