

## Chapter 9. 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. Others face barriers that make it difficult to obtain basic health care services. As shown by extensive research and confirmed in previous National Healthcare Disparities Reports (NHDRs), racial and ethnic minorities and people of low socioeconomic status (SES)<sup>i</sup> are disproportionately represented among those with access problems.

Previous findings from the National Healthcare Quality Report (NHQR) and NHDR showed that health insurance was the most significant contributing factor to poor quality of care for some of the core measures, and many are not improving. Uninsured people were less likely to get recommended care for disease prevention, such as cancer screening, dental care, counseling about diet and exercise, and flu vaccination. They also were less likely to get recommended care for disease management, such as diabetes care management.

Poor access to health care comes at both a personal and societal cost. For example, if people do not receive vaccinations, they may become ill and spread disease to others. This increases 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.”<sup>1</sup> 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.<sup>2</sup>

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).

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<sup>i</sup> As described in Chapter 1, Introduction and Methods, income and educational attainment are used to measure SES in the NHDR. Unless specified, poor = below the Federal poverty level (FPL), near poor = 100-199% of the FPL, middle income = 200-399% of the FPL, and high income = 400% or more of the FPL. The measure specifications and data source descriptions provide more information on income groups by data source.

# Access to Health Care

## Facilitators and Barriers to Health Care

Facilitators and barriers to health care discussed in this section include health insurance, usual source of care (including having a usual source of ongoing care and a usual primary care provider), and patient perceptions of need.

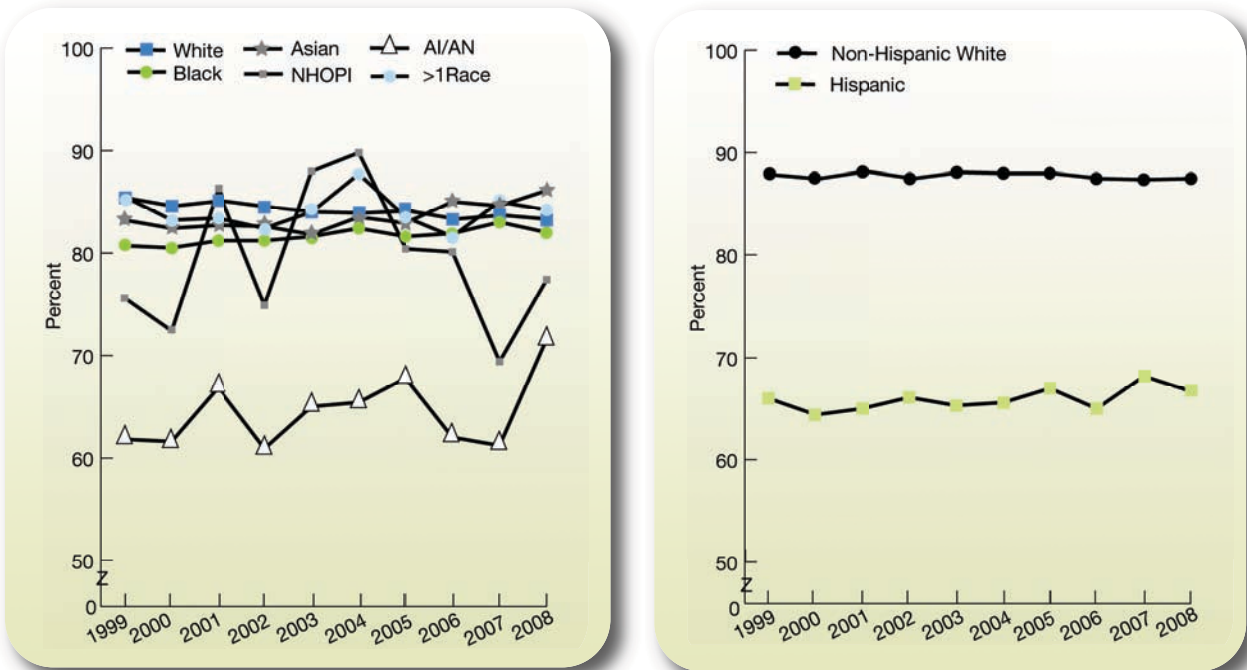
### Findings

#### Health Insurance

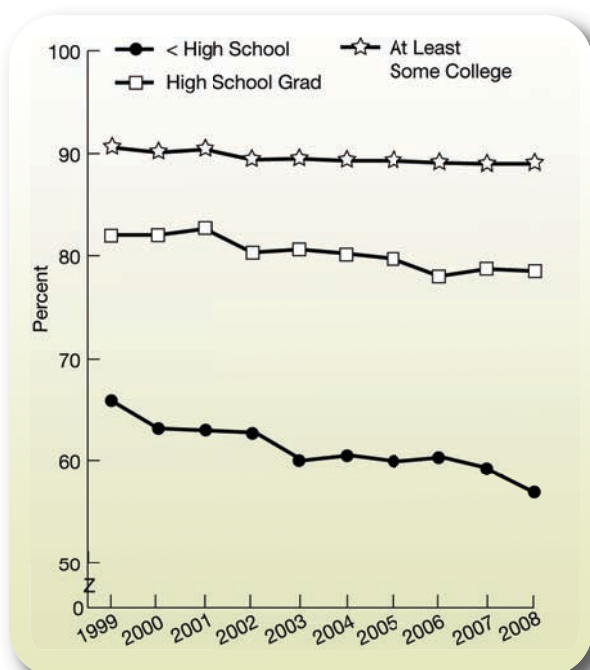
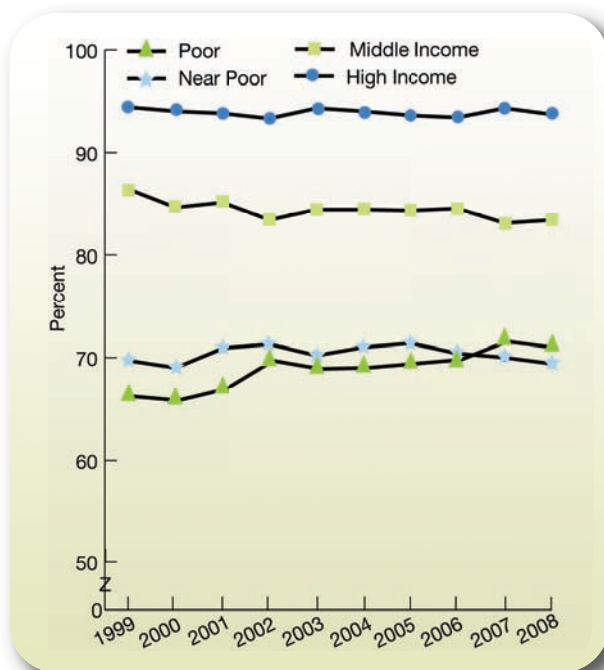
Health insurance facilitates entry into the health care system. Uninsured people are less likely to receive medical care<sup>3</sup> and more likely to have poor health status.<sup>4</sup> The costs of poor health among uninsured people total \$65 billion to \$130 billion annually.<sup>5</sup>

The financial burden of uninsurance is also high for uninsured individuals; almost 50% of personal bankruptcy filings are due to medical expenses.<sup>6</sup> Uninsured individuals report more problems getting care, are diagnosed at later disease stages, and get less therapeutic care.<sup>6,7</sup> They are sicker when hospitalized and more likely to die during their stay.<sup>7</sup>

**Figure 9.1. People under age 65 with health insurance, by race, ethnicity, income, and education, 1999-2008**



# Access to Health Care



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

**Source:** Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey (NHIS), 1999-2008.

**Denominator:** Analyses by race, ethnicity, and income performed for civilian noninstitutionalized population under age 65. Analyses by education performed for civilian noninstitutionalized population ages 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, Medicare, Medicaid, State Children's Health Insurance Program, a State-sponsored health plan, other government-sponsored health plan, or a military health plan, or if their only coverage is through the Indian Health Service.

- Overall, there was no significant change from 1999 to 2008 in the percentage of people with health insurance. In 2008, about 83.2% of people under age 65 had health insurance (data not shown).
- In 2008, Asians under age 65 were more likely than Whites to have health insurance (86.1% compared with 83.3%; Figure 9.1). American Indians and Alaska Natives under age 65 were less likely than Whites to have health insurance (71.6% compared with 83.3%). There were no statistically significant differences for other racial groups.
- In 2008, Hispanics under age 65 were less likely than non-Hispanic Whites to have health insurance (66.7% compared with 87.5%).
- From 1999 to 2008, while the percentage of people with health insurance increased for poor people (from 66.2% to 71.0%), the percentage worsened for middle-income people (from 86.4% to 83.4%). In 2008, the percentage of people with health insurance was significantly lower for poor, near-poor, and middle-income people than for high-income people (71.0%, 69.4%, and 83.4%, respectively, compared with 93.8%).
- In 2008, the percentage of people with health insurance was about one-third lower for people with less than a high school education than for people with at least some college education (56.9% compared with 89.0%).

# Access to Health Care

Also, in the NHQR:

- From 1999 to 2008, the percentage of children ages 0-17 who had health insurance increased. However, adults ages 18-44 and 45-64 were less likely than children to have health insurance, and the percentage decreased during this time.
- From 1999 to 2008, the percentage of males who had health insurance decreased and males were less likely than females to have health insurance.
- During this period, there were no statistically significant changes by residence location in the percentage of people who had health insurance. In 2008, residents of large fringe metropolitan areas and medium metropolitan areas were more likely than residents of large central metropolitan areas to have health insurance. There were no statistically significant differences within nonmetropolitan areas.

Research has shown that within-category variation (e.g., variation between Asian subpopulations) is sometimes as large as differences between minority groups and Whites.<sup>8,9</sup> Differences in English proficiency and place of birth are also significant. The following data show some of the significant disparities for racial and ethnic subgroups in California from the California Health Interview Survey (CHIS).

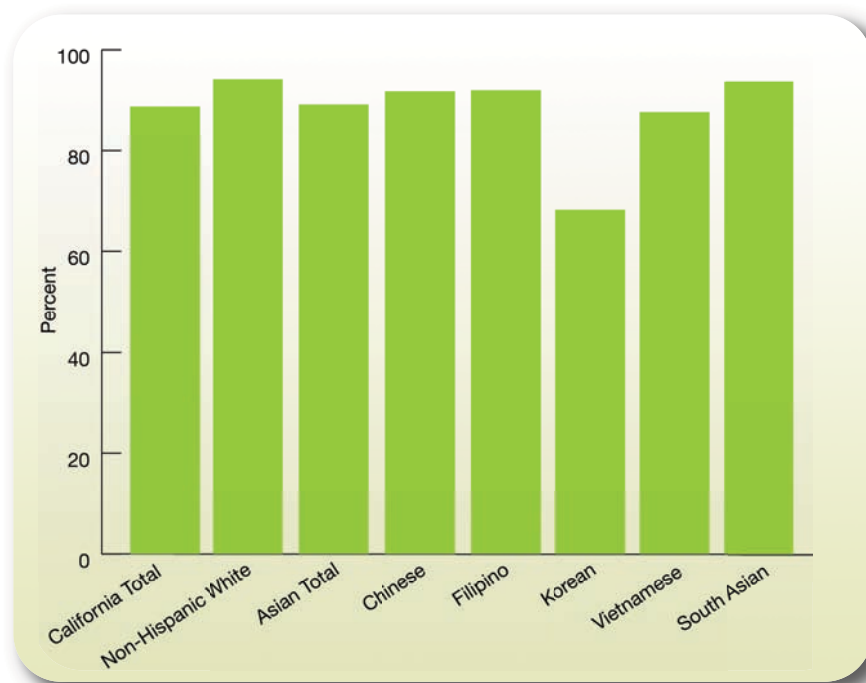
## Asian Subgroups

To show differences within racial groups, this year's NHDR includes information from CHIS on Asians in California. The geographic distribution of Asian subpopulations allows such comparisons in California using CHIS data.

In 2008, an estimated 4.6 million people, or about 34% of the Asian population in the United States, lived in California.<sup>10</sup> The proportion of many Asian subpopulations in California is also greater than the proportion in the overall U.S. population. For example, the Vietnamese population is 1.3% of California's population compared with only 0.4% of the U.S. population, and the Filipino population is 2.7% of California's population compared with only 0.7% of the U.S. population. This finding is especially important when examining data for these relatively smaller groups, as most national data sources do not have sufficient data to report estimates for these groups.

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**Figure 9.2. People under age 65 with health insurance in the past year, by Asian subgroup, California, 2007**



**Source:** University of California, Los Angeles, Center for Health Policy Research, California Health Interview Survey, 2007.

**Denominator:** Civilian noninstitutionalized adults under age 65 in California.

**Note:** Data for Japanese people did not meet criteria for statistical reliability, data quality, or confidentiality.

- In California, Asians overall were less likely than non-Hispanic Whites to have health insurance in the past year (89.2% compared with 94.2%; Figure 9.2).
- Among Asians, Koreans were the least likely to have health insurance compared with non-Hispanic Whites (68.3% compared with 94.2%). This finding was also true across all income groups (data not shown).
- Vietnamese people were also less likely than non-Hispanic Whites to have health insurance (87.7% compared with 94.2%).

## Hispanic Subgroups

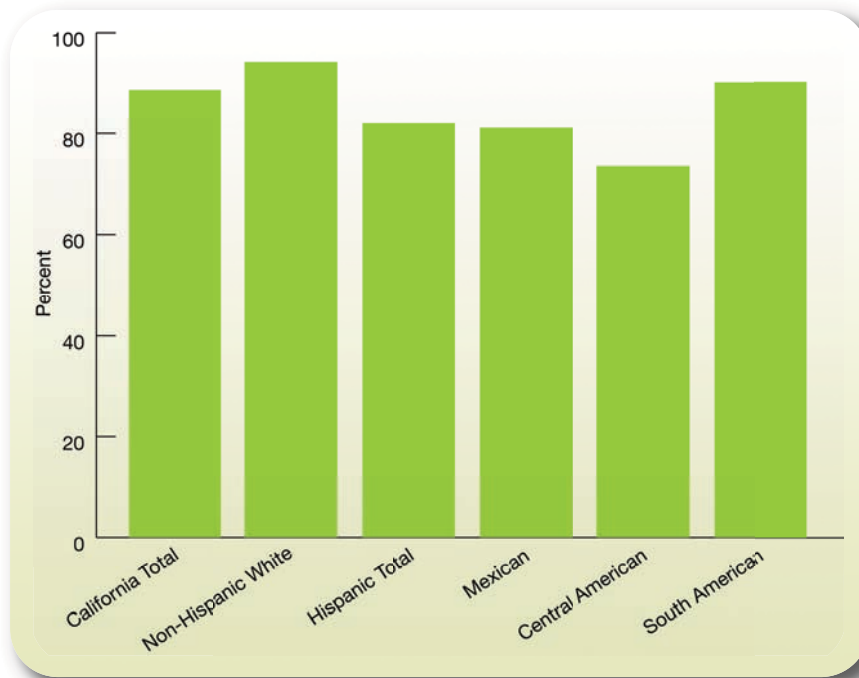
The Hispanic population in the United States is highly heterogeneous. Almost 60% of all Hispanics in the country are of Mexican extraction, making this group the largest subpopulation. People originating from Puerto Rico, Central America, and South America are the next largest subgroups. Variation is seen in access to care among Hispanics related to country of origin. Findings are presented below on differences among Hispanic subpopulations on health insurance.

In 2008, California's Hispanic population was more than twice the percentage in the United States overall (36.6% in California compared with 15.4% of the U.S. population).<sup>10</sup> Almost 30% of the Hispanic population in the United States lives in California.<sup>11</sup>

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CHIS data show disparities among Hispanics in California, not only compared with non-Hispanic Whites but also within Hispanic subgroups (Mexican, Puerto Rican, Central American, and South American). The data also show disparities across Hispanic subgroups by income. This section shows only some of the significant disparities for these groups in California from CHIS data.

**Figure 9.3. People under age 65 with health insurance in the past year, by Hispanic subgroup, California, 2007**



**Source:** University of California, Los Angeles, Center for Health Policy Research, California Health Interview Survey, 2007.

**Denominator:** Civilian noninstitutionalized adults under age 65 in California.

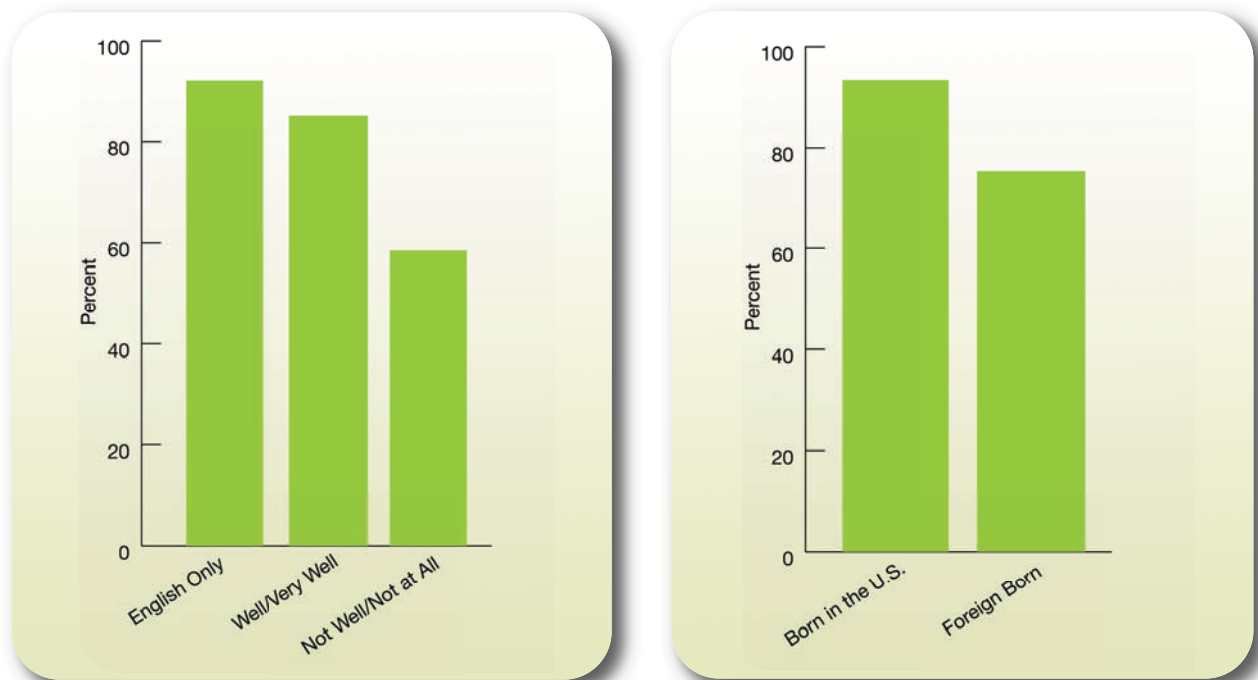
**Note:** Data for Puerto Ricans did not meet criteria for statistical reliability, data quality, or confidentiality.

- In California, Hispanics overall were less likely than non-Hispanic Whites to have health insurance in the past year (82.0% compared with 94.2%; Figure 9.3).
- Among Hispanics, Central Americans were the least likely to have health insurance compared with non-Hispanic Whites (73.6% compared with 94.2%), followed by Mexicans (81.1% compared with 94.2%).
- Mexicans also were less likely than non-Hispanic Whites to have health insurance across all income groups (data not shown).

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## English Proficiency and Place of Birth

Figure 9.4. People under age 65 with health insurance, by English proficiency and place of birth, California, 2007



**Source:** University of California, Los Angeles, Center for Health Policy Research, California Health Interview Survey, 2007.  
**Denominator:** Civilian noninstitutionalized adults under age 65 in California.

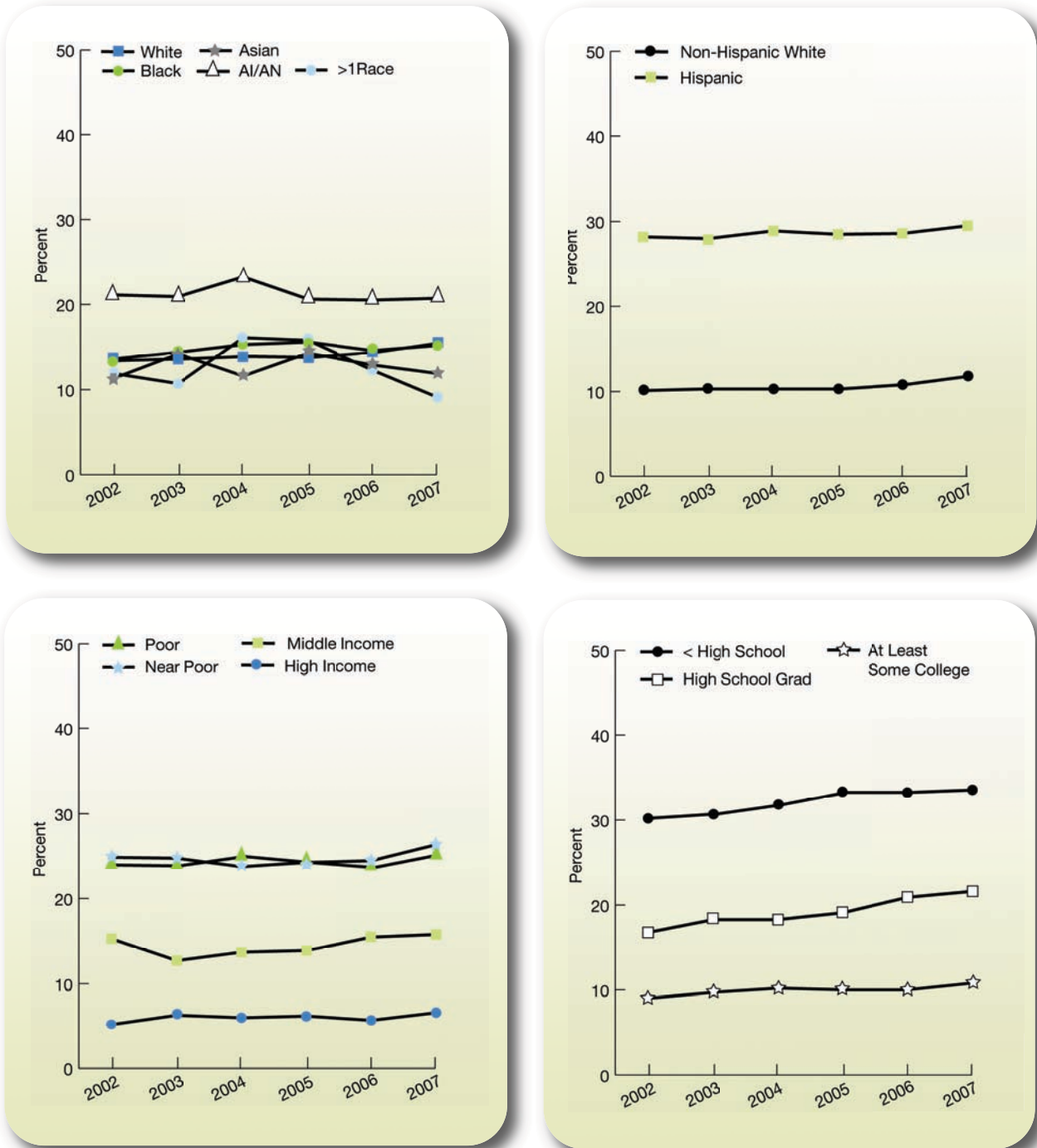
- People under age 65 who spoke English well or very well and people who did not speak English well or did not speak English at all were less likely than native English speakers to have health insurance (85.4% and 58.5%, respectively, compared with 92.2%; Figure 9.4).
- People under age 65 who were not born in the United States were less likely to have health insurance than those who were born in the United States (75.4% compared with 93.4%).

## Uninsurance

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

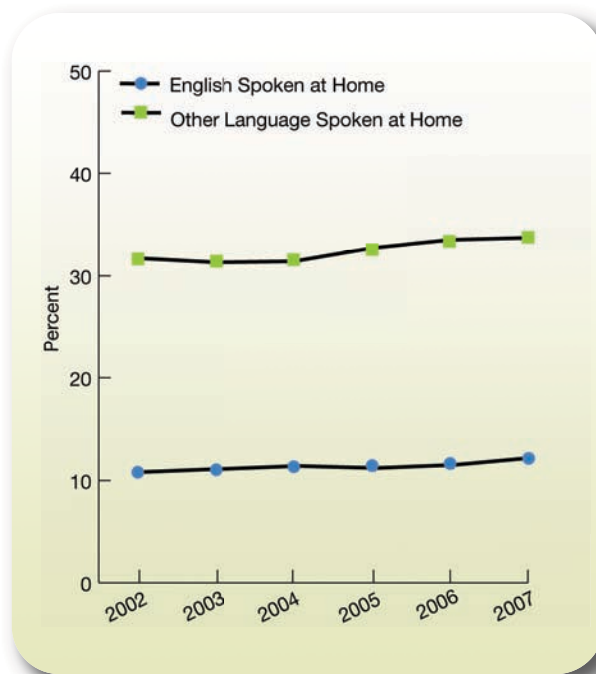
# Access to Health Care

Figure 9.5. People under age 65 who were uninsured all year, by race, ethnicity, income, education, and language spoken at home, 2002-2007





# Access to Health Care



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

**Source:** Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.

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

- Overall, from 2002 to 2007, the percentage of people under age 65 who were uninsured all year worsened (from 13.4% to 15.2%; data not shown).
- In 2007, Asians were less likely than Whites to be uninsured all year (11.9% compared with 15.5%; Figure 9.5). There was no statistically significant difference between Blacks and Whites.
- In 2007, Hispanics were much more likely than non-Hispanic Whites to be uninsured all year (29.5% compared with 11.8%).
- The percentage of poor people and near-poor people who were uninsured all year was about four times as high as that for high-income people (25.2% and 26.4%, respectively, compared with 6.6%). The percentage of middle-income people uninsured all year was more than twice as high as that for high-income people (15.8% compared with 6.6%).
- People with less than a high school education and people with a high school education were more likely to be uninsured all year than people with at least some college education (33.6% and 21.6%, respectively, compared with 10.8%).
- From 2002 to 2007, the percentage of people who were uninsured all year was nearly three times as high for people who spoke another language at home as that for people who spoke English at home (in 2007, 33.7% compared with 12.2%).

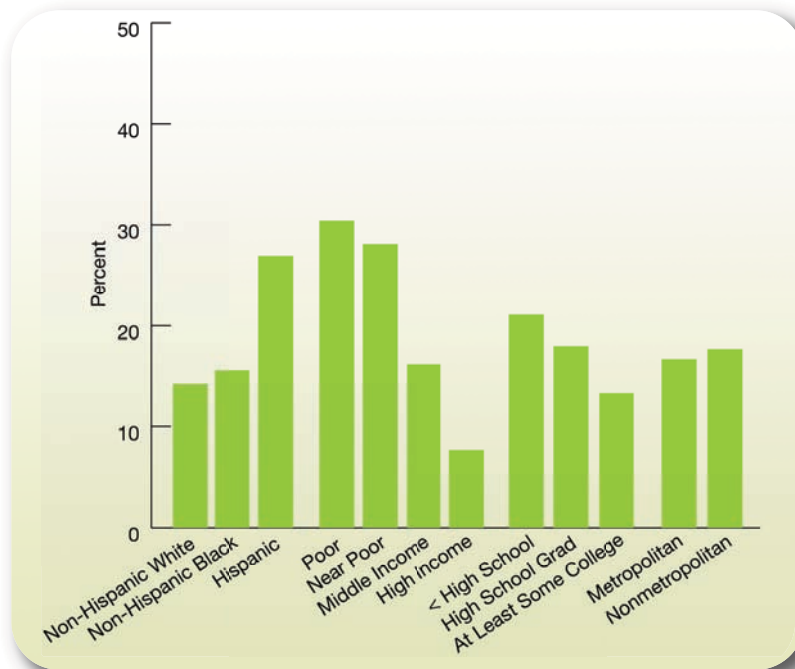
Also, in the NHQR:

- Children ages 0-17 were less likely to be uninsured than adults ages 18-44 and age 65 and over.
- From 2002 to 2007, females were less likely to be uninsured all year than males.
- Among metropolitan areas, residents of large fringe metropolitan areas were least likely to be uninsured all year while residents of large central metropolitan areas were most likely to be uninsured all year.

# Access to Health Care

Each year, multivariate analyses are conducted in support of the NHDR to identify the independent effects of race, ethnicity, income, and education on quality of health care. Past reports have listed some of these findings as odds ratios. This year, the NHDR presents the results of a multivariate model as adjusted percentages for this measure: people under age 65 who were uninsured all year. Adjusted percentages show the expected percentage for a given subpopulation after controlling for a number of factors, which include race/ethnicity, family income, education, health insurance status, and residence location.

**Figure 9.6. Adjusted percentages of people under age 65 who were uninsured all year, by race/ethnicity, family income, education, and residence location, 2002-2007**



**Source:** Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, pooled 2002-2007 fiscal year files.

**Note:** Adjusted percentages are predicted marginals from a statistical model that includes the covariates race/ethnicity, family income, education, health insurance, and residence location.

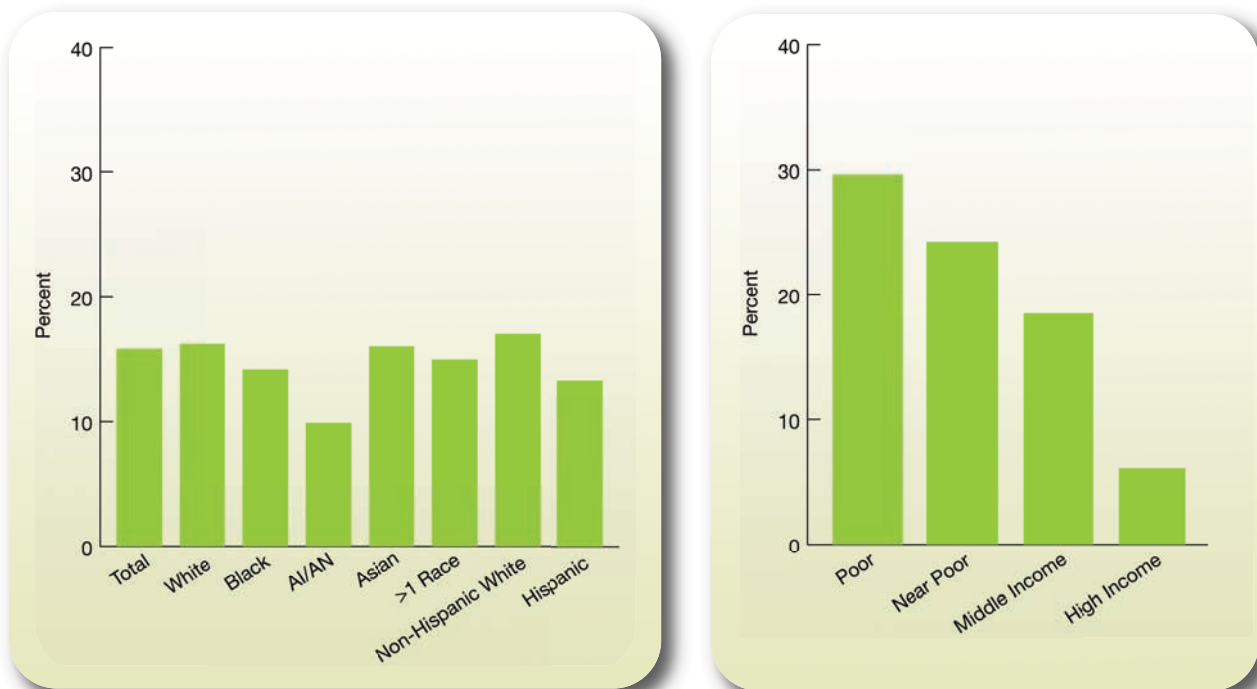
- In the multivariate model used, after adjustment, 16% of non-Hispanic Blacks and 27% of Hispanics would have been uninsured all year compared with 14% of non-Hispanic Whites (Figure 9.6).
- After adjustment, about 30% of poor, 28% of near-poor, and 16% of middle-income individuals would have been uninsured all year compared with 8% of those with high income.
- After adjustment, 21% of people with less than a high school education and 18% of high school graduates would have been uninsured all year compared with 13% of those with at least some college education.
- After adjustment, 18% of people living in nonmetropolitan areas would have been uninsured all year compared with 17% of those living in metropolitan areas.

# Access to Health Care

## Financial Burden of Health Care Costs

Health insurance is supposed to protect individuals from the burden of high health care costs. However, even with health insurance, the financial burden for health care can still be high and is increasing.<sup>12</sup> High premiums and out-of-pocket payments can be a significant barrier to accessing needed medical treatment and preventive care.<sup>13</sup> One way to assess the extent of financial burden is to determine the percentage of family income spent on a family's health insurance premium and out-of-pocket medical expenses.

**Figure 9.7. People under age 65 whose family's health insurance premium and out-of-pocket medical expenses were more than 10% of total family income, by race, ethnicity, and family income, 2007**



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

**Source:** Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2007.

**Denominator:** Civilian noninstitutionalized population.

**Note:** Total financial burden includes premiums and out-of-pocket costs for health care services.

- Overall, in 2007, 16.3% of people under age 65 had health insurance premium and out-of-pocket medical expenses that were more than 10% of total family income (Figure 9.7).
- In 2007, the percentage of people under age 65 whose family's health insurance premium and out-of-pocket medical expenses were more than 10% of total family income was lower for American Indians and Alaska Natives than for Whites (9.9% compared with 16.8%). The percentage was also lower for Hispanics than for non-Hispanic Whites (12.8% compared with 17.8%).
- The percentage of people under age 65 whose family's health insurance premium and out-of-pocket medical expenses were more than 10% of total family income was about five times as high for poor individuals (29.7%), about four times as high for near-poor individuals (23.6%), and about three times as high for middle-income individuals (18.7%) compared with high-income individuals (6.7%).

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Also, in the NHQR:

- The percentage of people under age 65 whose family's health insurance premium and out-of-pocket medical expenses were more than 10% of total family income was nearly three times as high for individuals with private nongroup insurance as for individuals with private employer-sponsored insurance.
- The percentage of people under age 65 whose family's health insurance premium and out-of-pocket medical expenses were more than 10% of total family income was higher for individuals living in nonmetropolitan areas than for those in metropolitan areas.

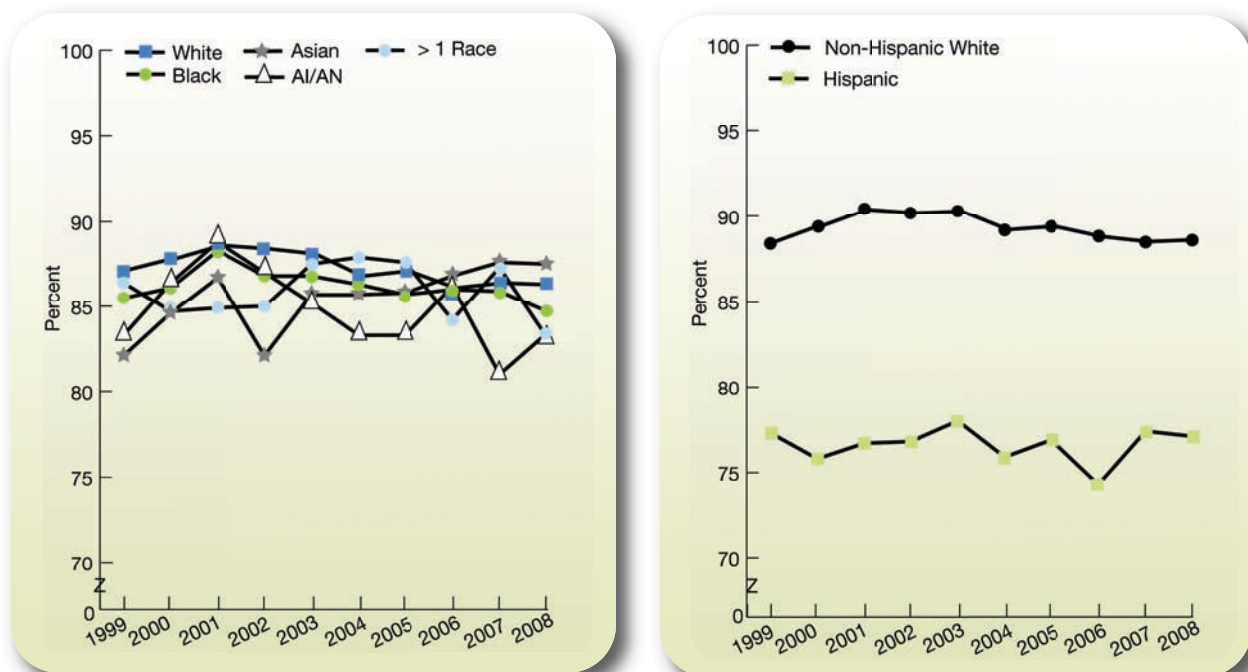
## Usual Source of Care

People with a usual source of care (a provider or facility where one regularly receives care) experience improved health outcomes and reduced disparities (smaller differences between groups)<sup>14</sup> and costs.<sup>15</sup> Evidence suggests that the effect on quality of the combination of health insurance and a usual source of care is additive.<sup>16</sup> In addition, people with a usual source of care are more likely to receive preventive health services.<sup>17</sup>

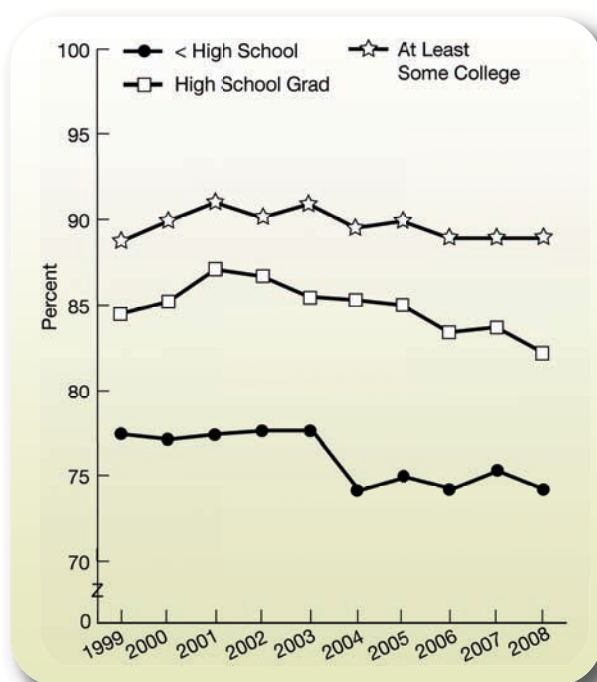
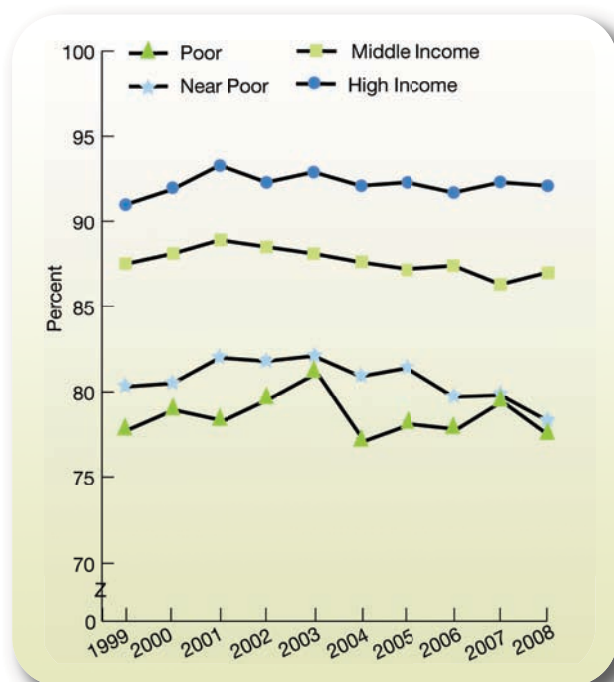
## Specific Source of Ongoing Care

More than 40 million Americans lack a specific source of ongoing care.<sup>18</sup> The term “specific source of ongoing care” accounts for patients who may have more than one source of care, such as women of childbearing age and older people, who tend to have more than one doctor.

**Figure 9.8. People with a specific source of ongoing care, by race, ethnicity, income, and education, 1999-2008**



# Access to Health Care



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

**Source:** Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 1999-2008.

**Denominator:** Analyses by race, ethnicity, and income performed for civilian noninstitutionalized population of all ages. Analyses by education performed for civilian noninstitutionalized population ages 25-64.

**Note:** Measure is age adjusted.

- Overall, 86.1% percent of people had a specific source of ongoing care in 2008 (data not shown).
- In 2008, the percentage of people with a specific source of ongoing care was lower for Blacks than Whites (84.7% compared with 86.3%; Figure 9.8) and significantly lower for Hispanics than for non-Hispanic Whites (77.1% compared with 88.6%).
- In 2008, the percentage of people with a specific source of ongoing care was significantly lower for poor people than for high-income people (77.5% compared with 92.1%).
- In 2008, the percentage of people with a specific source of ongoing care was lower for people with less than a high school education and for people with a high school education than for people with at least some college education (74.2% and 82.2% respectively, compared with 88.9%).

Also, in the NHQR:

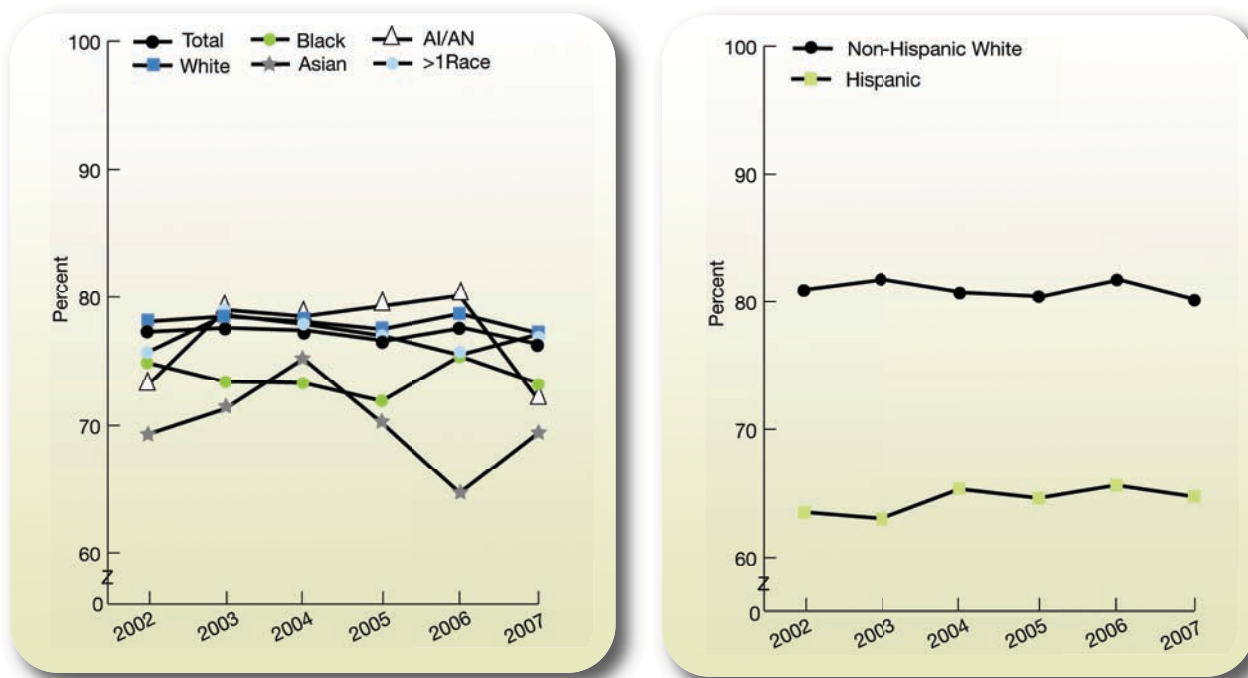
- In 2008, the percentage of people with a specific source of ongoing care was much lower for uninsured people than for people with private insurance.
- In 2008, for people 65 and over, the percentage of people with a specific source of ongoing care was lower for people with Medicare only than for people with Medicare and private insurance.

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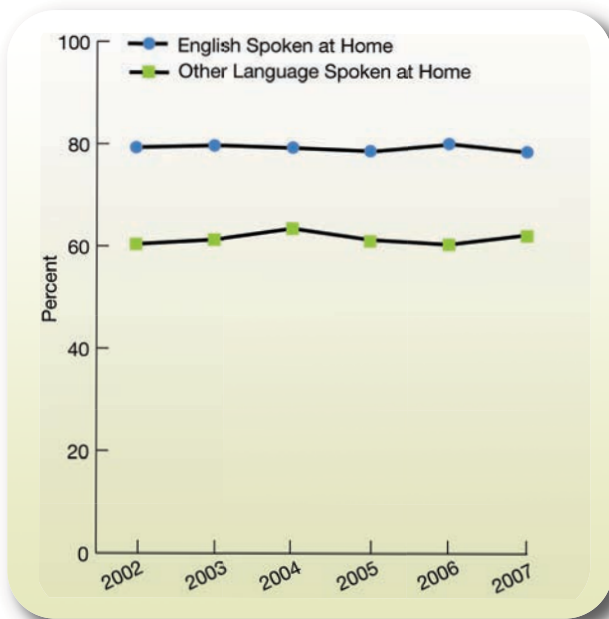
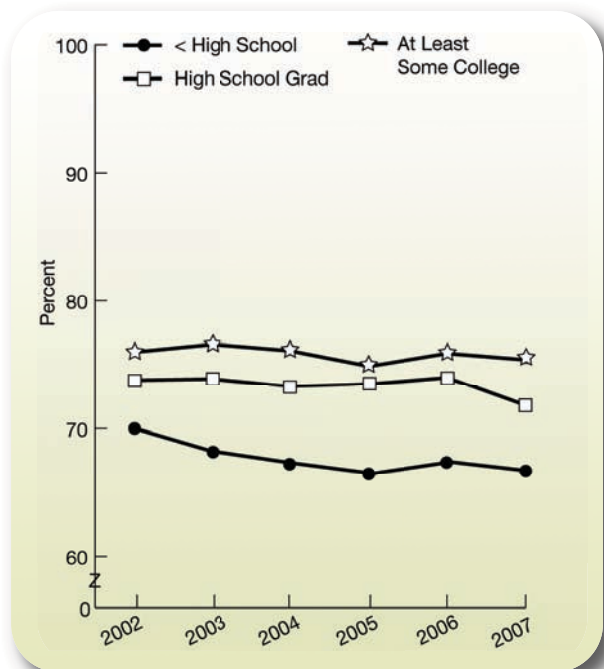
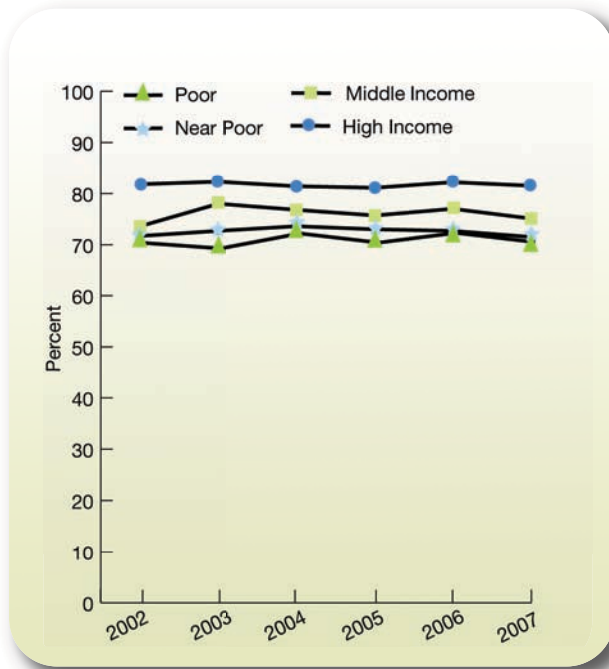
## Usual Primary Care Provider

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<sup>19</sup> and with good provider-patient communication. These factors increase the likelihood that patients will receive appropriate care.<sup>20</sup> By learning about patients' diverse health care needs over time, a usual primary care provider can coordinate care (e.g., visits to specialists) to better meet patients' needs.<sup>21</sup> Having a usual primary care provider correlates with receipt of higher quality care.<sup>22, 23</sup>

**Figure 9.9. People with a usual primary care provider, by race, ethnicity, family income, education, and language spoken at home, 2002-2007**



# Access to Health Care



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

**Source:** Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.

**Denominator:** Analyses by race, ethnicity, and income performed for civilian noninstitutionalized population of all ages. Analyses by education performed for civilian noninstitutionalized population 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.

- In 2007, about 76.3% of people had a usual primary care provider (Figure 9.9).
- In 2007, Blacks and Asians were less likely than Whites to have a usual primary care provider (73.3% and 69.4%, respectively, compared with 77.2%).

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- In 2007, the percentage of people with a usual primary care provider was significantly lower for Hispanics than for non-Hispanic Whites (64.7% compared with 80.1%).
- In 2007, the percentage of people with a usual primary care provider was significantly lower for poor people, near-poor people, and middle-income people than for high-income people (70.5%, 71.5%, and 75.1% respectively, compared with 81.5%).
- In 2007, the percentage of people with a usual primary care provider was significantly lower for people with less than a high school education and for people with a high school education than for people with some college education (66.7% and 71.8%, respectively, compared with 75.4%).
- In 2007, the percentage of people who had a primary care provider was lower for people who spoke a language other than English at home than for people who spoke English at home (62.3% compared with 78.4%).

Also, in the NHQR:

- People ages 18-44 were least likely to have a usual primary care provider, while people age 65 and over were most likely to have a usual primary care provider.
- In 2007, uninsured people were almost half as likely as people with private insurance to have a usual primary care provider and people age 65 and over with Medicare only were less likely than people with Medicare and private insurance to have a usual primary care provider.
- Females were more likely to have a usual primary care provider than males.
- In 2007, residents of nonmetropolitan areas were more likely to have a usual primary care provider than residents of metropolitan areas overall.

## Patient Perceptions of Need

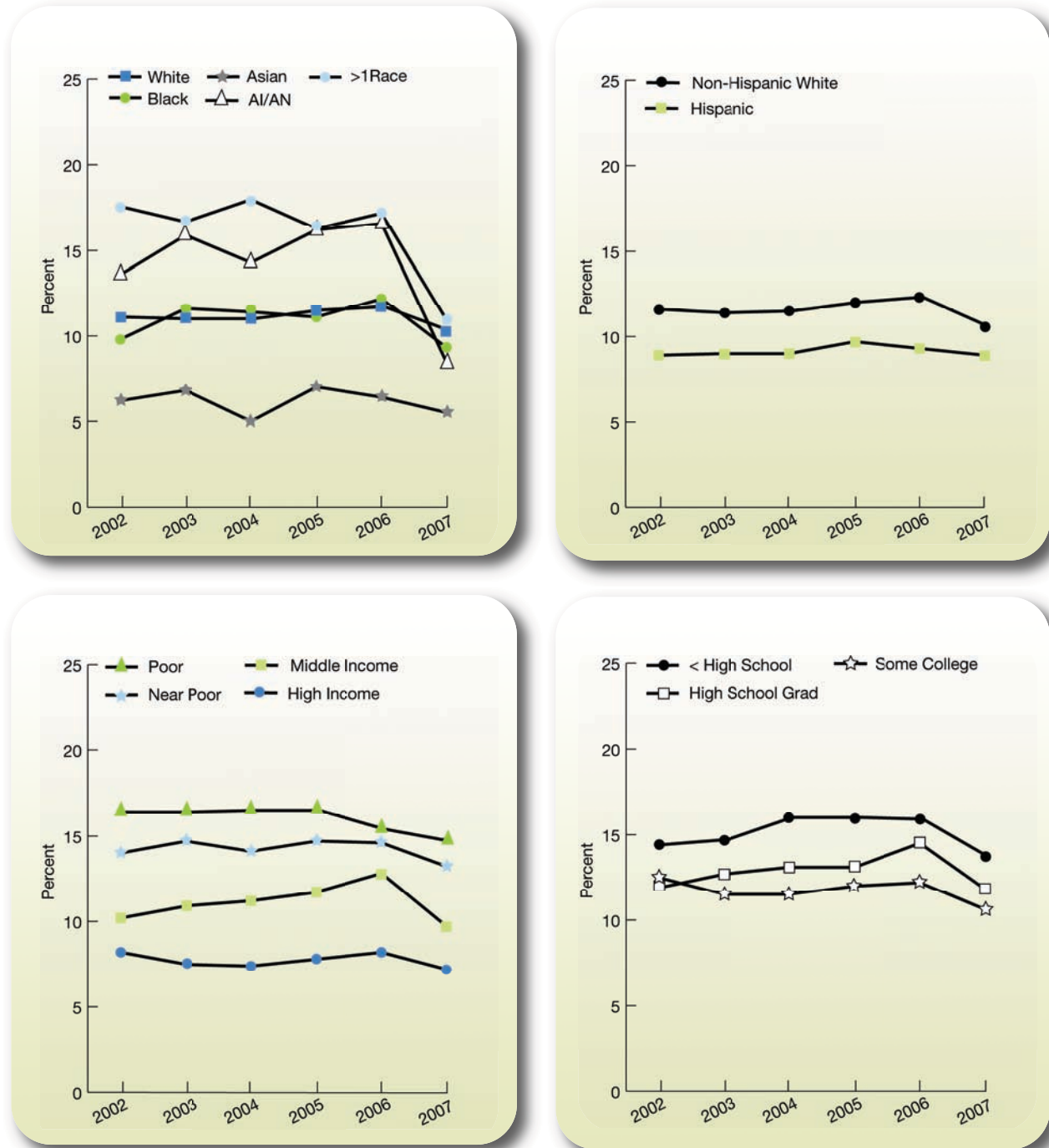
Patient perceptions of need include perceived difficulties or delays in obtaining care and problems getting care as soon as wanted. Although patients may not always be able to assess their need for care, problems getting care when patients perceive that they are ill or injured likely reflect significant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



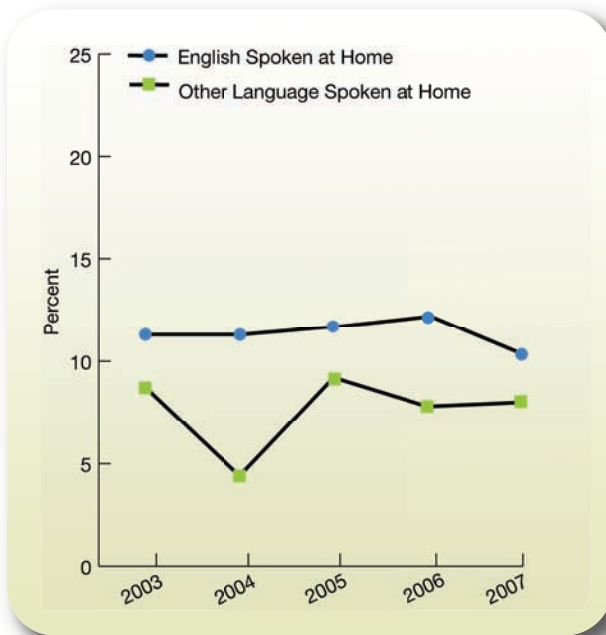


# Access to Health Care

Figure 9.10. People who were unable to get or delayed in getting needed medical care, dental care, or prescription medicines in the last 12 months, by race, ethnicity, income, education, 2002-2007 and language spoken at home, 2003-2007



# Access to Health Care



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

**Source:** Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.

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

- Overall, in 2007, 10.0% of people were unable to receive or delayed in receiving needed medical care, dental care, or prescription medicines due to financial or insurance reasons (data not shown).
- In 2007, the percentage of people who were unable to get or delayed in getting needed medical care, dental care, or prescription medicines was lower for Asians than for Whites (5.5% compared with 10.3%; Figure 9.10).
- In 2007, the percentage of people who were unable to get or delayed in getting needed medical care, dental care, or prescription medicines was lower for Hispanics than for non-Hispanic Whites (8.9% compared with 10.6%).
- In 2007, the percentage of people who were unable to get or delayed in getting needed medical care, dental care, or prescription medicines was significantly worse for poor (14.7%), near-poor (13.2%), and middle-income (9.7%) people than for high-income people (7.2%).
- People with less than a high school education and people with a high school education were more likely than those with some college education to report they were unable to get or delayed in getting needed care (13.7% and 11.8%, respectively, compared with 10.6%).
- In 2007, the percentage of people who were unable to get or delayed in getting needed medical care, dental care, or prescription medicines was lower for people who spoke a language other than English at home than for people who spoke English at home (8.0% compared with 10.3%).

Also, in the NHQR:

- For people under age 65, the percentage of people who were unable to get or delayed in getting needed medical care, dental care, or prescription medicines was more than twice as high for people with no health insurance as for people with private insurance. The percentage was also worse for people with public insurance than for people with private insurance.

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