

## 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).

### 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.

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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.

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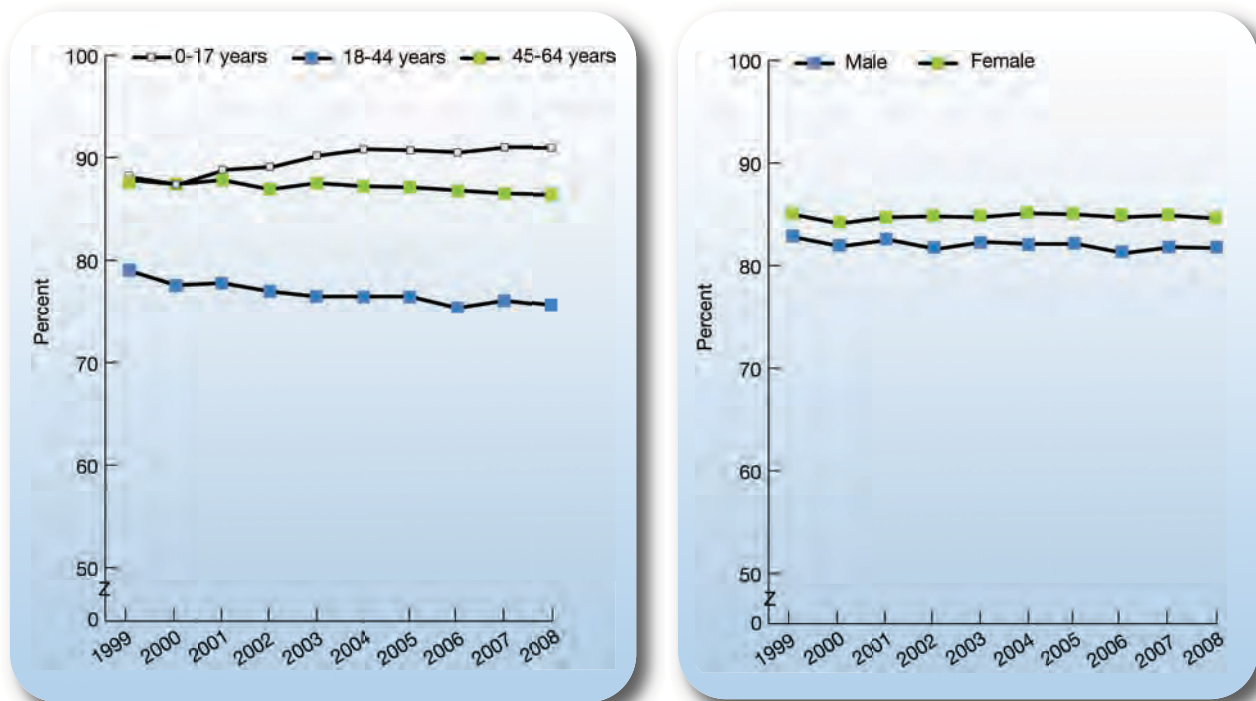
## Findings

### 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 age and gender, 1999-2008**



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

**Denominator:** Civilian noninstitutionalized population under age 65.

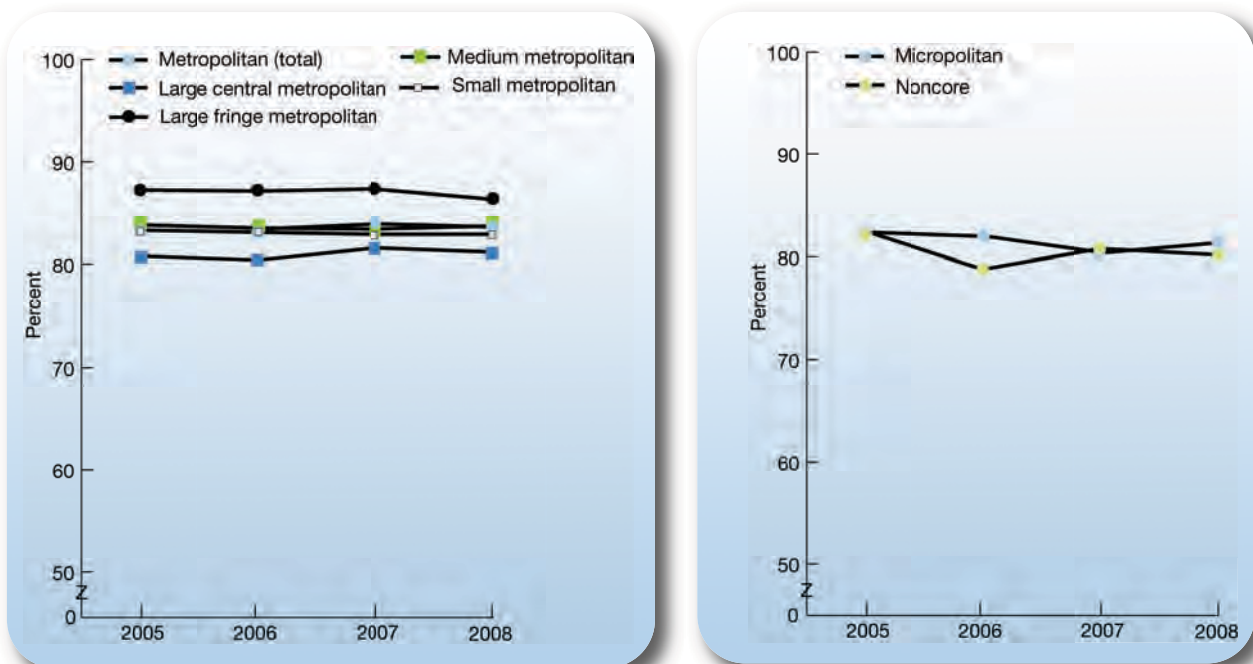
**Note:** NHIS respondents are asked about health insurance coverage at the time of interview. Respondents are considered uninsured if they lack private health insurance, Medicare, Medicaid, State Children's Health Insurance Program, a State-sponsored health plan, other government-sponsored health plan, or a military health plan, or if their only coverage is through the Indian Health Service.

- Overall, there was no statistically significant change from 1999 to 2008. In 2008, 83.2% of people under age 65 had health insurance (data not shown).

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- From 1999 to 2008, the percentage of children ages 0-17 who had health insurance improved (from 88.1% to 91.0%; Figure 9.1). However, for adults ages 18-44 and 45-64, the percentage worsened (for ages 18-44, from 79.0% to 75.6%; and for ages 45-64, from 87.8% to 86.4%).
- In 2008, adults ages 18-44 and 45-64 were less likely than children ages 0-17 to have health insurance (75.6% and 86.4% respectively, compared with 91.0%).
- From 1999 to 2008, the percentage of males who had health insurance decreased (from 82.8% to 81.7%). There was no statistically significant change for females during this period.
- Females were more likely to have health insurance than males throughout this period.

**Figure 9.2. People under age 65 with health insurance, by residence location, 2005-2008**



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

**Denominator:** Civilian noninstitutionalized population 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, 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. This measure reflects the percentage of survey respondents under age 65 who were covered by health insurance at the time of the interview.

- From 2005 to 2008, there were no statistically significant changes by residence location (Figure 9.2).
- 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 (86.4% and 83.7%, respectively, compared with 81.2%). There were no statistically significant differences in nonmetropolitan areas between micropolitan areas and noncore<sup>ii</sup> areas.

<sup>ii</sup> Noncore areas are outside of metropolitan or micropolitan statistical areas. Micropolitan and noncore areas are typically regarded as "rural."

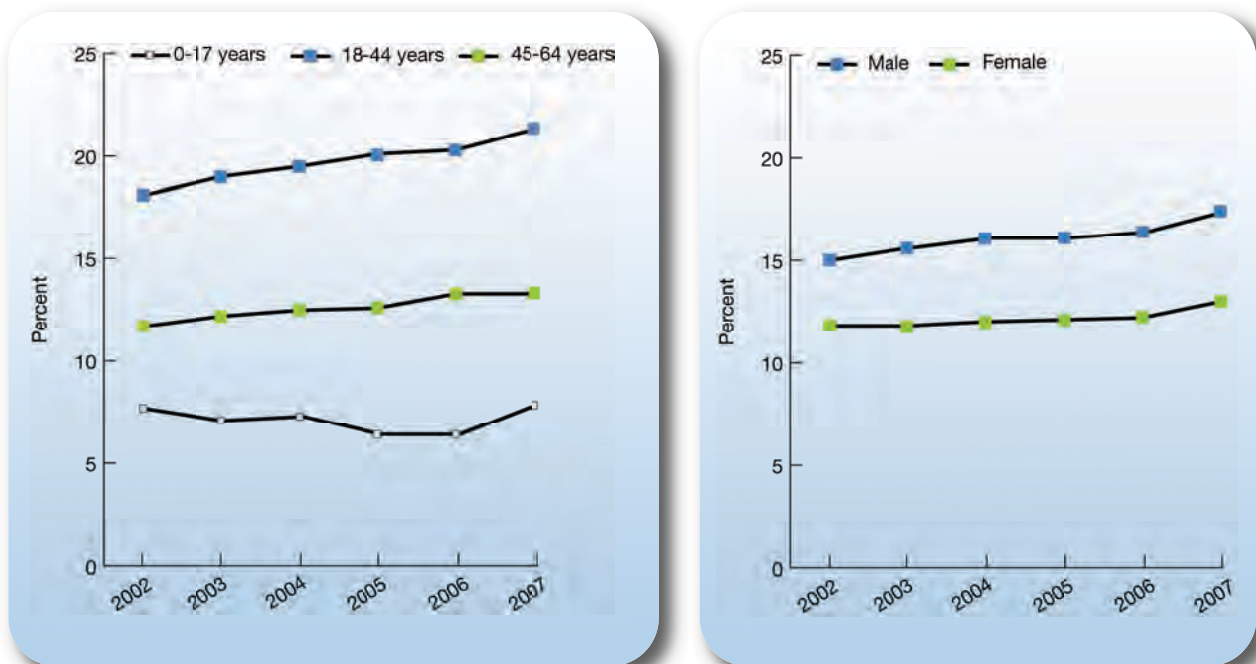
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Also, in the NHDR:

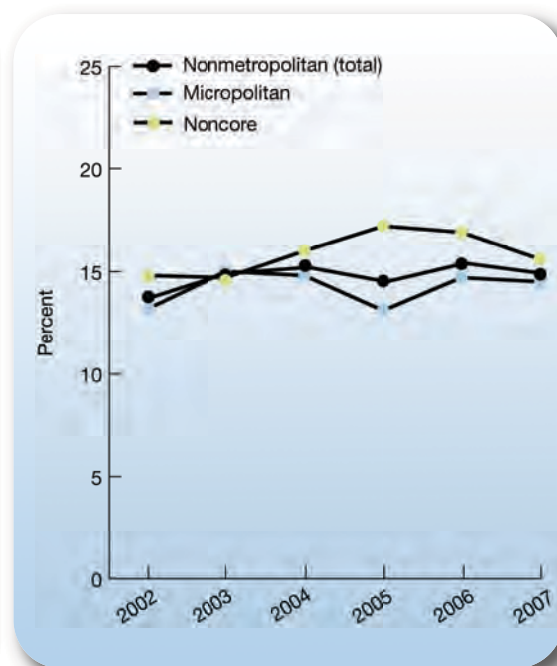
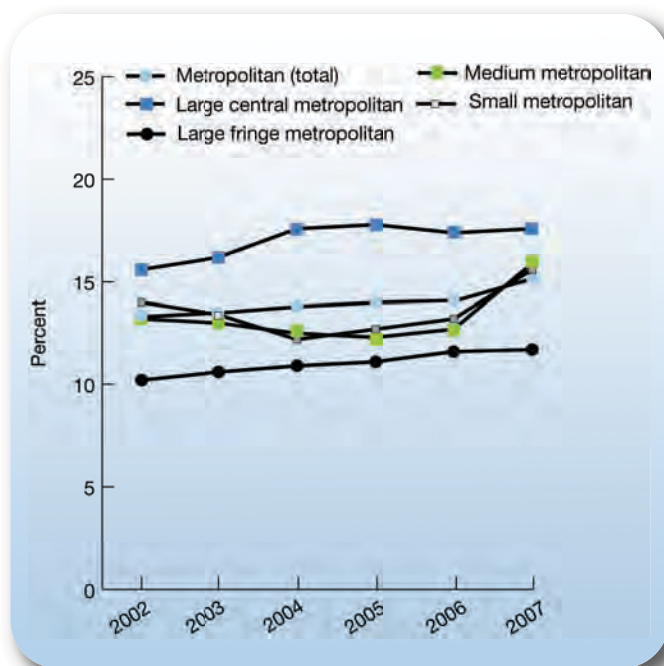
- From 2005 to 2008, the percentage of people with health insurance improved for poor people, but they were still less likely to have health insurance than high-income people. Middle-income people were also less likely than high-income people to have health insurance and the percentage worsened from 2005 to 2008.
- Asians were more likely than Whites to have health insurance. American Indians and Alaska Natives were less likely than Whites to have health insurance, and Hispanics were less likely than non-Hispanic Whites to have health insurance.
- In California, there were also differences among Hispanic and Asian subgroups. Koreans and Vietnamese people were less likely than non-Hispanic Whites to have health insurance. Central Americans and Mexicans were less likely to have health insurance than non-Hispanic Whites.
- In California, people under age 65 who did not speak English well or very well and people who did not speak English at all were less likely than native English speakers to have health insurance. Also, 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.

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.

**Figure 9.3. People under age 65 who were uninsured all year, by age, gender, and residence location, 2002-2007**



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

**Denominator:** Civilian noninstitutionalized population under age 65.

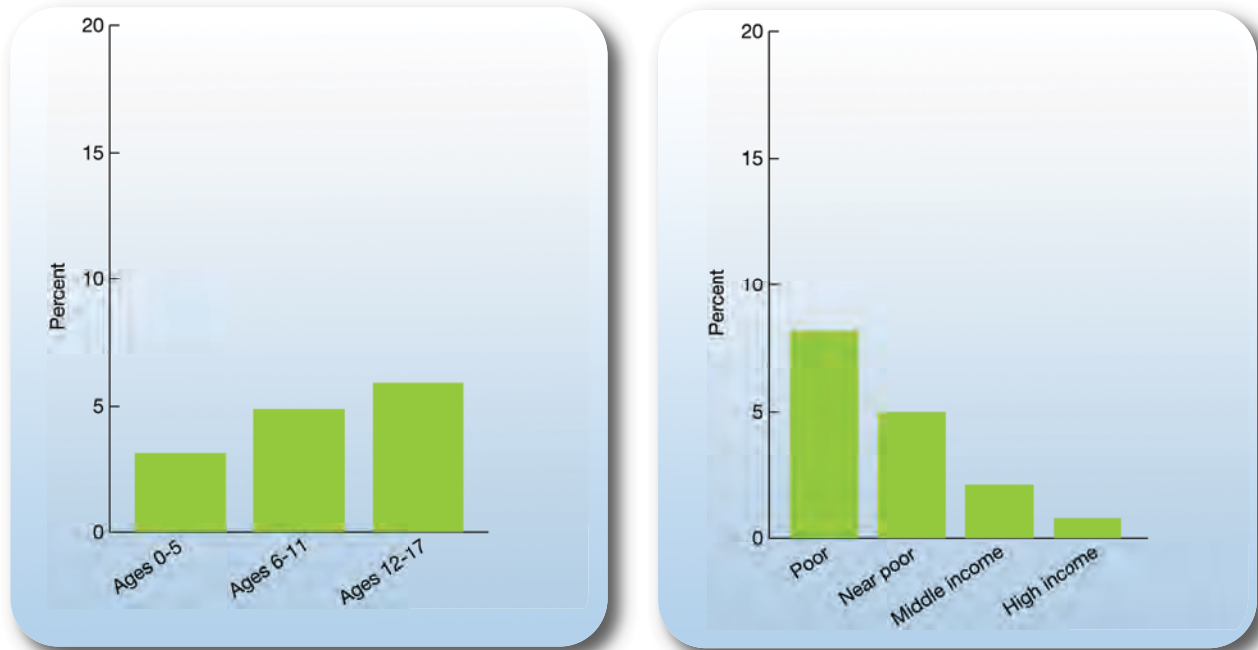
- Overall, from 2002 to 2007, the percentage of people under age 65 who were uninsured all year worsened (from 13.4% to 15.2%; data not shown).
- From 2002 to 2007, children ages 0-17 were least likely to be uninsured all year, while adults ages 18-44 were most likely to be uninsured all year (in 2007, 7.9% for ages 0-17 and 21.3% for ages 18-44; Figure 9.3).
- From 2002 to 2007, females were less likely to be uninsured all year than males (in 2007, 13.0% compared with 17.4%).
- In 2007, among metropolitan areas, residents of large fringe metropolitan areas were least likely to have been uninsured all year (11.7%) while residents of large central metropolitan areas were most likely to be uninsured all year (17.6%).
- In 2007, there was no statistically significant difference overall in the percentage of people who were uninsured all year between residents of metropolitan areas and residents of nonmetropolitan areas (15.2% compared with 14.9%).

Also, in the NHDR:

- In 2007, Asians were less likely to be uninsured all year compared with Whites, while Hispanics were more likely to be uninsured all year compared with non-Hispanic Whites.
- Poor people and people with less than a high school education were much more likely to be uninsured all year than high-income people and people with at least some college education.
- People who spoke a language other than English at home were more likely to be uninsured all year than people who spoke English at home.

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**Figure 9.4. Children who were uninsured for the past 12 months, by age and income, 2007**



**Source:** Health Resources and Services Administration, Maternal and Child Health Bureau; Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health, 2007.

**Denominator:** Children under age 18.

**Note:** Analyses performed by the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health (<http://childhealthdata.org>).

- In 2007, children ages 6-11 and 12-17 were more likely to be uninsured than children ages 0-5 (4.9% and 5.9%, respectively, compared with 3.1%; Figure 9.4).
- Poor children were more than 10 times as likely as high-income children to be uninsured for the past 12 months (8.2% compared with 0.8%). Near-poor children were more than six times as likely and middle-income children were more than twice as likely as high-income children to be uninsured (5.0% and 2.1%, respectively, compared with 0.8%).

Also, in the NHDR:

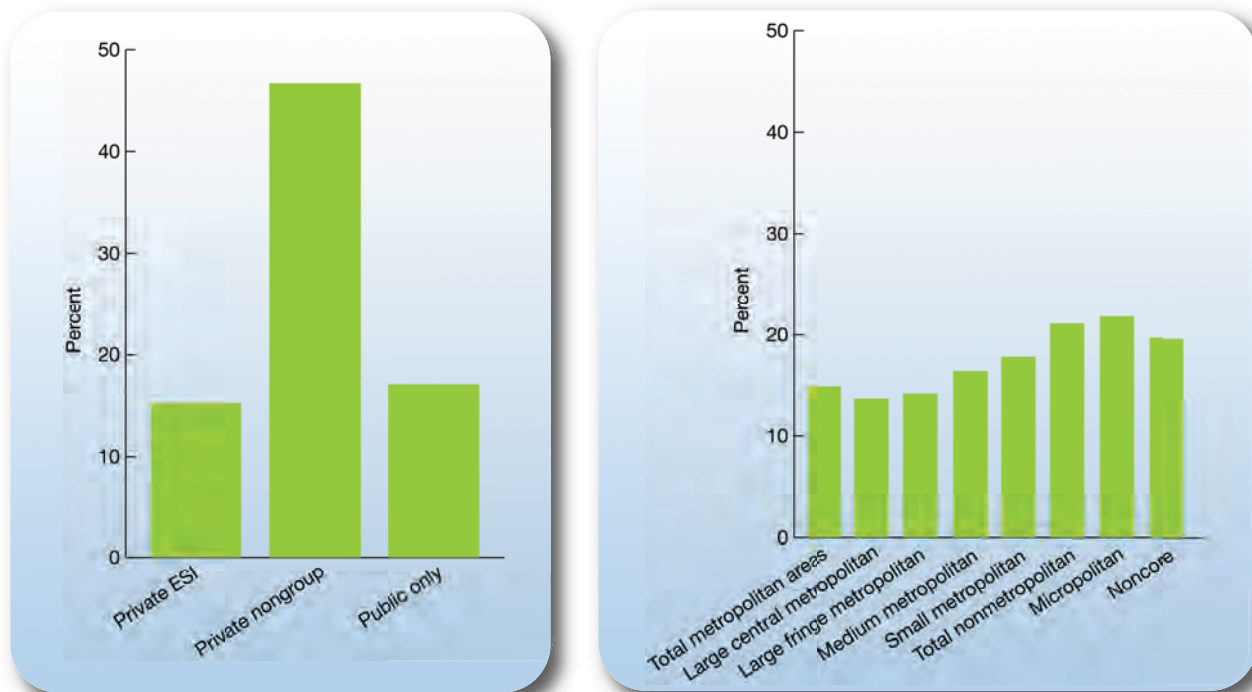
- Black children were more likely than non-Hispanic White children to be uninsured for the past 12 months.
- Hispanic children were about five times as likely to be uninsured as non-Hispanic White children (12.0% compared with 2.4%).

## 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>8</sup> High premiums and out-of-pocket payments can be a significant barrier to accessing needed medical treatment and preventive care.<sup>9</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.

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**Figure 9.5. 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 insurance and geographic region, 2007**



**Key:** ESI = employer-sponsored insurance.

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

**Denominator:** Civilian noninstitutionalized population under age 65.

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

- Overall, in 2007 about 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 (data not shown).
- 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 (46.7% compared with 15.8%; Figure 9.5). There was no significant difference between publicly insured individuals and individuals with 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 overall (21.1% compared with 15.4%).
- Individuals living in noncore areas were more likely than individuals living in large central metropolitan areas to have health insurance premium and out-of-pocket medical expenses of more than 10% of family income (19.7% compared with 14.0%).

Also, in the NHDR:

- American Indians and Alaska Natives and Hispanics were less likely than Whites and non-Hispanic Whites to have health insurance premium and out-of-pocket medical expenses that were more than 10% of total family income.

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- Poor individuals were almost five times as likely as high-income individuals to have health insurance premium and out-of-pocket medical expenses that were more than 10% of total family income.

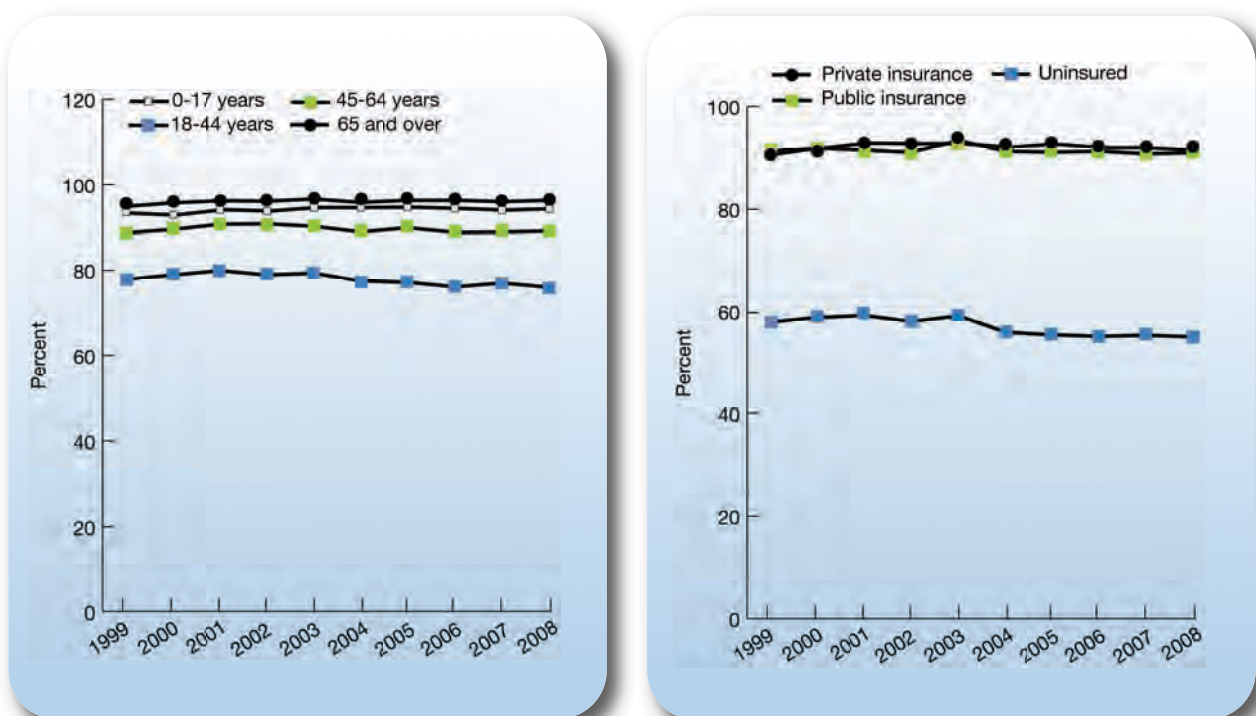
## Usual Source of Care

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>10</sup> and costs.<sup>11</sup> Evidence suggests that the effect on quality of the combination of health insurance and a usual source of care is additive.<sup>12</sup> In addition, people with a usual source of care are more likely to receive preventive health services.<sup>13</sup>

## Specific Source of Ongoing Care

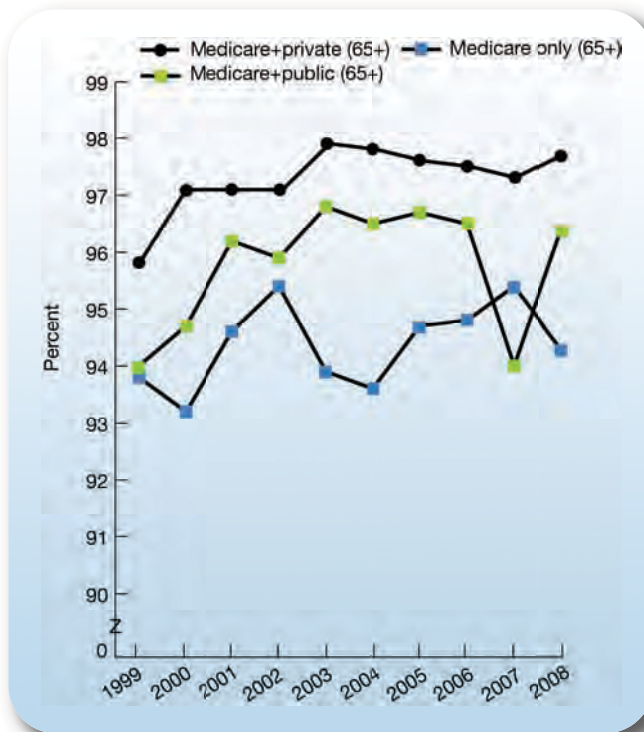
More than 40 million Americans do not have a specific source of ongoing care.<sup>12</sup> The term “specific source of ongoing care” accounts for patients who may have more than one source of care, such as women of childbearing age and older people, who tend to have more than one doctor.

**Figure 9.6. People with a specific source of ongoing care, by age and insurance, 1999-2008**





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

**Denominator:** Civilian noninstitutionalized population.

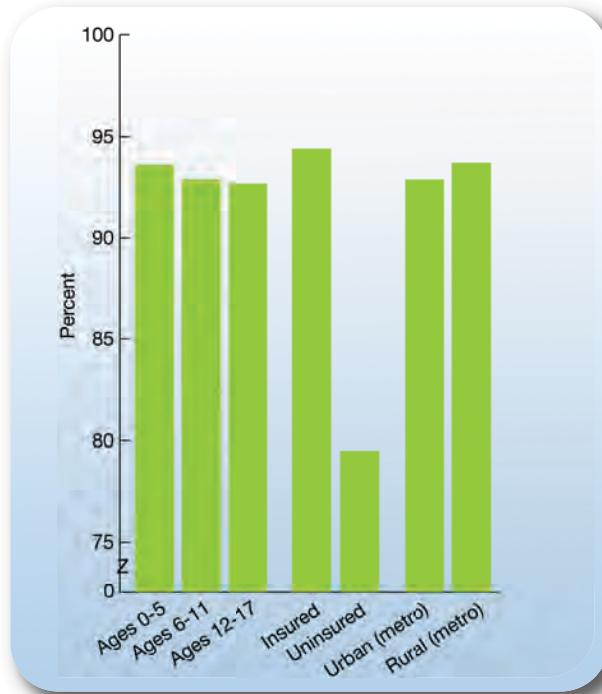
- Overall, 86.1% of people had a specific source of ongoing care in 2008 (data not shown).
- In 2008, the percentage of people with a specific source of ongoing care was much lower for uninsured people than for people with private insurance (Figure 9.6).
- In 2008, for people age 65 and over, the percentage of people with a specific source of ongoing care was lower for people with Medicare only than for people with Medicare and private insurance (94.3% compared with 97.7%).

Also, in the NHDR:

- In 2008, the percentage of people with a specific source of ongoing care was lower for Blacks than for Whites and significantly lower for Hispanics than for non-Hispanic Whites.
- In 2008, the percentage of people with a specific source of ongoing care was significantly lower for poor people than for high-income people. The percentage was also lower for people with less than a high school education and people with a high school education than for people with at least some college education.

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**Figure 9.7. Children who have a usual source of care, 2007, by age, insurance, and residence location**



**Source:** Health Resources and Services Administration, Maternal and Child Health Bureau; Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health, 2007.

**Denominator:** Children under age 18.

**Note:** Analyses performed by the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health (<http://childhealthdata.org>).

- In 2007, about 93.1% of children had a usual source of care (data not shown).
- Uninsured children were less likely than children with health insurance to have a usual source of care (79.5% compared with 94.4%; Figure 9.7).

Also, in the NHDR:

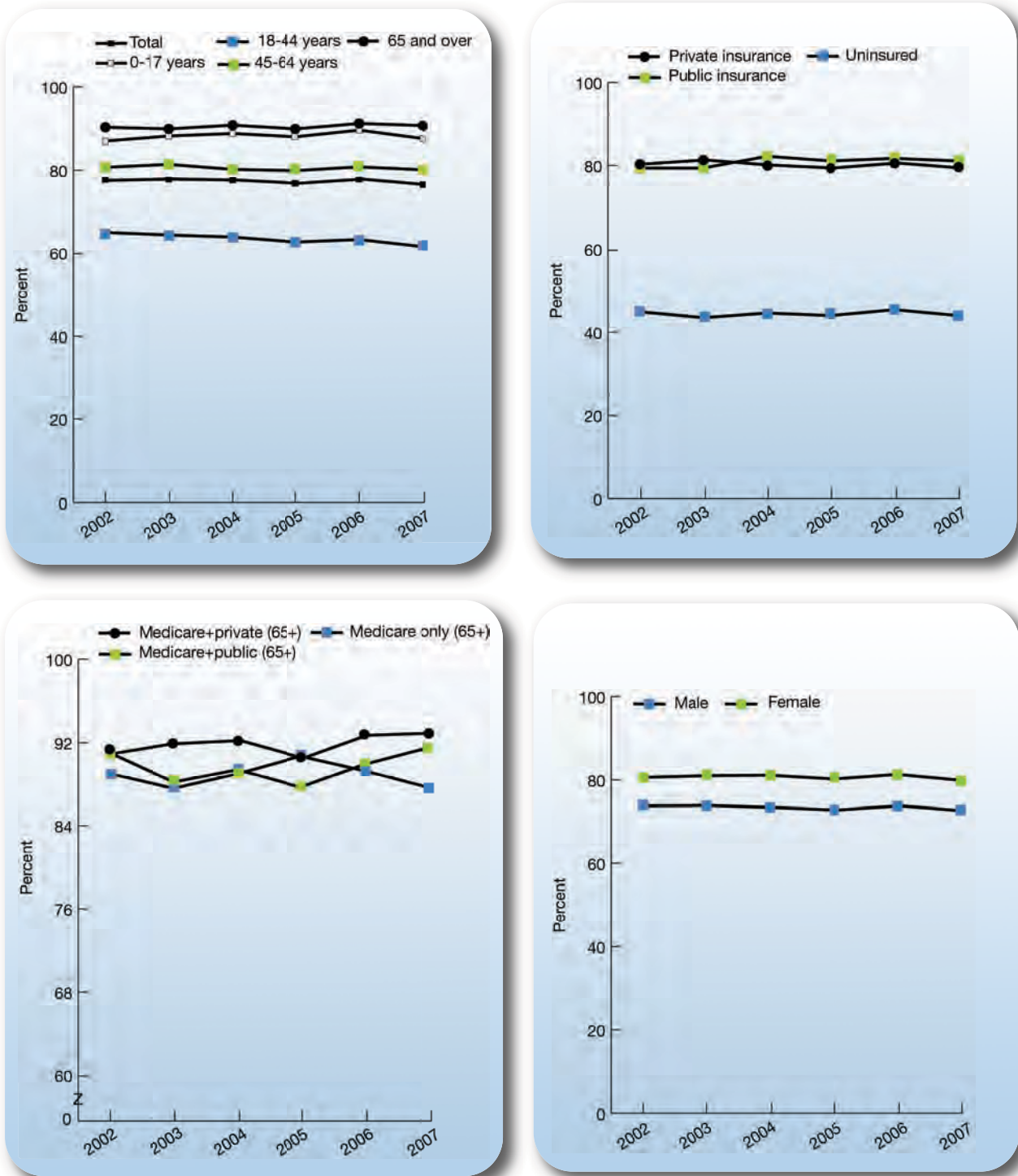
- Black and Asian children and children of more than one race were less likely than White children to have a usual source of care (89.4%, 92.1%, and 91.4%, respectively, compared with 96.8%).

## Usual Primary Care Provider

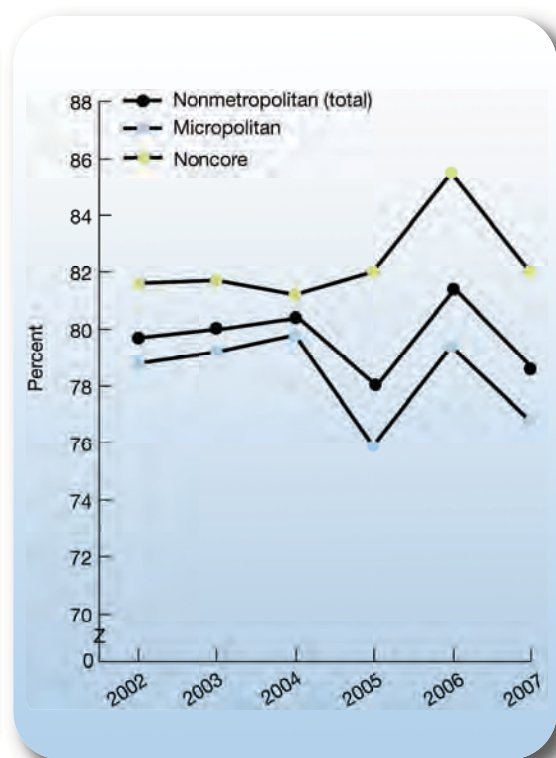
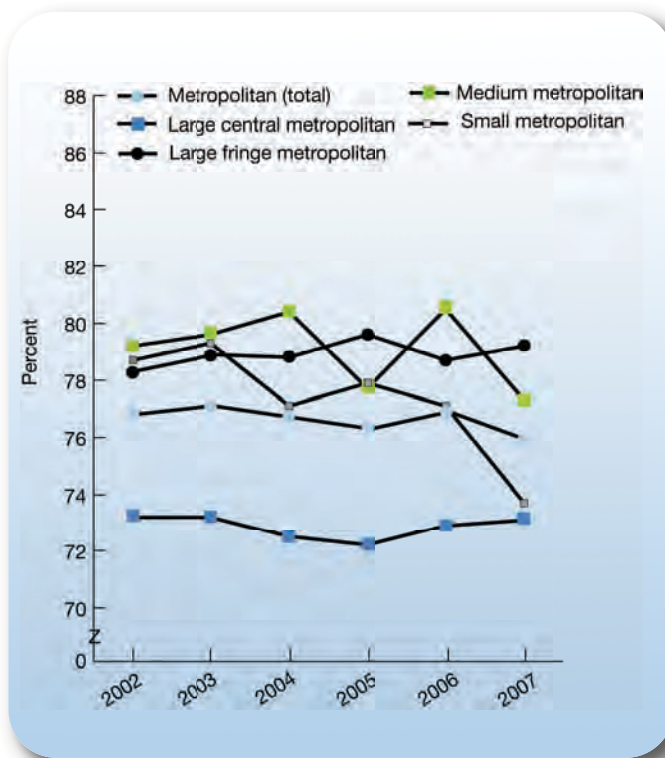
Having a usual primary care provider (a doctor or nurse from whom one regularly receives care) is associated with patients' greater trust in their provider<sup>14</sup> and with good provider-patient communication. These factors increase the likelihood that patients will receive appropriate care.<sup>15</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>16</sup> Having a usual primary care provider correlates with receipt of higher quality care.<sup>17, 18</sup>

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Figure 9.8. People with a usual primary care provider, by age, insurance, gender, and residence location, 2002-2007



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

**Denominator:** Civilian noninstitutionalized population.

**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.

- Overall, in 2007, about 76.3% of people had a usual primary care provider (data not shown).
- 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 (61.5% and 90.6%, respectively; Figure 9.8).
- In 2007, uninsured people were almost half as likely as people with private insurance to have a usual primary care provider (44.0% compared with 79.4%).
- In 2007, 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 (87.7% compared with 92.9%).
- In 2007, females were more likely to have a usual primary care provider than males (79.9% compared with 72.6%).
- In 2007, residents of nonmetropolitan areas were more likely to have a usual primary care provider than residents of metropolitan areas overall (78.6% compared with 75.9%).
- In 2007, residents of large central metropolitan areas and residents of small metropolitan areas were less likely than residents of large fringe metropolitan areas to have a primary care provider (73.1% and 73.7%, respectively, compared with 79.2%).
- In 2007, among nonmetropolitan areas, residents of noncore areas were more likely to have a usual primary care provider than residents of micropolitan areas (82.0% compared with 76.8%).

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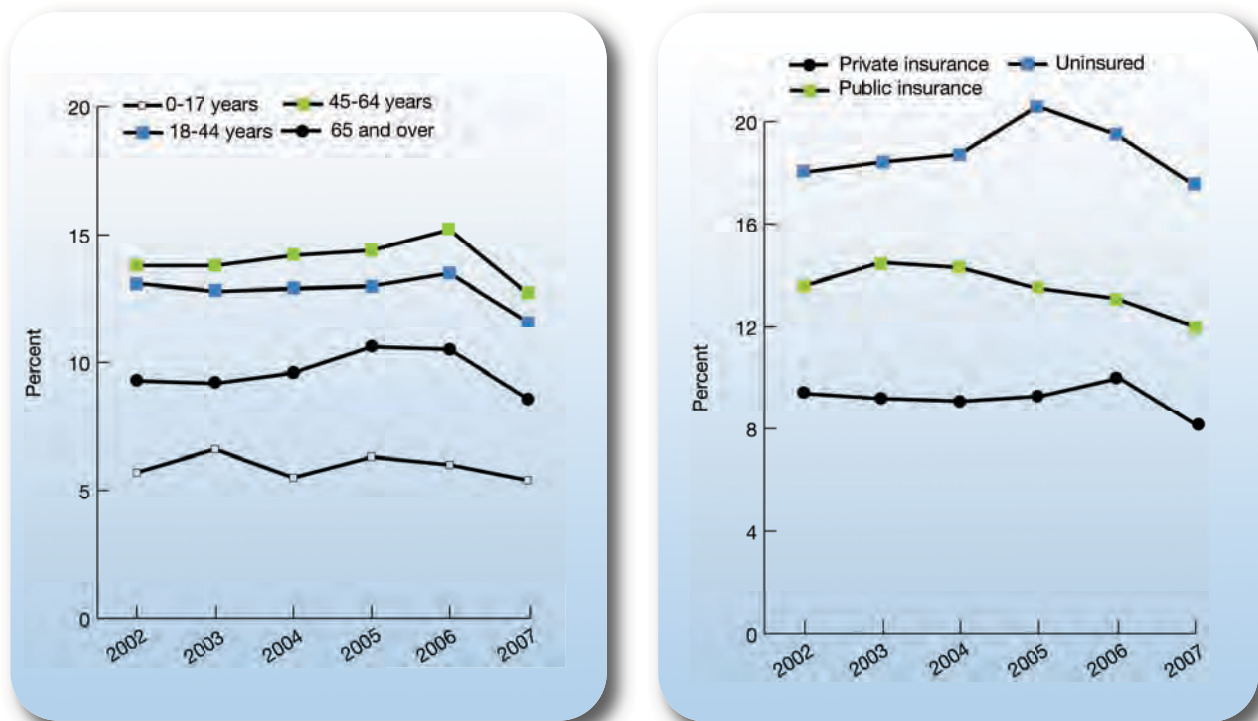
Also, in the NHDR:

- Blacks, Asians, and Hispanics were less likely than Whites and non-Hispanic Whites to have a usual primary care provider.
- Poor, near-poor, and middle-income people were less likely to have a usual primary care provider than people with high income. People with less than a high school education and people with a high school education were less likely than people with at least some college education to have a usual primary care provider.
- The percentage of people who had a primary care provider was lower for people who spoke a language other than English at home than the proportion for people who spoke English at home.

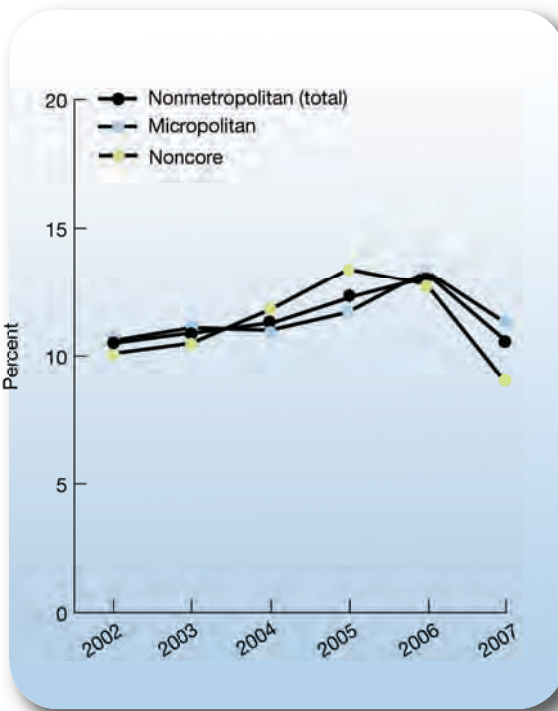
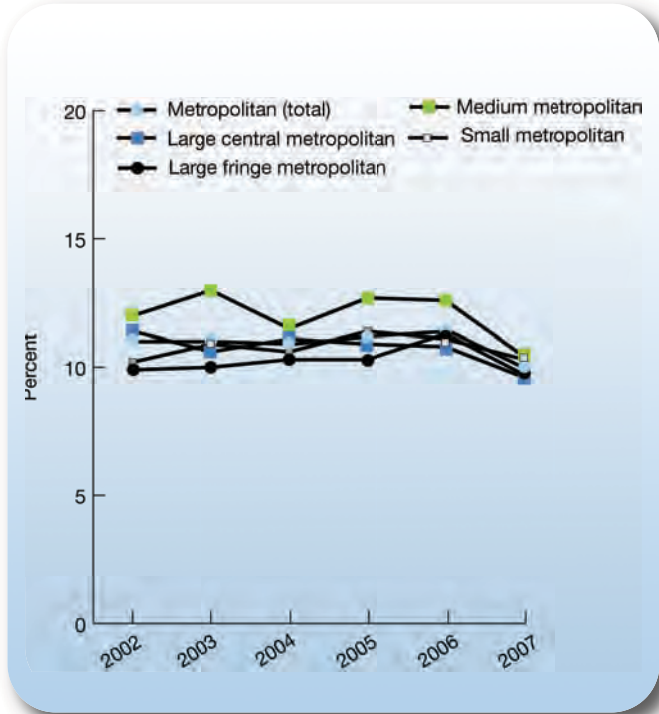
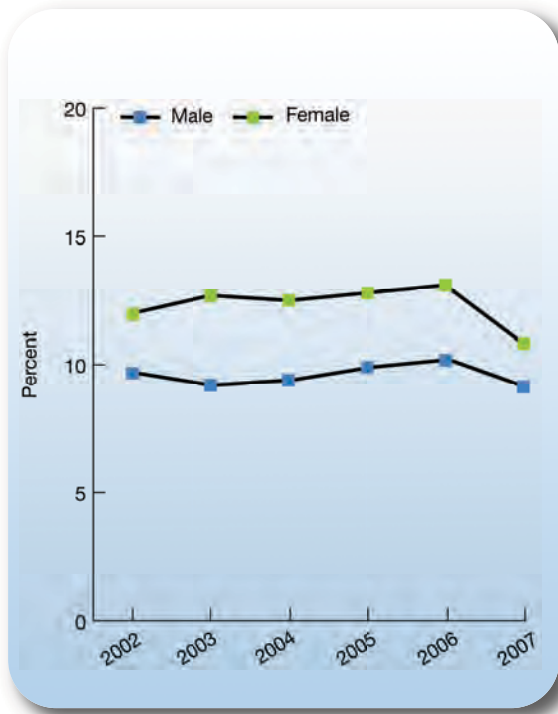
## Patient Perceptions of Need

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.

**Figure 9.9. People who were unable to get or delayed in getting needed medical care, dental care, or prescription medicines in the last 12 months, by age, insurance, gender, and residence location, 2002-2007**



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

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- Overall, in 2007, 10% of people were unable to receive or delayed in receiving needed medical care, dental care, or prescription medicines. This percentage did not change significantly from 2002 (data not shown).
- In 2007, people ages 18-44, 45-64, and 65 and over were more likely to be unable to get or delayed in getting needed medical care, dental care, or prescription medicines than people ages 0-17 (11.6%, 12.7%, and 8.6%, respectively, compared with 5.4%; Figure 9.9).
- In 2007, 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 (17.5% compared with 8.1%). The percentage was also worse for people with public insurance than for people with private insurance (12.0% compared with 8.1%).
- In all years, females were more likely than males to be unable to get or delayed in getting needed medical care, dental care, or prescription medicines.
- There were no statistically significant differences between residents living in metropolitan and nonmetropolitan areas or within those areas.

Also, in the NHDR:

- 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 and lower for Hispanics than for non-Hispanic Whites.
- 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.



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