

Health Care Coverage Analyses of the 2006 National Healthcare Quality and Disparities Reports

U.S. Department of Health and Human Services

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Highlights

This section offers a concise overview of findings from the *Health Care Coverage Analyses of the 2006 National Healthcare Quality and Disparities Reports (Coverage Analyses)*. For this report, the Medicaid and SCHIP populations were approximated by examining data on individuals under age 65 with public insurance. While there is substantial room for improvement for all measures for all insurance types and for all races and ethnicities, there are some notable variations by insurance and race/ethnicity.

Insurance Highlights

- Individuals without insurance fared worse than either privately or publicly insured individuals on virtually every measure.
- Privately insured adults were more likely to have cancer screenings than publicly insured adults.
- Publicly insured diabetics were less likely to have their hemoglobin A1c tested and to have received all three recommended diabetes services, but otherwise received similar care as privately insured diabetics.
- Preventive care for heart disease was similar among privately and publicly insured adults.
- Child health care was similar among privately and publicly insured children, with the exceptions that privately insured children were more likely to have a vision check and more likely to be advised about using safety helmets.
- There were few differences between privately and publicly insured adults in the timeliness or patient-centeredness of the care they received. The one exception was that publicly insured adults were less likely than privately insured adults, but more likely than uninsured adults, to report always getting care for illness or injury as soon as wanted.
- Similar proportions of privately and publicly insured adults reported having a specific source of ongoing care and usual primary care provider, but publicly insured adults were more than 2½ times as likely to report their ongoing source of care being a hospital, emergency room, or clinic.
- Publicly insured individuals experienced more difficulties accessing care than privately insured adults. They were less likely to have providers who were open at night or on weekends, more likely to have been unable to get or delayed getting needed care, and more likely to have problems getting a referral to a specialist.
- Publicly insured children were less likely than privately insured children to have had a dental visit in the past year.
- Privately insured and uninsured individuals were equally likely to have visited an emergency room in the past year. Publicly insured individuals were much more likely to have had an emergency room visit.

Disparities Highlights

- There were racial or ethnic disparities for 26 of the 33 measures in this report.
- Many racial and ethnic disparities were present among individuals with the same type of insurance as well as among the uninsured. In all but a handful of measures, these disparities favored White individuals.
- Overall, Hispanic individuals fared worse than White individuals on more than two-thirds of the measures, while Black individuals fared worse than White individuals on more than one-third of the measures.
- Privately insured Black adults fared better than White adults on most cancer and heart disease screenings.
- Almost half of the instances of disparities among the uninsured favored minority group members.
- Disparities in child dental visits were extremely large.

Chapter 1: Introduction and Methods

In 1999, Congress directed the Agency for Healthcare Research and Quality (AHRQ) to produce two annual reports on health care quality and disparities in health care delivery. The *National Healthcare Quality Report* (NHQR) and the *National Healthcare Disparities Report* (NHDR) were designed and produced by AHRQ starting in 2003, with support from the Department of Health and Human Services (HHS) and private-sector partners.

Health Care Coverage Analyses of the 2006 National Healthcare Quality and Disparities Reports (Coverage Analyses) reports for the first time on quality and racial and ethnic disparity measures by payer. Using data submitted for the 2006 NHQR and NHDR, *Coverage Analyses* examines how the health care experiences of individuals with public insurance—primarily Medicaid—compare with individuals with private insurance and individuals with no insurance, and examines racial and ethnic disparities among and within payers.

Coverage Analyses supports HHS Secretary Mike Leavitt’s 500-Day Plan to fulfill the President’s vision of a healthier America, specifically in the areas of better transparency of health care quality information and eliminating inequalities in health care. It also supports the Centers for Medicare & Medicaid Services’ Center for Medicaid and State Operations’ quality improvement goals. *Coverage Analyses* was planned and written by AHRQ staff in consultation with the Center for Medicaid and State Operations. State Medicaid agencies make their own decisions regarding which measures to collect and, within broad Federal guidelines, which services to cover.

How This Report Is Organized

Coverage Analyses follows the structure of the NHDR, which is rooted in the Institute of Medicine’s framework for quality articulated in its 2001 report *Crossing the Quality Chasm*.

- **Highlights** summarizes key themes in payer and racial and ethnic disparities across the measures.
- **Chapter 1: Introduction and Methods** documents the organization of and methods used in this report.
- **Chapter 2: Quality of Ambulatory Health Care** examines payer and racial and ethnic disparities in quality of health care. Sections cover three components of health care quality: effectiveness, timeliness, and patient-centeredness.
- **Chapter 3: Access to Health Care** covers two components of health care access: barriers and facilitators to health care and health care utilization.

Population Analyzed

The goal of *Coverage Analyses* was to compare the health care performance of the Medicaid program with the performance of private insurers and the safety net for the uninsured. Because some sources of data submit payer data for the NHQR and the NHDR that do not distinguish between types of public insurance (i.e., Medicaid and Medicare are combined), *Coverage Analyses* is unable to report on quality and disparities measures solely for the Medicaid program.

To most closely approximate the Medicaid population, *Coverage Analyses* includes data on individuals under the age of 65 only. This excludes most of the individuals in the public insurance category who only have Medicare coverage. *Coverage Analyses*' public insurance data do contain some individuals under age 65 who have only Medicare coverage, but sensitivity analyses revealed that inclusion of these individuals does not significantly bias ambulatory measures.

In addition to Medicaid and Medicare beneficiaries, the *Coverage Analyses*' public insurance data contain children enrolled in the State Children's Health Insurance Program, but not recipients of other forms of government health subsidies (e.g., Title V funding for children with special health care needs, federally qualified community health centers, State-funded premium subsidy programs). Data on the uninsured were not available for all measures.

Selection of Measures

Measures for *Coverage Analyses* were selected from the NHQR and NHDR measures that were available by payer. Core measures were used when data were available, but many core outcome measures were not available by payer. Core measures were supplemented by other measures with special relevance to the Medicaid population. For example, because a large proportion of Medicaid beneficiaries are children, some pediatric measures are included in *Coverage Analyses* that appeared only in the data tables of the NHQR and NHDR.

Unlike the NHQR and NHDR, *Coverage Analyses* reports solely on ambulatory care measures. The decision to omit inpatient measures reflects both the greater use of ambulatory care visits among nonelderly Medicaid beneficiaries and the greatest opportunities for Medicaid-driven quality improvement.

Categorization

Coverage Analyses uses the same conventions as the NHQR and NHDR to categorize individuals by insurance and by race/ethnicity.

- Data on individuals who had private coverage part of the year, and had public coverage or were uninsured the remainder of the year, are reported as privately insured. The public insurance category includes only individuals who had public coverage exclusively.
- All Hispanic individuals are included in the Hispanic category. The White and Black categories include only non-Hispanic individuals.

Measuring Disparities

Coverage Analyses contains only bivariate analyses; that is, it does not control for other possible determinants of health care disparities, such as education, income, age, illness severity, or patient preference. We therefore cannot conclude that observed disparities are *caused* by insurance or racial/ethnic differences. Nevertheless, the measures do reflect the experiences of the population, regardless of the cause.

Coverage Analyses examines disparities of only one of the priority populations covered in the NHDR: racial and ethnic minorities. The rationale for examining racial and ethnic disparities stems from the prevalence of minority Americans among Medicaid beneficiaries. Because

Medicaid serves a disproportionate number of minority Americans, it is critical that Medicaid provide them with high-quality care in order to make progress in reducing disparities nationally. Racial and ethnic comparisons are not made for all measures. Racial and ethnic data by insurance were not available for all measures. Racial and ethnic data were not reported when there was no significant variation among or within payers.

Statistical tests were performed on insurance and racial/ethnic differences to determine the likelihood that observed differences could be due to chance rather than reflecting real disparities. All disparities—payer as well as racial and ethnic—noted in the narrative of this report met the standard test of statistical significance; there is no more than a 1 in 20 chance that any of the reported disparities are due to chance.

Chapter 2: Quality of Ambulatory Health Care

Effectiveness

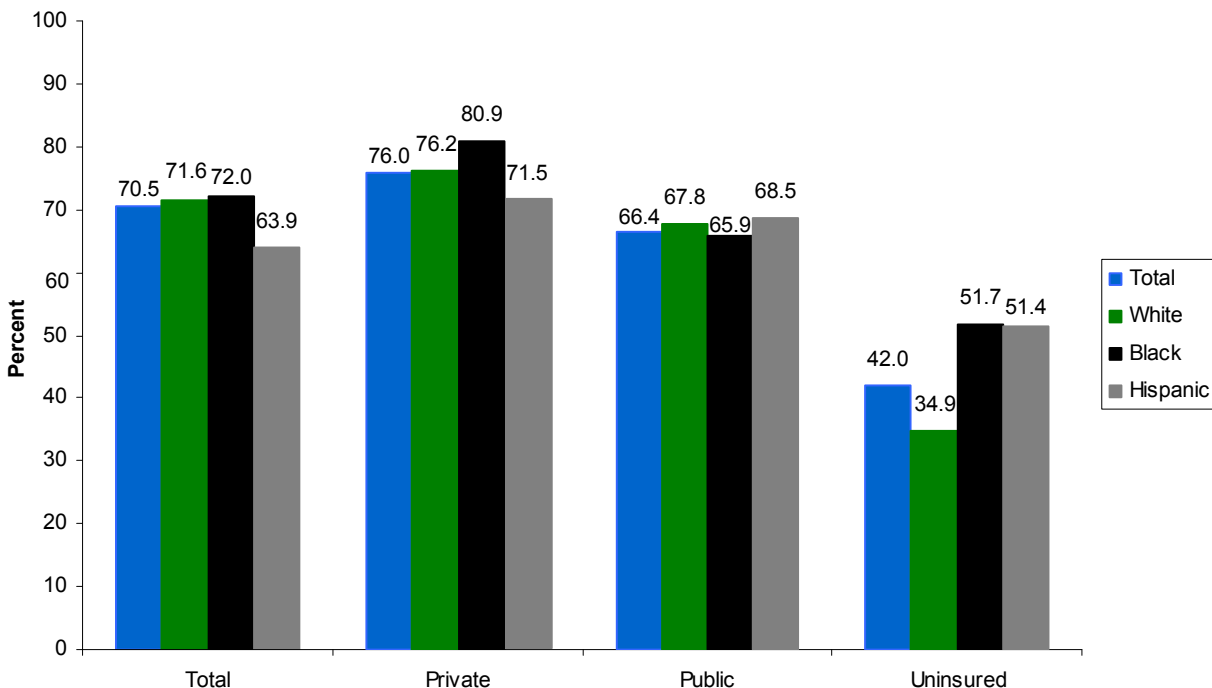
Cancer

Ensuring that all populations have access to appropriate cancer screening services is a core element of reducing cancer morbidity, mortality, and disparities. Evidence-based consensus defining good quality care and how to measure it currently exists for only a few cancers and aspects of care.

Prevention: Mammograms

Screening mammography is an effective way to discover breast cancer before a patient has symptoms and to reduce new cases of late-stage disease and mortality caused by this cancer.

Figure 2.1. Women ages 40 to 64 who report they had a mammogram within the past 2 years, by race/ethnicity, stratified by insurance, 2003



Note: White and Black are non-Hispanic.

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

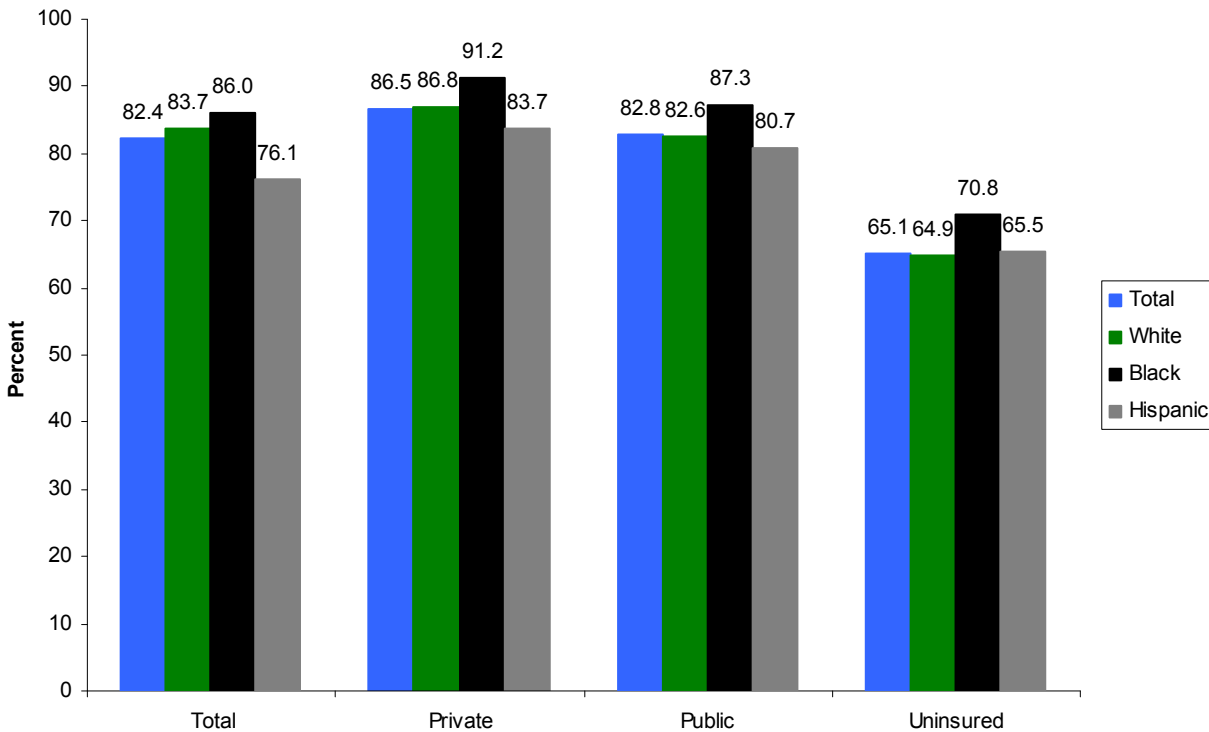
- Over two-thirds of women ages 40 to 64 had a mammogram within the past 2 years.
- Three-quarters of privately insured women reported having had a mammogram within the past 2 years, compared with two-thirds of publicly insured women and 42 percent of uninsured women.

- Overall, White women were more likely than Hispanic women to report having had a mammogram. There were no racial and ethnic disparities in mammogram rates among publicly insured women. In contrast, privately insured White women were less likely to have had a mammogram than privately insured Black women, but more likely than privately insured Hispanic women. White uninsured women were less likely to have had a mammogram than either Black or Hispanic uninsured women.

Prevention: Pap Smears

The U.S. Preventive Services Task Force has found that cervical cancer screening with Pap smears reduces incidence of and mortality from cervical cancer. The U.S. Preventive Services Task Force recommends that women under age 65 have Pap smears at least every 3 years.

Figure 2.2. Women ages 18 to 64 who report they had a Pap smear within the past 3 years, by race/ethnicity, stratified by insurance, 2003



Note: White and Black are non-Hispanic.

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

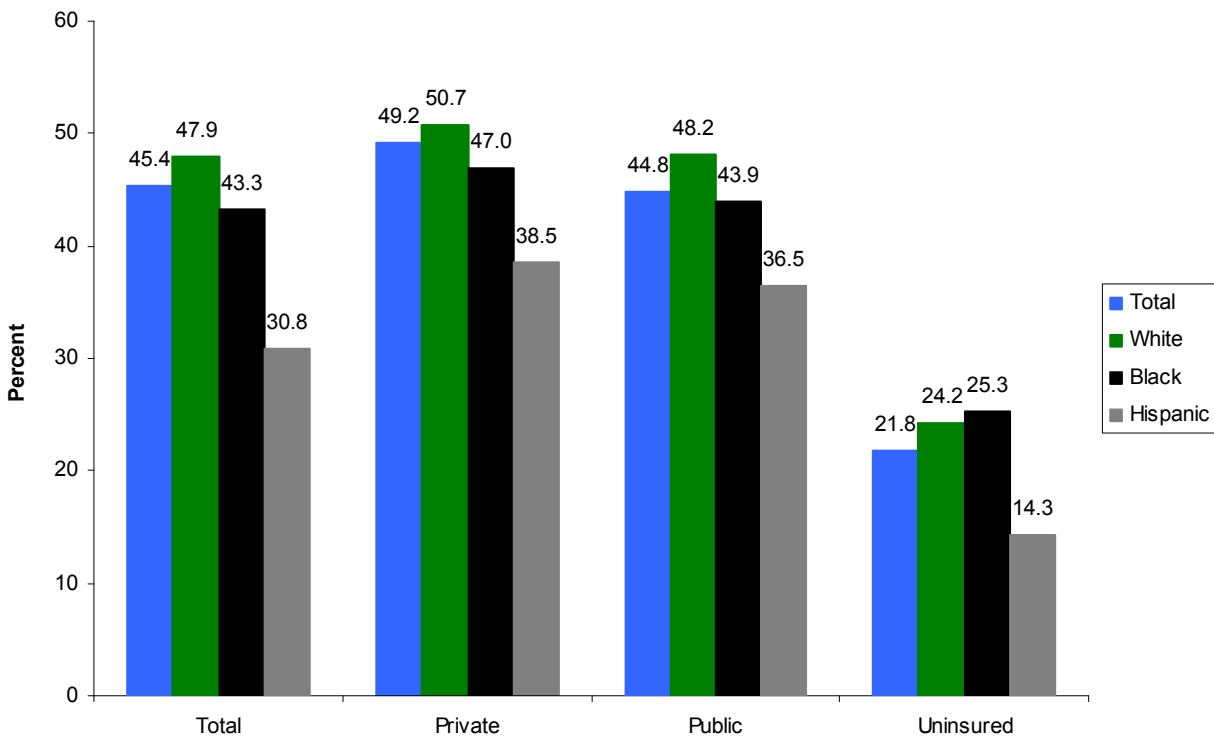
- Approximately 80 percent of women ages 18 to 64 had a Pap smear in the last 3 years.
- Women with private insurance were more likely to have had a Pap smear in the last 3 years than women with public insurance, who in turn were more likely to have had a Pap smear than uninsured women.
- There were no racial and ethnic disparities in Pap smear rates among publicly insured women. In contrast, privately insured White women were less likely to have had a Pap

smear than privately insured Black women, but more likely than privately insured Hispanic women. White uninsured women were less likely to have had a Pap smear than Black uninsured women.

Prevention: Screening for Colon Cancer

Colorectal cancers are the second leading cause of cancer mortality. Early detection of cancer increases treatment options and the chances for survival. Colorectal cancer screening is able to detect abnormal growths before they develop into cancer. The U.S. Preventive Services Task Force recommends colorectal cancer screening for men and women age 50 and older. Screening tests for colorectal cancer include fecal occult blood testing, flexible sigmoidoscopy, colonoscopy, proctoscopy, and barium enema.

Figure 2.3. Adults ages 50 to 64 who report they had a colonoscopy, sigmoidoscopy, proctoscopy, or fecal occult blood test in the last 2 years, by race/ethnicity, stratified by insurance, 2003



Note: White and Black are non-Hispanic.

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

- Less than half of men and women ages 50 to 64 reported having had a colonoscopy, sigmoidoscopy, proctoscopy, or fecal occult blood test in the past 2 years.
- Adults with private insurance were most likely to have been screened, followed by those with public insurance, trailed by the uninsured.

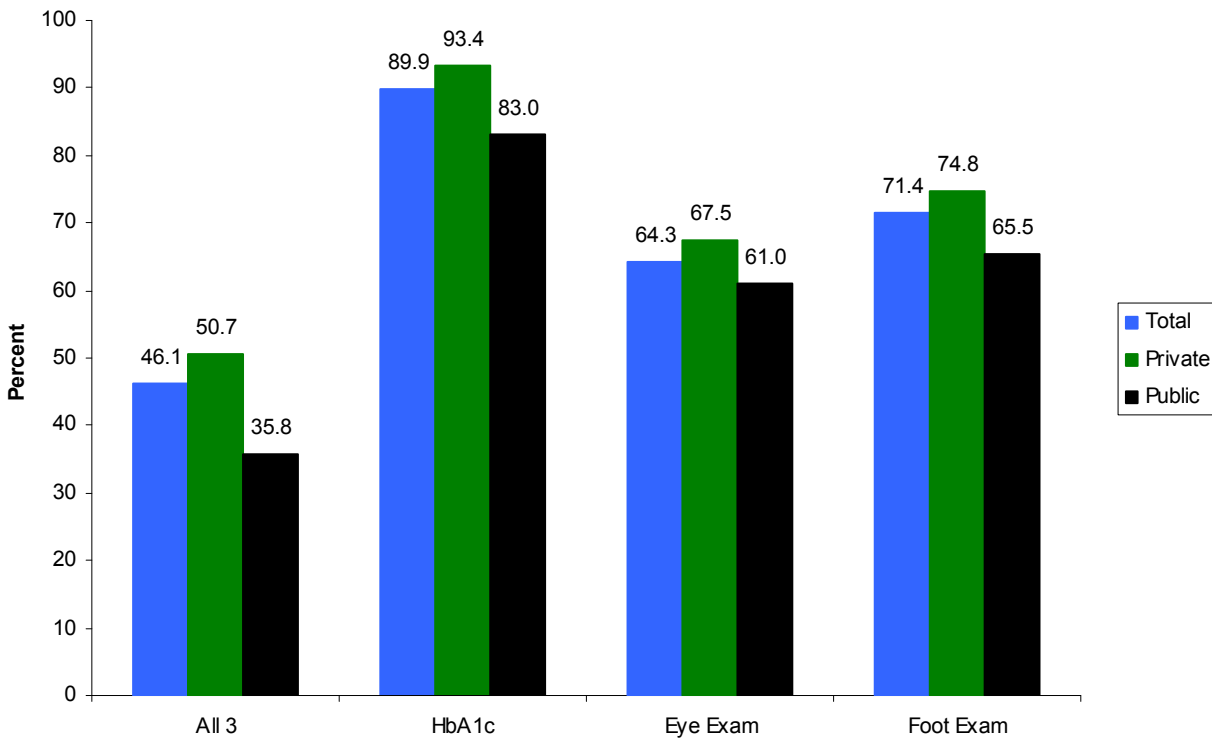
- White adults were more likely to have been screened for colon cancer than Black or Hispanic adults. Disparities between White and Hispanic adults were present within each insurance type.

Diabetes

Management: Receipt of Recommended Services for Diabetes

Effective management of diabetes includes hemoglobin A1c (HbA1c) testing, eye examination, and foot examination every year. People diagnosed with diabetes are often at higher risk for infectious diseases and cardiovascular risk factors. Therefore, in addition to controlling blood sugar levels, diabetes management often includes appropriate influenza immunization (flu shots) and lipid profiling.

Figure 2.4. Adults ages 40 to 64 with diagnosed diabetes who report having received at least one HbA1c test, retinal eye exam, and foot exam in the past 2 years, by insurance, 2003



Note: All 3 is a composite measure of receipt of all three recommended diabetes services: HbA1c test, retinal eye exam, and foot exam.

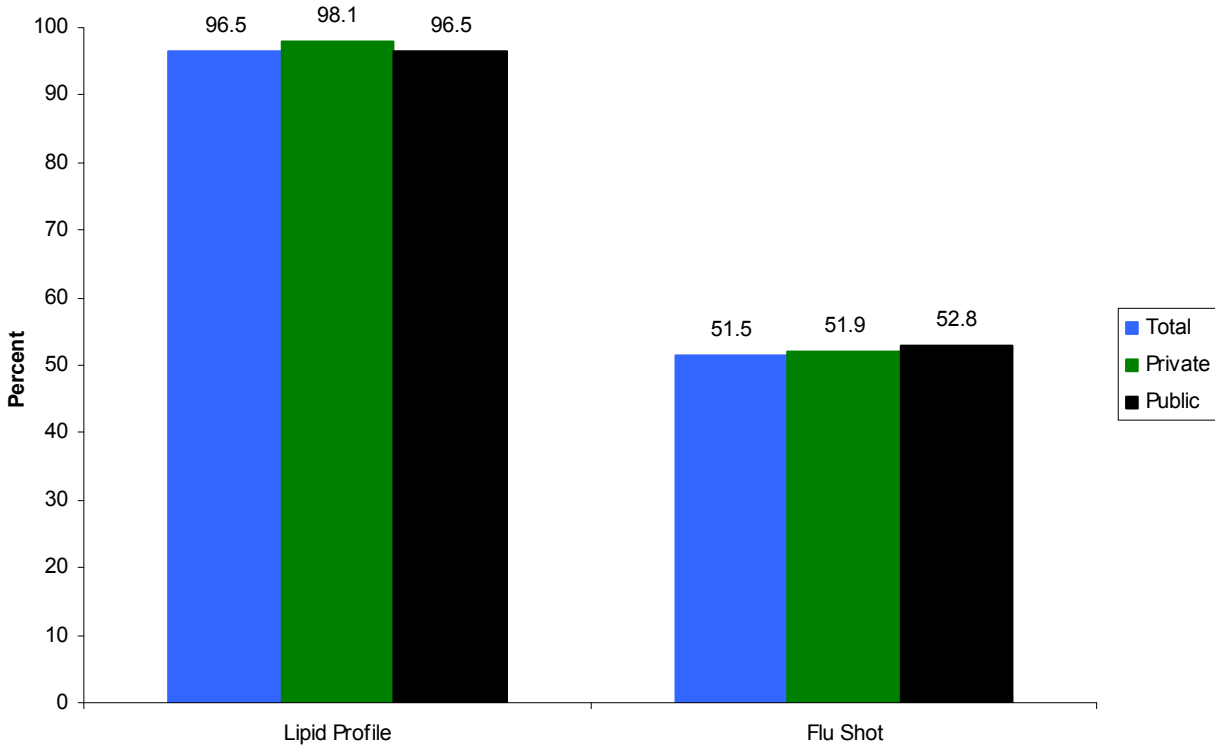
Source: Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey.

- Most diabetic adults ages 40 to 64 had their hemoglobin A1c (HbA1c) measured. Less than two-thirds received eye exams, and less than three-quarters received foot exams. Less than half of diabetics had all three exams (HbA1c, eye, and foot).
- Publicly insured diabetics were about as likely as privately insured diabetics to have received eye and foot exams. Publicly insured diabetics were less likely to have had their

HbA1c measured and were much less likely to have had all three exams (HbA1c, eye, and foot) than privately insured diabetics.

- White diabetics were more likely than Black and Hispanic diabetics to have had an HbA1c exam (92 percent compared with 85 percent).

Figure 2.5. Adults ages 40 to 64 with diagnosed diabetes who report having received a lipid profile in the past 2 years or a flu shot in the past year, by insurance, 2003



Source: Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey.

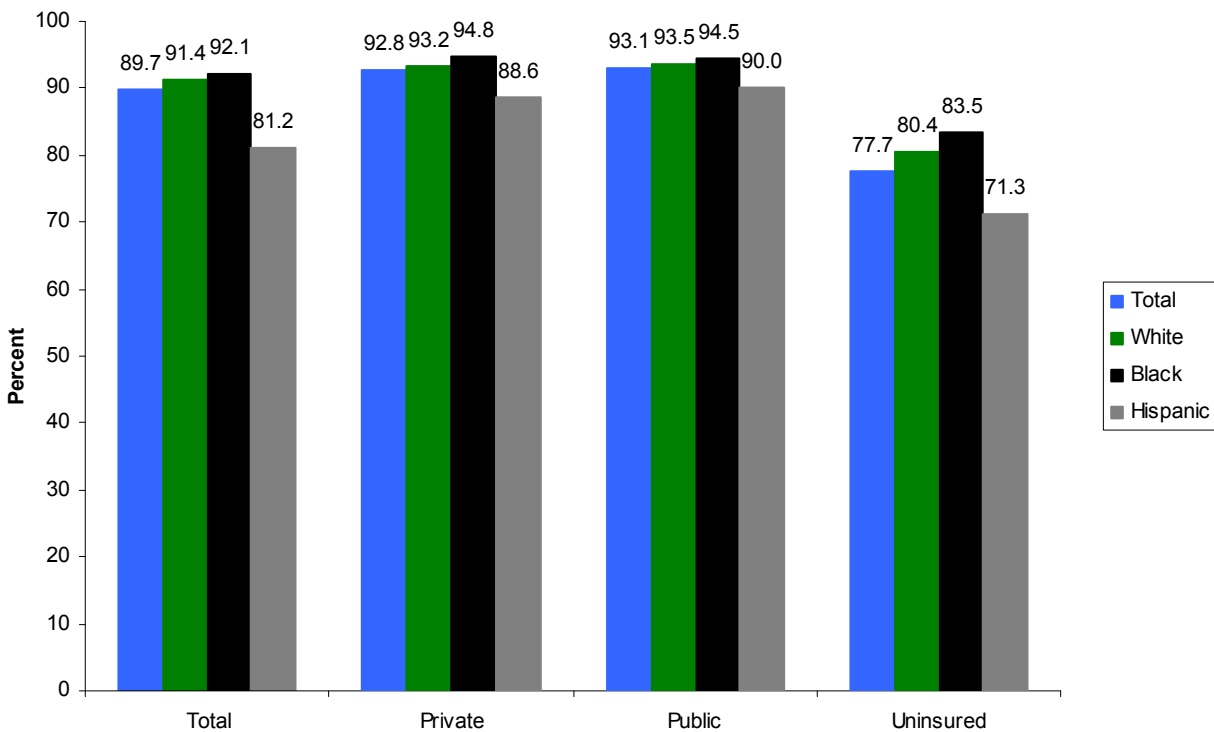
- Most diabetic adults ages 40 to 64 had received their lipid profile in the past 2 years. Approximately half of diabetics received a flu shot in the past year.
- Publicly and privately insured diabetics were equally likely to have had a lipid profile and a flu shot.
- White diabetics were more likely than Black and Hispanic diabetics to have had a flu shot and a lipid profile (92 percent versus 85 and 84 percent, respectively; data not shown). Disparities data by insurance coverage were unavailable.

Heart Disease

Prevention: Blood Pressure, Cholesterol Checks, and Advice To Quit Smoking

Awareness and control of blood pressure and cholesterol can help reduce the risk of heart attack. High cholesterol is a major risk factor for heart disease. Smoking may be the single most important modifiable risk factor for heart disease, and providers can encourage patients to quit smoking.

Figure 2.6. Adults ages 18 to 64 who report having had their blood pressure taken within the past 2 years and can state whether their blood pressure was normal or high, by race/ethnicity, stratified by insurance, 2003

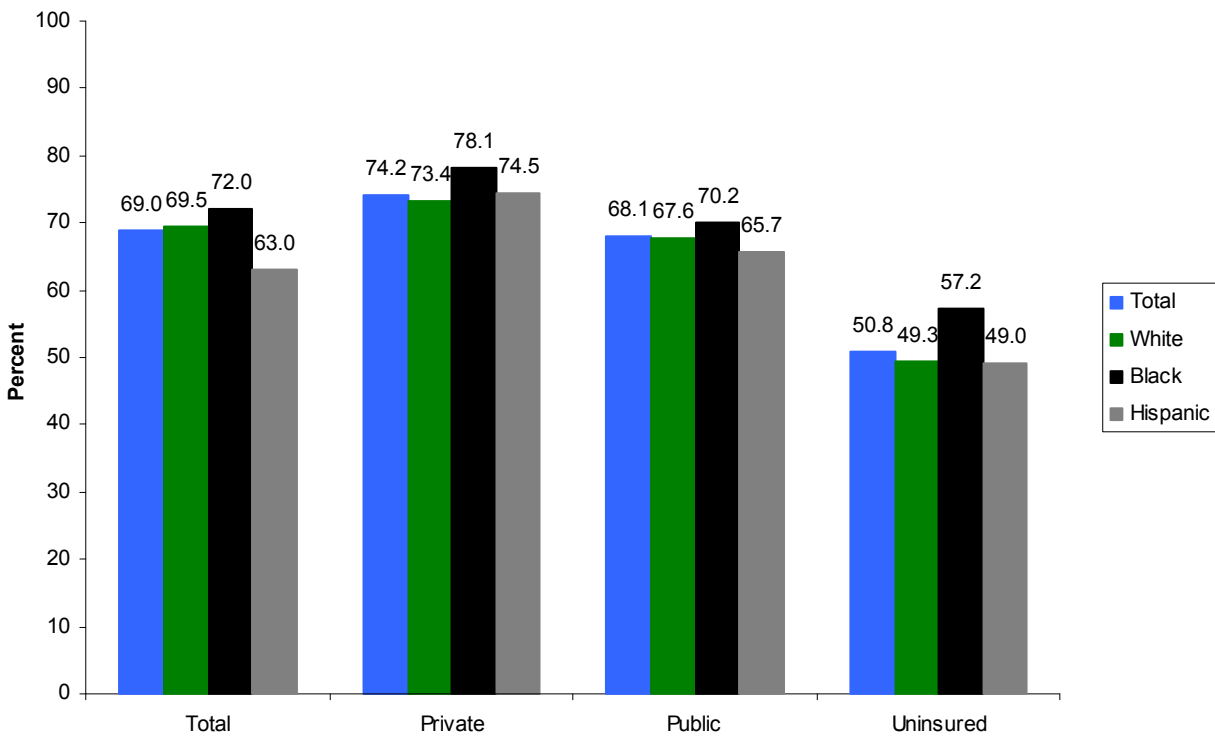


Note: White and Black are non-Hispanic.

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

- Approximately 90 percent of adults ages 18 to 64 have had their blood pressure checked in the past year and can state whether their blood pressure was normal or high.
- Overall, publicly and privately insured adults were equally likely to have had their blood pressure checked. Uninsured adults were less likely to have had their blood pressure checked than insured adults.
- White adults were more likely to have had their blood pressure checked than Hispanic adults. This was true within all insurance types. Among the privately insured, Black adults were more likely than White adults to have had their blood pressure checked.

Figure 2.7. Adults ages 18 to 64 who report having had their blood cholesterol checked within the past 5 years, by race/ethnicity, stratified by insurance, 2003

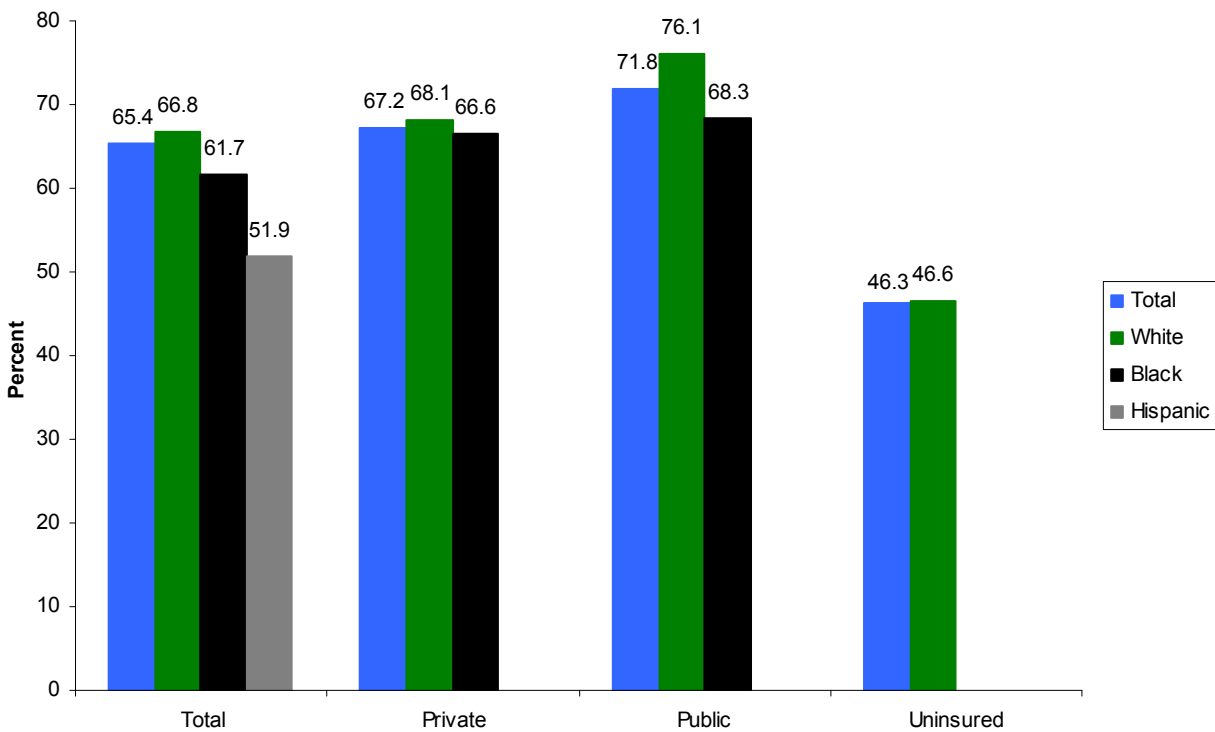


Note: White and Black are non-Hispanic.

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

- Less than three-quarters of adults ages 18 to 64 have had their cholesterol checked in the past 5 years.
- Privately insured adults were somewhat more likely than publicly insured adults to have had their cholesterol checked, who in turn were more likely to have had their cholesterol checked than uninsured adults.
- Privately insured and uninsured Black adults were more likely to have had their cholesterol checked than similarly insured White adults. There were no racial/ethnic disparities among publicly insured adults.

Figure 2.8. Smokers ages 18 to 64 who report being advised to quit smoking, by race/ethnicity, stratified by insurance, 2003



Note: White and Black are non-Hispanic. Data do not meet the criteria for statistical reliability, data quality, or confidentiality for uninsured Black adults and for Hispanic adults by insurance status.

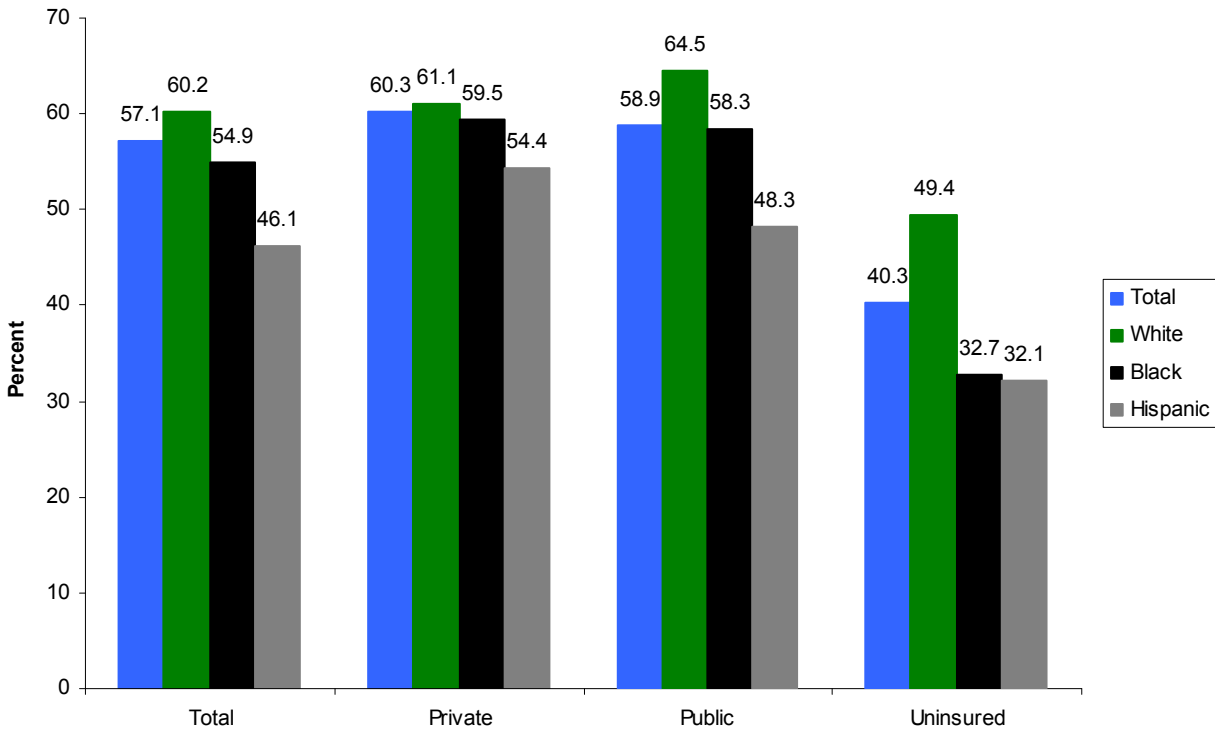
Source: Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey.

- Approximately two-thirds of smokers ages 18 to 64 were given advice to quit smoking.
- Uninsured adults were much less likely to have been advised to quit smoking than insured adults.
- Hispanic smokers were less likely than White smokers to be advised to quit smoking.

Prevention: Counseling Obese Adults About Exercise

More than 32 percent of adults age 20 and older in the United States are obese. Physician-based exercise counseling is an important component of effective weight loss interventions and has been shown to produce increased levels of physical activity among sedentary patients. Regular exercise aids in weight loss and blood pressure control efforts, reducing the risk of heart disease, stroke, diabetes, and other diseases.

Figure 2.9. Obese adults (body mass index of 30 or higher) ages 18 to 64 who were given advice to exercise, by race/ethnicity, stratified by insurance, 2003



Note: White and Black are non-Hispanic.

Source: Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey.

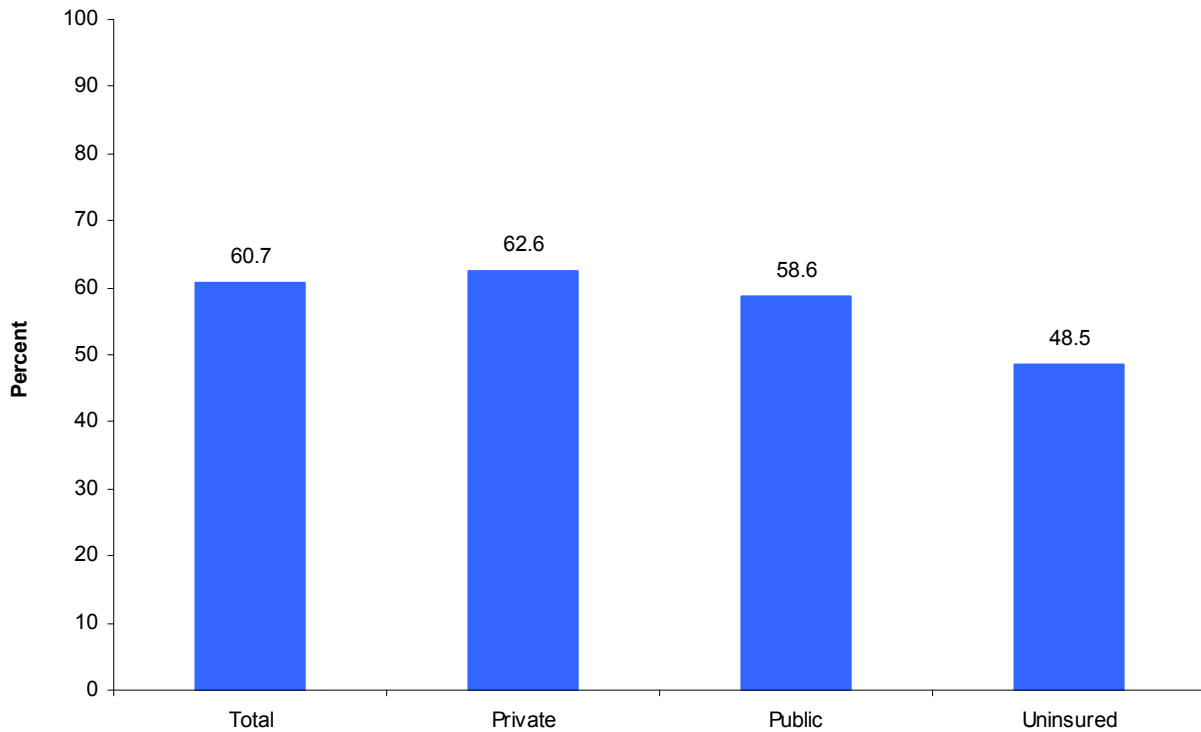
- Almost 60 percent of obese adults ages 18 to 64 were advised to exercise.
- Privately insured and publicly insured obese adults were equally likely to be advised to exercise. Uninsured obese adults were far less likely to be given advice to exercise.
- Hispanic obese adults were less likely than White obese adults to be given advice to exercise; these disparities existed within each insurance type. Black obese adults were less likely to be given advice to exercise than White obese adults if they were publicly insured or uninsured.

Child Health

Prevention: Vision Care

Vision checks for young children can help to detect eye problems early and improve the chances that corrective treatments will be prescribed.

Figure 2.10. Children ages 3 to 6 with a vision check, by insurance, 2003



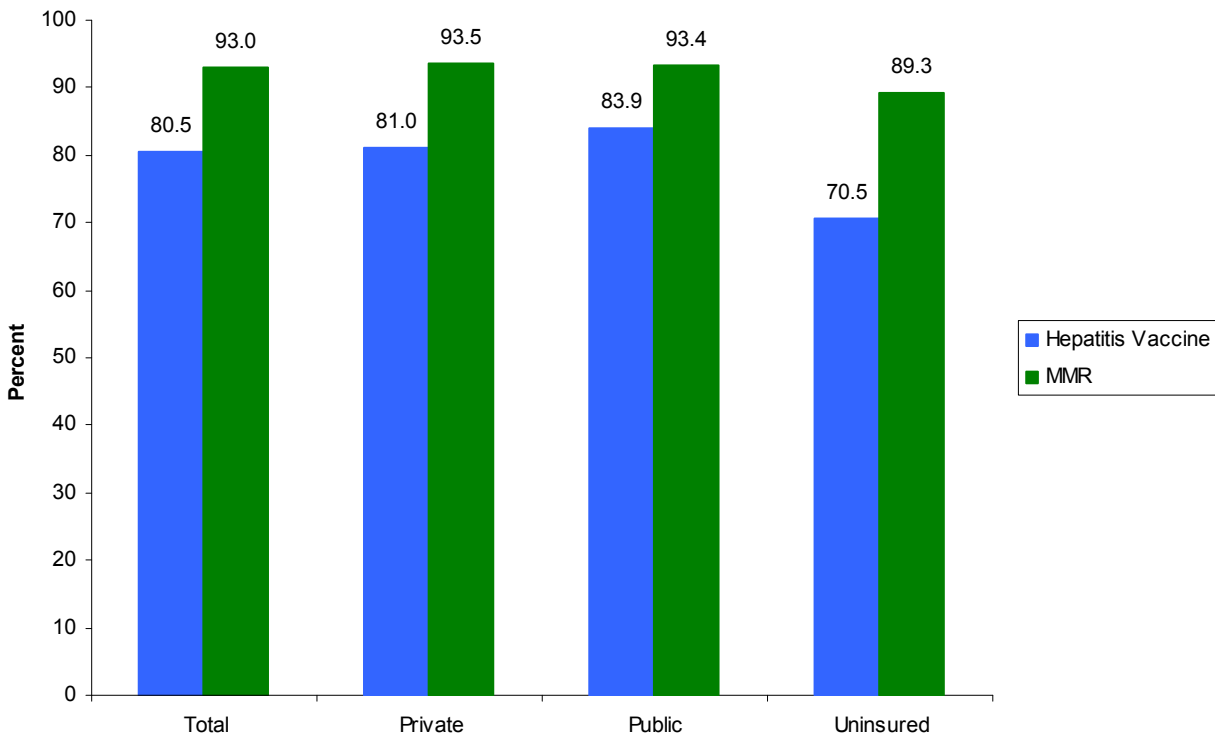
Source: Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey.

- About 60 percent of children ages 3 to 6 had a vision check.
- Children ages 3 to 6 with private insurance were more likely to have a vision check than uninsured children.

Prevention: Adolescent Vaccinations

Immunizations are important for reducing mortality and morbidity. They protect recipients, as well as others in the community who cannot be vaccinated, from illness and disability. Although early childhood vaccination rates have increased, adolescents are not always up to date on recommended vaccinations.

Figure 2.11. Adolescents ages 13 to 15 who received 3 or more doses of hepatitis and 2 or more doses of measles-mumps-rubella (MMR) vaccine, by insurance, 2003



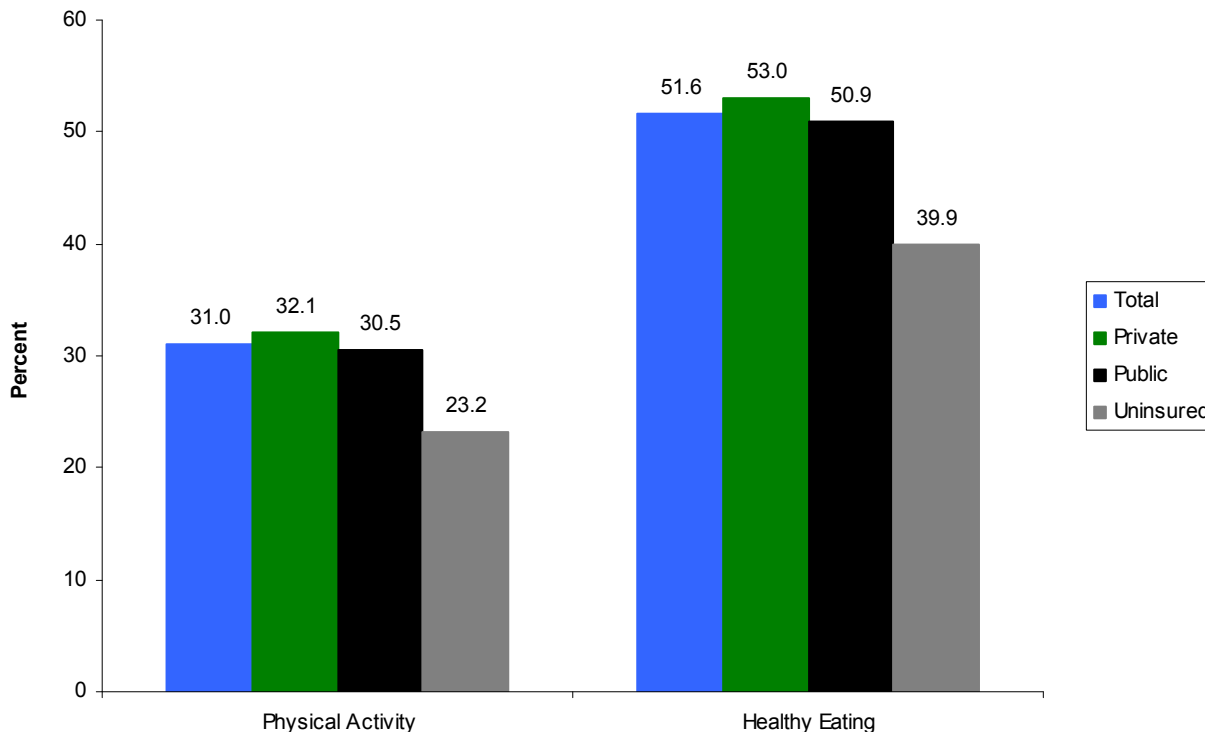
Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

- Adolescents ages 13 to 15 were more likely to be appropriately vaccinated for MMR than for hepatitis B.
- Adolescents covered by public and private insurance were equally likely, and were more likely than uninsured adolescents, to be appropriately vaccinated for hepatitis B.

Prevention: Advice on Eating Healthily and Physical Activity

Childhood represents a unique period when healthy lifelong habits of diet and exercise can be formed, and physicians play an important role in encouraging these good behaviors in children. Overweight and obesity during childhood often persist into adulthood, with consequences that are numerous and costly. Unfortunately, the prevalence of overweight and obesity among children has risen dramatically in recent decades. The American Academy of Pediatrics recommends that pediatricians discuss and promote healthy diets and physical activity.

Figure 2.12. Children ages 2 to 17 whose parents or guardians report advice from a doctor or other health provider about physical activity and healthy eating, by insurance, 2003



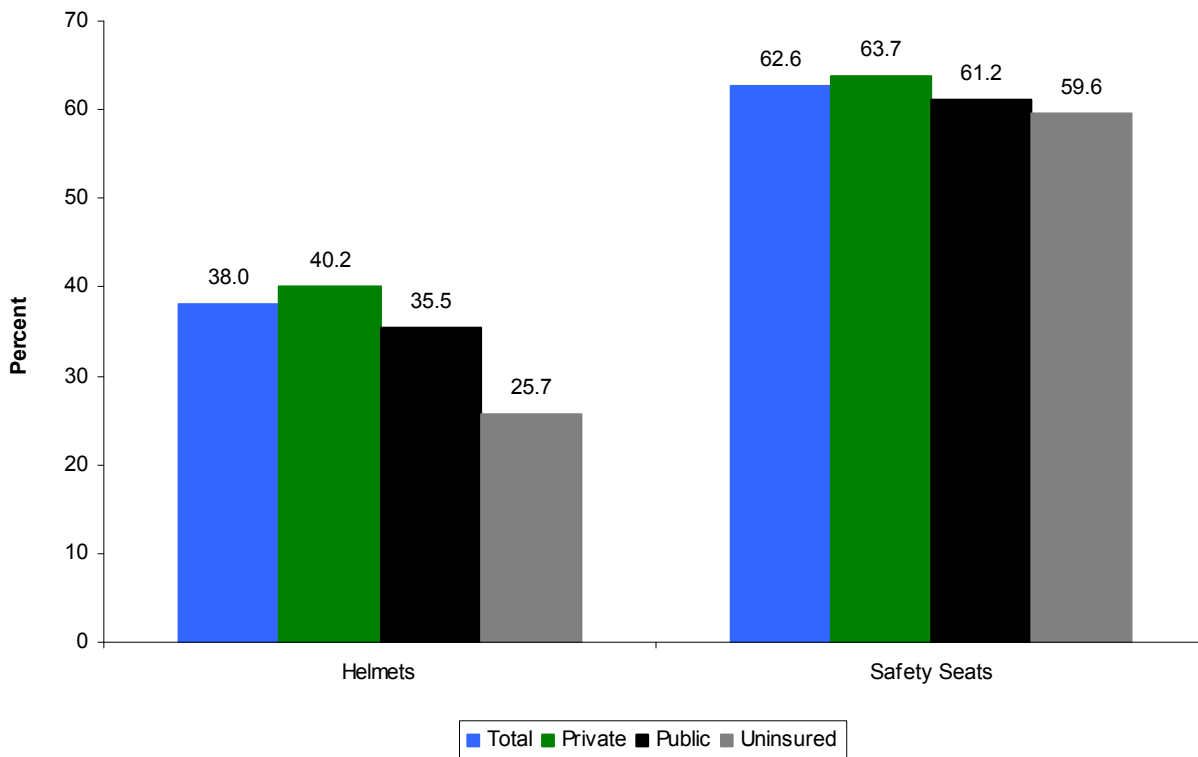
Source: Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey.

- Less than one-third of parents or guardians of children ages 2 to 17 reported advice from a health provider about physical activity. Approximately one-half reported advice about healthy eating.
- Parents or guardians of privately and publicly insured children were equally likely to receive advice about physical activity and healthy eating, and more likely than uninsured children.
- There were no racial or ethnic disparities in reports of advice about physical activity or healthy eating (data not shown).

Prevention: Advice on Vehicle Safety

Unintentional injury is the leading cause of death of children. Wearing a helmet reduces the risk of head injury by 63 percent and of loss of consciousness by 86 percent. The American Academy of Pediatrics recommends pediatricians and other child health care providers advise children to wear a bicycle helmet when they begin riding tricycles or other wheeled vehicles or toys and the use of child safety seats in cars.

Figure 2.13. Children ages 2 to 17 whose parents or guardians report advice about using helmets and children 0-40 pounds with advice about using child car safety seat, by insurance, 2003



Source: Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey.

- Almost 40 percent of parents or guardians of children ages 2 to 17 reported advice from a health provider about using helmets. In contrast, more than 60 percent of parents or guardians of children weighing 40 or fewer pounds reported advice from a health provider about using child car safety seats.
- Parents or guardians of privately insured children were more likely than publicly insured children to report advice about using helmets. Parents or guardians of uninsured children were less likely than insured children to report advice about using helmets.
- There were no disparities by insurance status for advice about using child car safety seats.

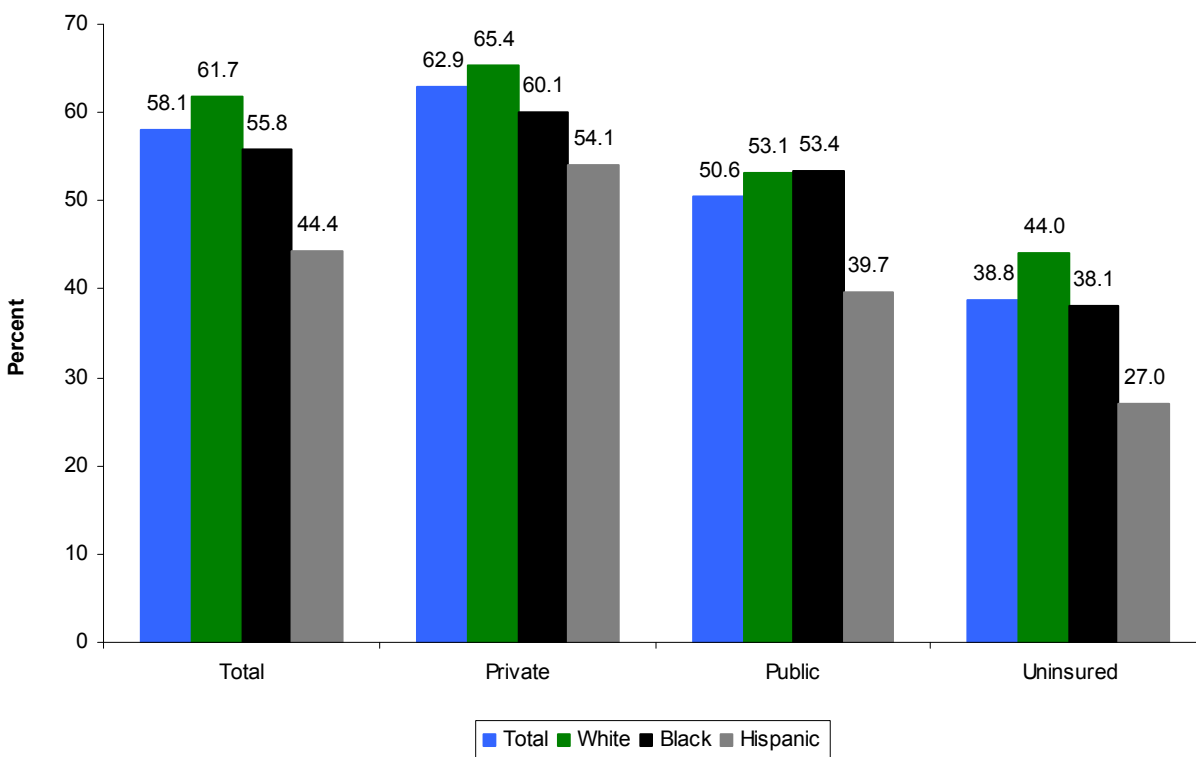
Timeliness

Timeliness is the health care system's capacity to provide care quickly after a need is recognized. For patients, lack of timeliness can result in emotional distress, physical harm, and financial consequences. Timely delivery of appropriate care can also help reduce mortality and morbidity for chronic conditions. Timely delivery of care can reduce complications from disease and overall costs.

Getting Care for Injury or Illness As Soon As Wanted

The ability of patients to receive illness and injury care in a timely fashion is a key element in a patient-focused health care system.

Figure 2.14. Adults ages 18 to 64 who report always getting care for illness or injury as soon as wanted in the past year by race/ethnicity, stratified by insurance, 2003



Note: White and Black are non-Hispanic.

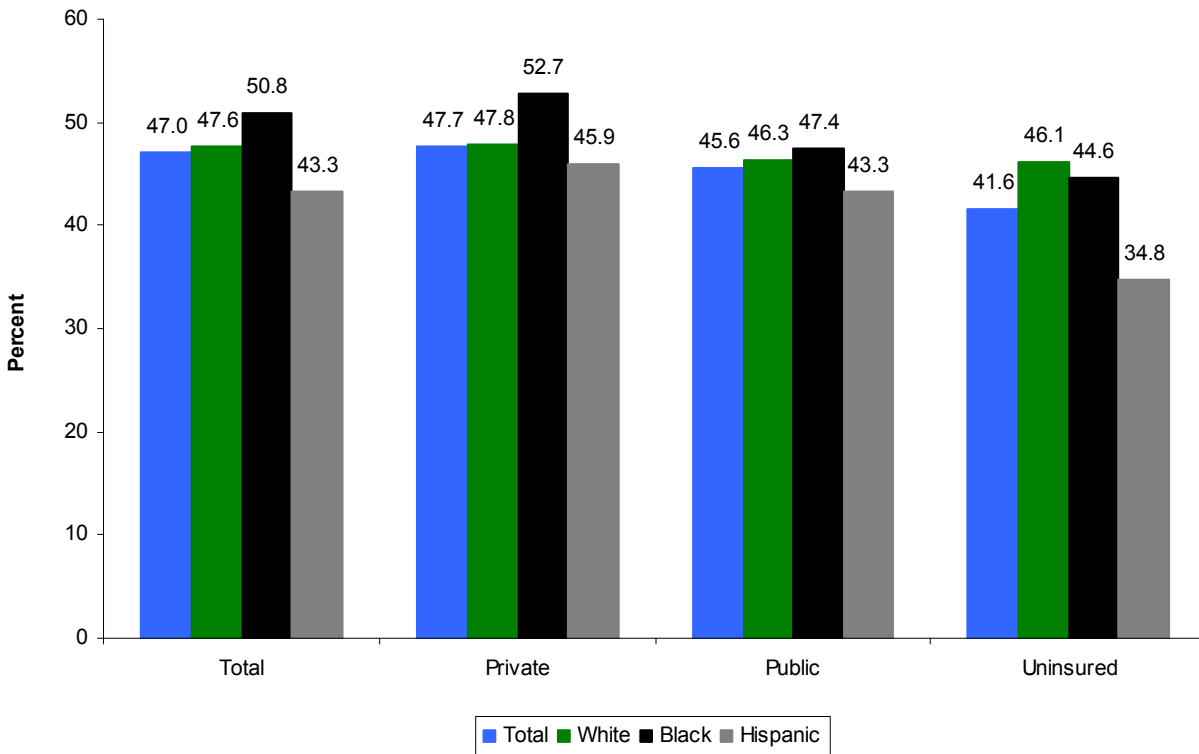
Source: Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey.

- More than half of adults ages 18 to 64 reported always getting care for illness or injury as soon as wanted.
- Adults with public insurance were less likely than those with private insurance, but more likely than those without insurance, to report always getting care for illness or injury as soon as wanted.
- Overall, White adults were more likely than Black and Hispanic adults to always get care for illness or injury as soon as wanted. Among similarly insured adults, Hispanic adults were less likely than White adults to always get care for illness or injury as soon as wanted. There were no White-Black disparities within insurance type.

Getting Routine Care As Soon As Wanted

Timely delivery of routine care, such as preventive services, safeguards public health and aids early detection and treatment of health conditions.

Figure 2.15. Adults ages 18 to 64 who report always getting routine care as soon as wanted in the past year, by race/ethnicity, stratified by insurance, 2003



Note: White and Black are non-Hispanic.

Source: Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey.

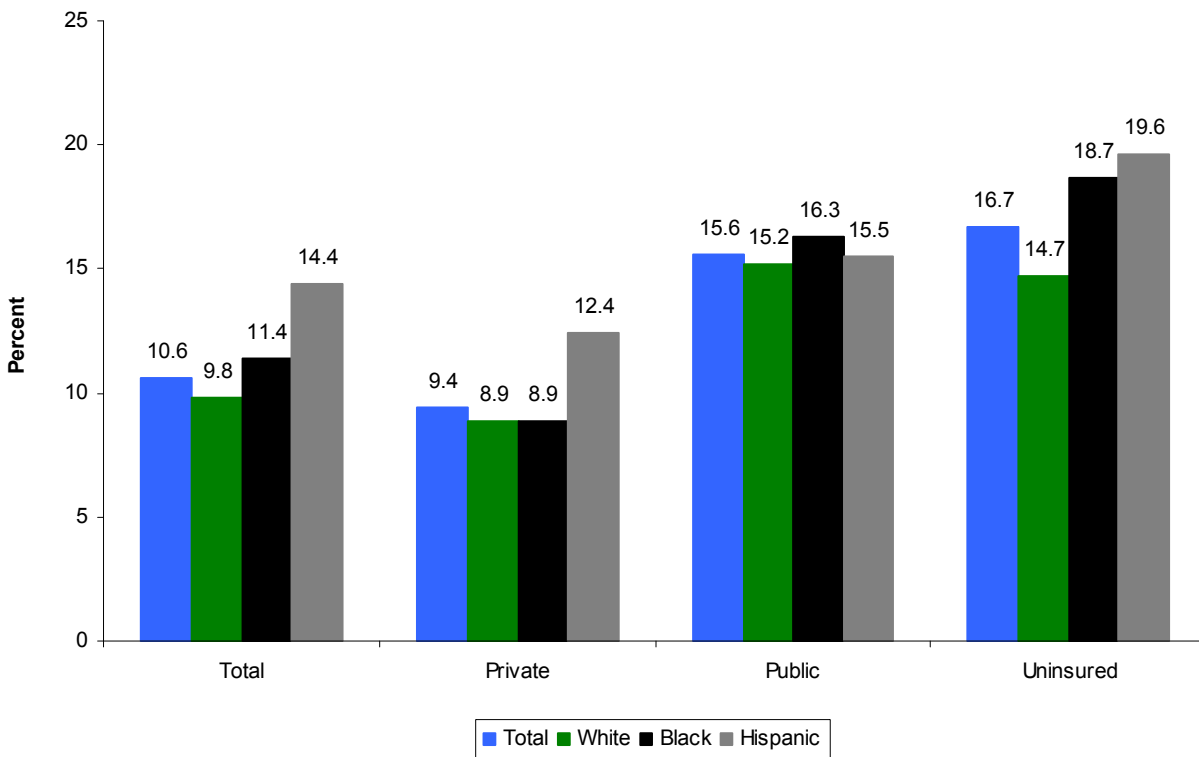
- Almost half of adults ages 18 to 64 always got appointments for routine care as soon as wanted.
- Uninsured adults were less likely than adults with private insurance to always get appointments as soon as wanted for routine care.
- Hispanic adults were less likely than White adults to always get appointments as soon as wanted for routine care. However, this result is a product of disparities among the uninsured; no racial or ethnic disparities existed among adults with private or public insurance.

Patient-Centeredness

Patient Experiences of Care

Using methods developed for the CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey, this report uses a composite measure that combines four measures of the patient experience of care into a single core measure—providers who always listen carefully, explain things clearly, respect what patients say, and spend enough time with patients.

Figure 2.16. Adults ages 18 to 64 whose health providers sometimes or never listened carefully, explained things clearly, respected what they had to say, and spent enough time with them, by race/ethnicity, stratified by insurance, 2003



Note: White and Black are non-Hispanic.

Source: Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey.

- Approximately 10 percent of adults ages 18 to 64 reported sometimes or never getting patient-centered care.
- Privately insured adults were less likely than publicly insured or uninsured adults to report sometimes or never getting patient-centered care.
- Black and Hispanic adults were more likely to report sometimes or never getting patient-centered care than White adults. White—Hispanic disparities existed among the privately insured and the uninsured, but not among the publicly insured.

Chapter 3: Access to Health Care

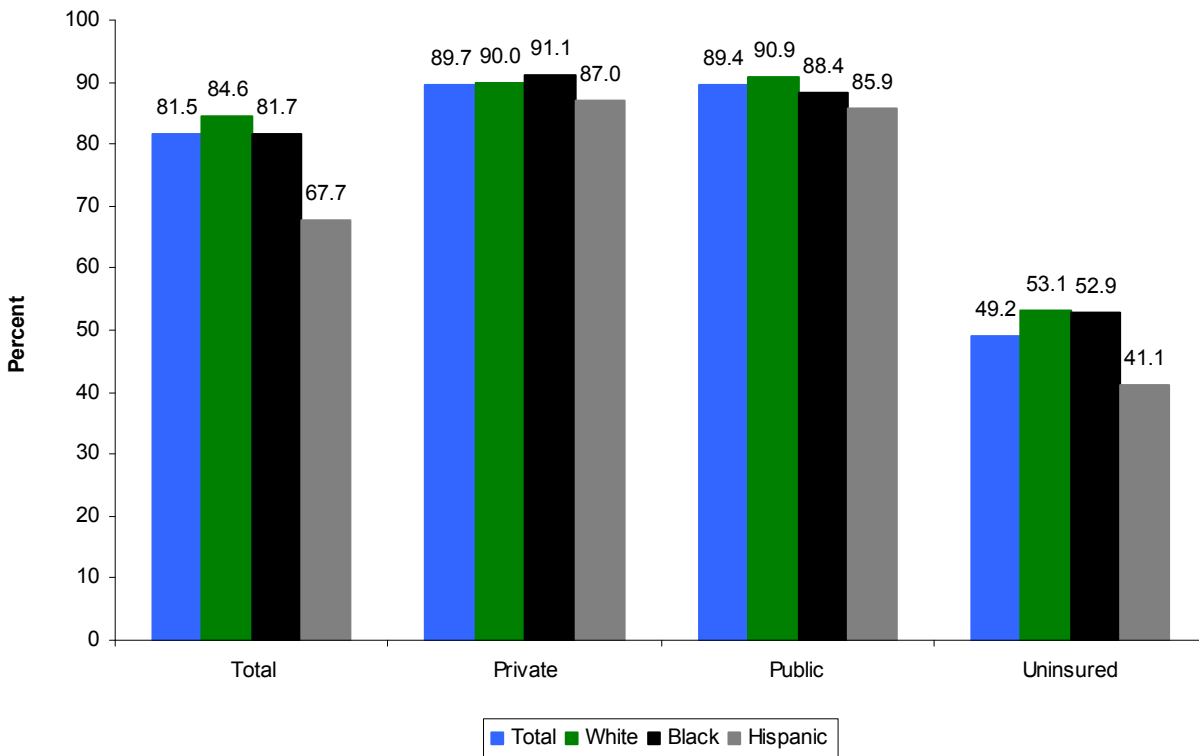
Facilitators and Barriers to Health Care

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.

Specific Source of Ongoing Care

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

Figure 3.1. Adults ages 18 to 64 who had a specific source of ongoing care, by race/ethnicity, stratified by insurance, United States, 2004



Note: White and Black are non-Hispanic.

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

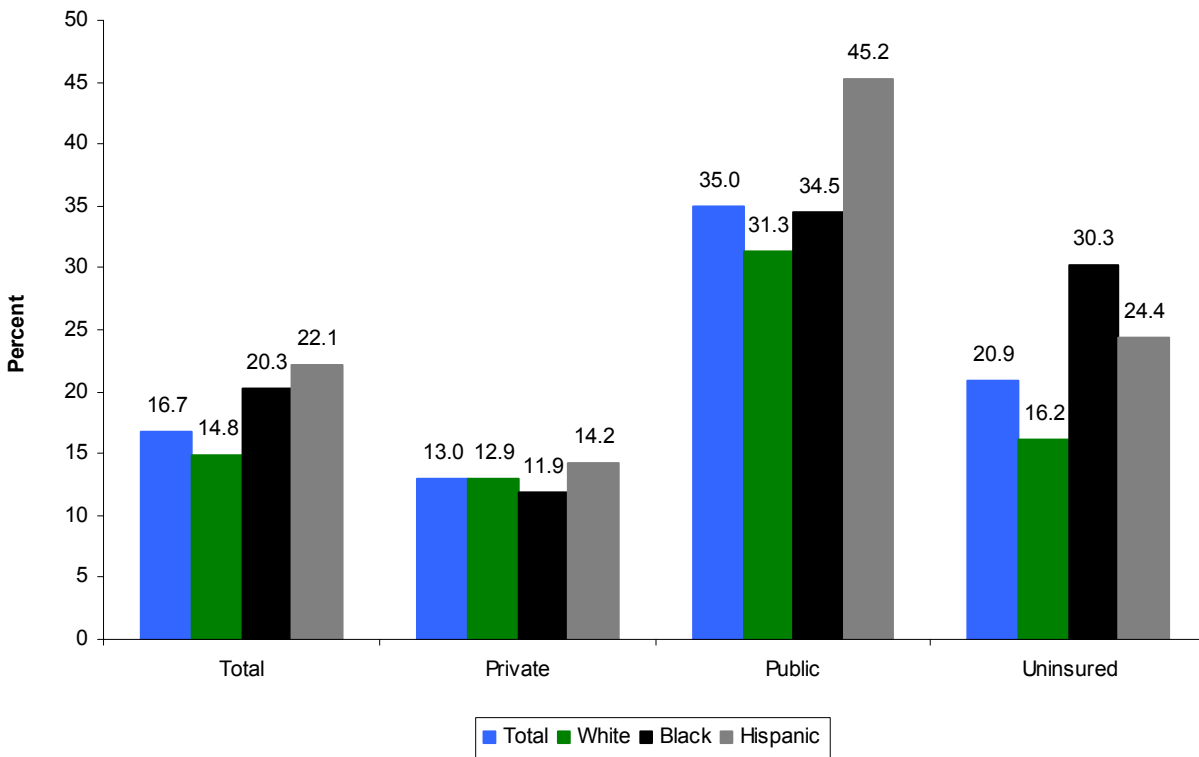
- Approximately 80 percent of adults ages 18-64 had a specific source of ongoing care.
- The proportions of publicly insured and privately insured adults with a specific source of ongoing care were similar, while the uninsured had a significantly lower proportion compared with either group.

- Overall, White individuals were significantly more likely to have a specific source of ongoing care compared with Black or Hispanic individuals, with the latter group displaying a markedly lower rate.

Hospital, Emergency Room, or Clinic as Source of Ongoing Care

Research has shown that organizational setting of care can affect the cost, quality, and patient satisfaction associated with care.

Figure 3.2. Adults ages 18 to 64 with a hospital, emergency room, or clinic as a source of ongoing care, by insurance, stratified by race/ethnicity, United States, 2004



Note: White and Black are non-Hispanic.

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

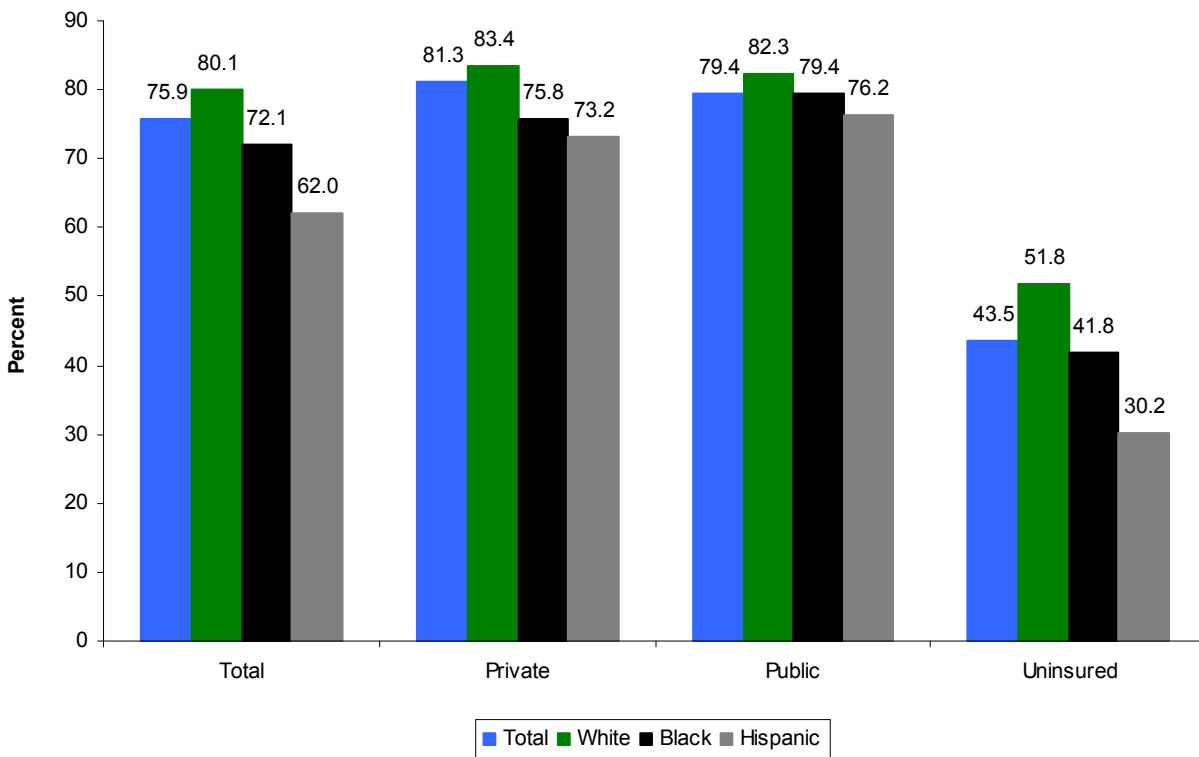
- Approximately one-sixth of adults ages 18 to 64 utilized a hospital, emergency room, or clinic as a source of ongoing care.
- The percentage of adults with a hospital, emergency room, or clinic as a source of ongoing care varied greatly by insurance. Publicly insured adults were over 2½ times as likely as privately insured adults to utilize a hospital, emergency room, or clinic as a source of ongoing care. Uninsured adults were more likely than privately insured adults, but less likely than publicly insured adults, to utilize a hospital, emergency room, or clinic as a source of ongoing care.

- Overall, Black and Hispanic adults had higher rates of having a hospital, emergency room, or clinic as a source of ongoing care compared with White adults.

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 and with good patient-provider communication, which, in turn, increases the likelihood that patients receive appropriate care. 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. Indeed, having a usual primary care provider correlates with receipt of higher quality care.

Figure 3.3. People under age 65 who have a usual primary care provider, by race/ethnicity, stratified by insurance, United States, 2003



Note: White and Black are non-Hispanic.

Source: Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey.

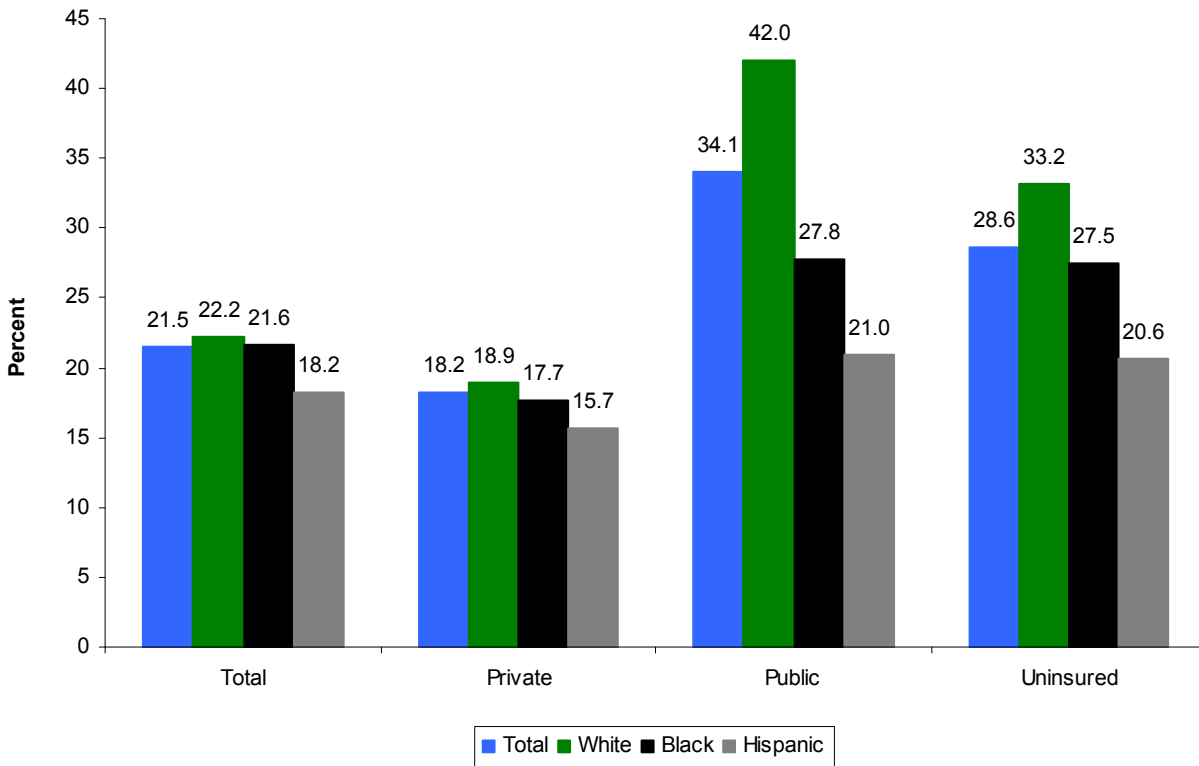
- Three-quarters of people under age 65 had a usual primary care provider.
- Publicly insured and privately insured individuals were equally likely to have a usual primary care provider. Uninsured individuals were much less likely than those with private or public insurance to have a usual primary care provider.

- Overall, White individuals were more likely than both Black and Hispanic individuals to have a usual primary care provider. These disparities were present among individuals with the same insurance coverage, except for publicly insured Black individuals, who were no less likely than publicly insured White individuals to have a usual primary care provider.

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 in care.

Figure 3.4. Percentage of families headed by adults ages 18 to 64 unable or delayed in receiving needed medical care, dental care, or prescription medications, by race/ethnicity, stratified by insurance status, United States, 2003



Note: White and Black are non-Hispanic.

Source: Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey.

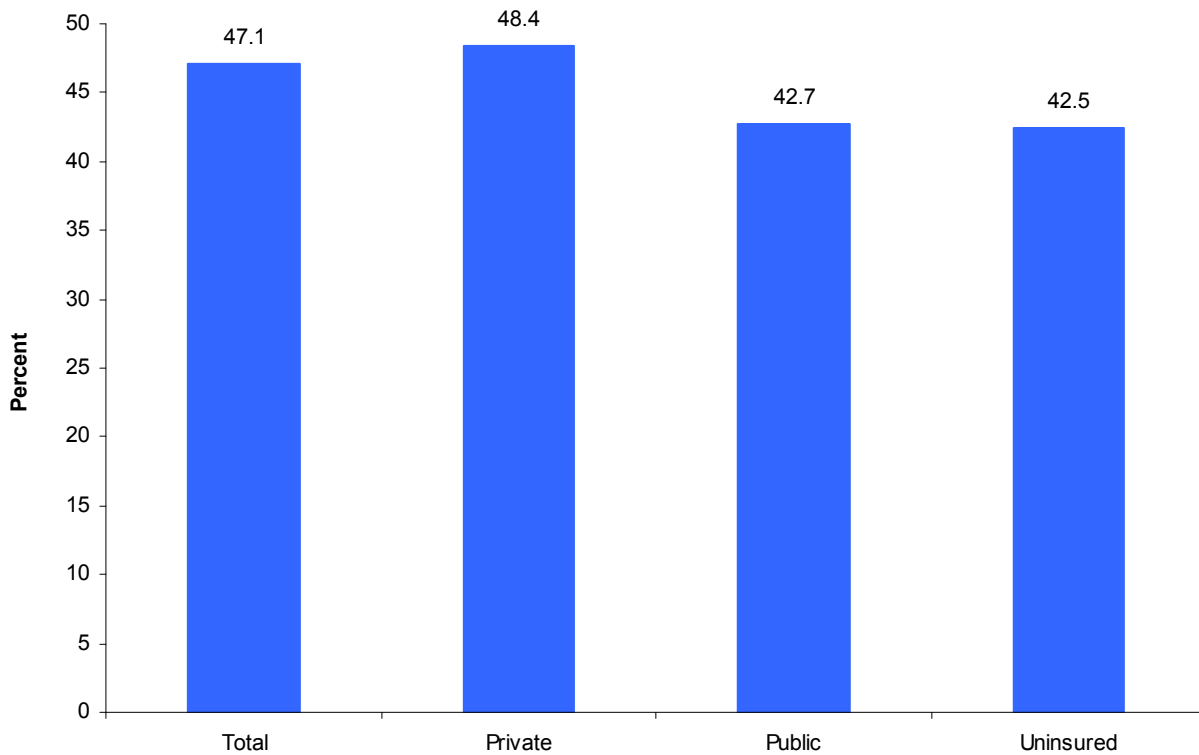
- One of five families was unable or delayed in receiving needed medical care, dental care, or prescription medications.
- There were significant differences in inability to obtain care or delays in care across insurance status. Publicly insured families were most likely to have unmet needs, followed by uninsured and privately insured families, respectively.

- There were no racial or ethnic disparities among privately insured families. In contrast, there were substantial racial and ethnic disparities among publicly insured and uninsured families. Among the publicly insured, White families were more likely than Black and Hispanic families to have unmet needs. White uninsured families were more likely to have unmet needs than Hispanic families.

Provider With Night or Weekend Hours

The health care delivery system’s structure and organization are critical factors in making health care accessible to low-income individuals. Services available at night and on weekends facilitate access to health care by increasing convenience to patients.

Figure 3.5. People under age 65 with provider who has office hours nights or weekends, by insurance status, United States, 2003



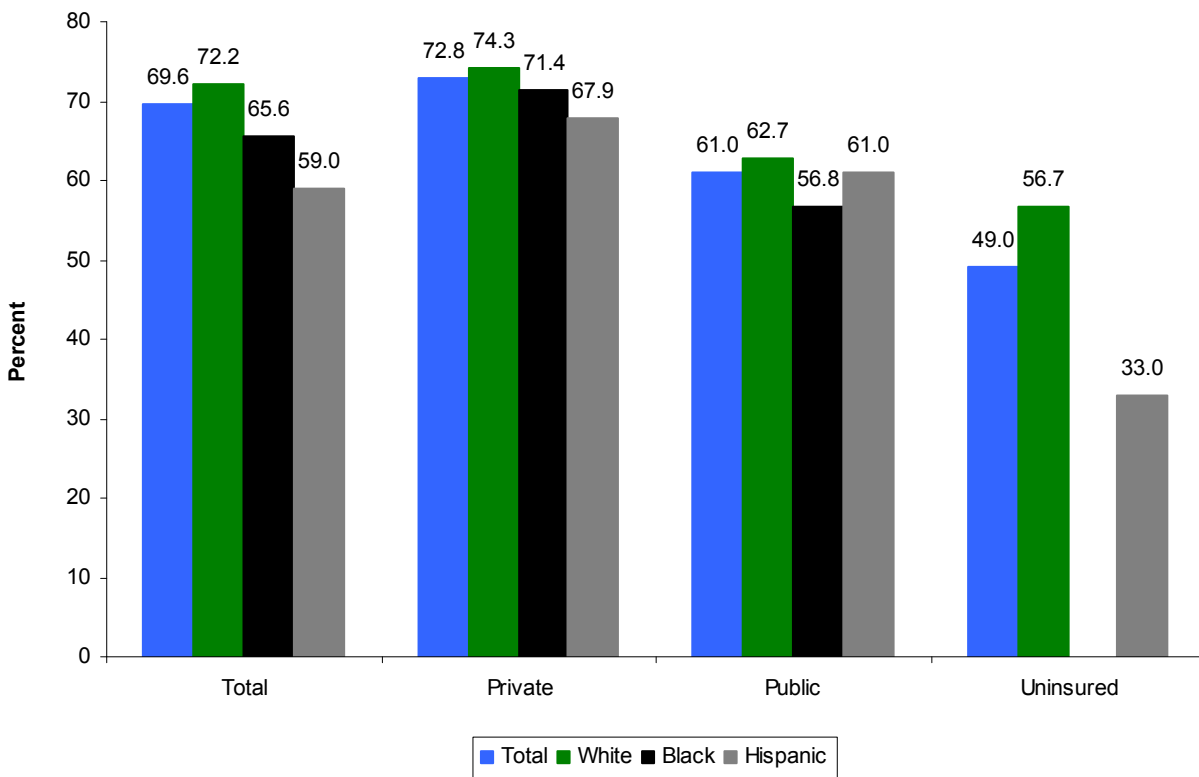
Source: Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey.

- Less than one-half of people had a provider with office hours at night or on the weekend.
- Privately insured adults were more likely than publicly or uninsured adults to have a provider who has office hours at night or on the weekends.
- There were no significant racial or ethnic differences regardless of insurance (data not shown).

Adults Without Problems Getting Specialist Referral

Some insurers require patients to be referred to specialists by primary care physicians to reduce unnecessary services and contain health care costs. Some consumer groups have expressed concern that referral requirements would impede access to care.

Figure 3.6. Adults ages 18 to 64 without problems getting referral to a specialist in past year, by race/ethnicity, stratified by insurance status, United States, 2003



Note: White and Black are non-Hispanic. Data do not meet the criteria for statistical reliability, data quality, or confidentiality for uninsured Black adults.

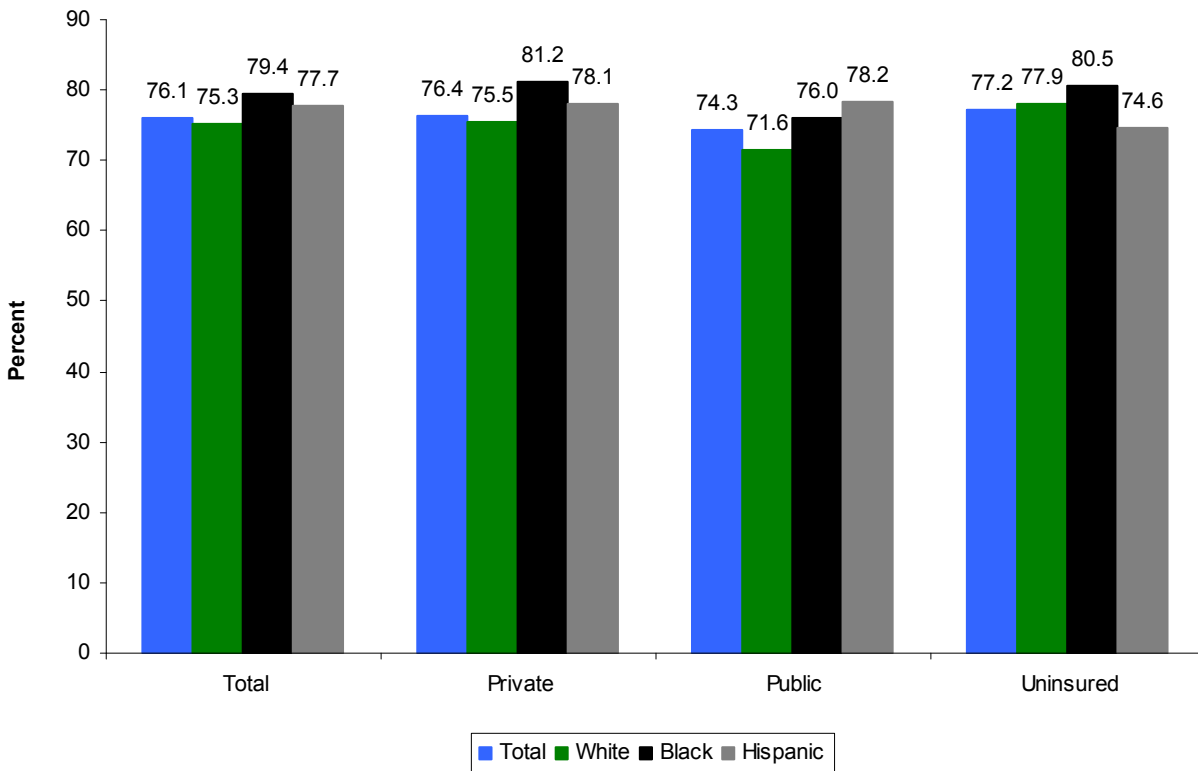
Source: Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, Medical Expenditure Survey.

- More than two-thirds of adults ages 18 to 64 did not have problems getting referral to a specialist in the past year.
- The proportion of adults without problems getting referral to a specialist varied significantly by insurance status, with the privately insured having the highest proportion followed by the publicly insured and uninsured, respectively. This trend remained constant across race and ethnicity.
- Black and Hispanic adults were more likely to experience problems getting referral to a specialist in the past year compared with White adults. There were no racial or ethnic disparities among privately or publicly insured adults. Uninsured Hispanic adults were more likely to experience problems than uninsured White adults.

Provider-Patient Communication

Effective provider-patient communication is necessary to ensure that medical decisions are consistent with the patient's needs and preferences and to ensure patient safety.

Figure 3.7. People under age 65 with provider who usually asks about medications and treatments other doctors may give, by race/ethnicity, stratified by insurance status, United States, 2003



Note: White and Black are non-Hispanic.

Source: Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey.

- Approximately three-quarters of people under age 65 reported that their provider inquired about other treatments and medications.
- There was no significant variation in the percentage by insurance status.
- Overall, Black individuals were more likely than White individuals to report that their provider inquired about other treatments and medications, but disparities varied depending on insurance status. Privately insured Black individuals were more likely to report that their provider inquired about other treatments and medications than privately insured White individuals. Publicly insured Hispanic individuals were more likely than publicly insured White individuals to have a provider who asks about medications and treatments given by other doctors.

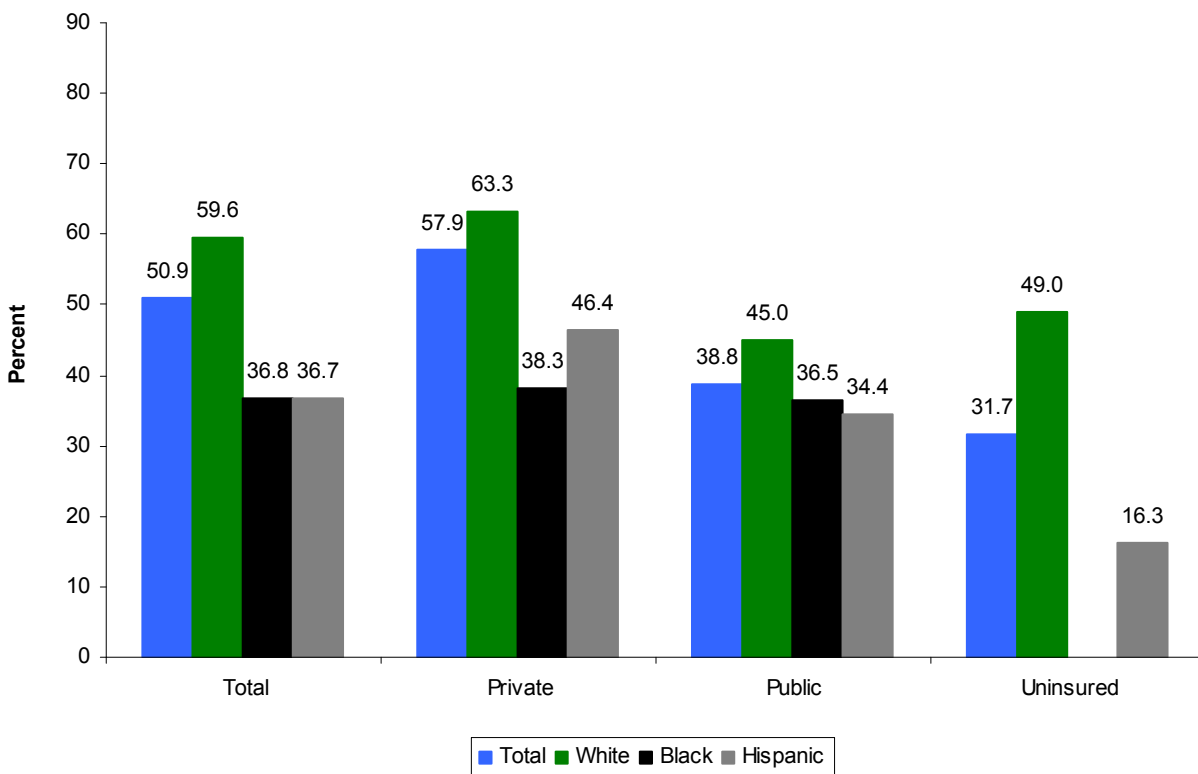
Utilization

This section considers measures of health care use. Some differences in receipt of care reflect individual needs, health status, preferences, type of care available, economic factors, and behaviors. However, regular use of dental and medical care is important to preserving health and functioning, while high rates of emergency department use suggest lack of access to routine care.

Dental Visits

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

Figure 3.8. Children ages 2 to 17 with a dental visit in the past year, by race/ethnicity and insurance, 2003



Note: White and Black are non-Hispanic. Data do not meet the criteria for statistical reliability, data quality, or confidentiality for uninsured Black children.

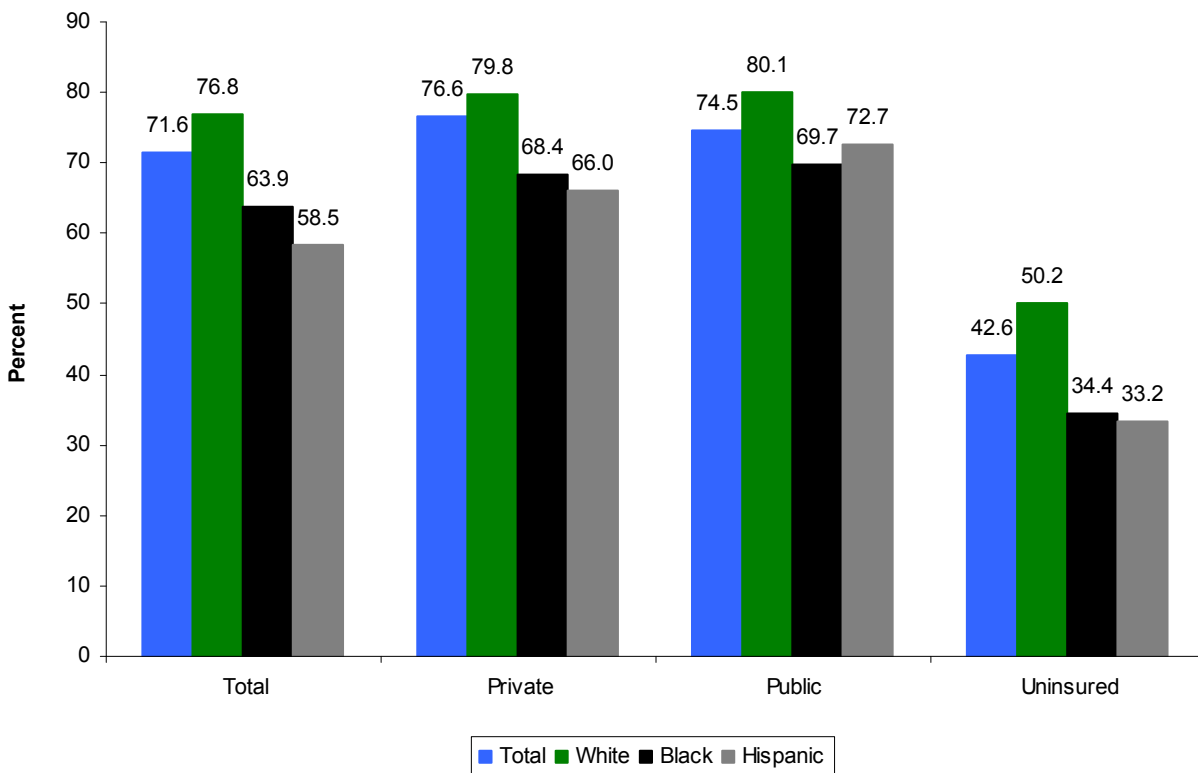
Source: Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey.

- Approximately one-half of all children had a dental visit in the past year.
- Privately insured children were much more likely than publicly insured children, who in turn were more likely than uninsured children, to have had a dental visit.
- Black and Hispanic children were less likely than White children to have had a dental visit; these disparities existed within all insurance types.

Outpatient Visits

Lower receipt of office or outpatient visits may indicate better health, patient preferences, or problems with access to services.

Figure 3.9. People under age 65 with an office or outpatient visit, by race/ethnicity, stratified by insurance status, United States, 2003



Note: White and Black are non-Hispanic.

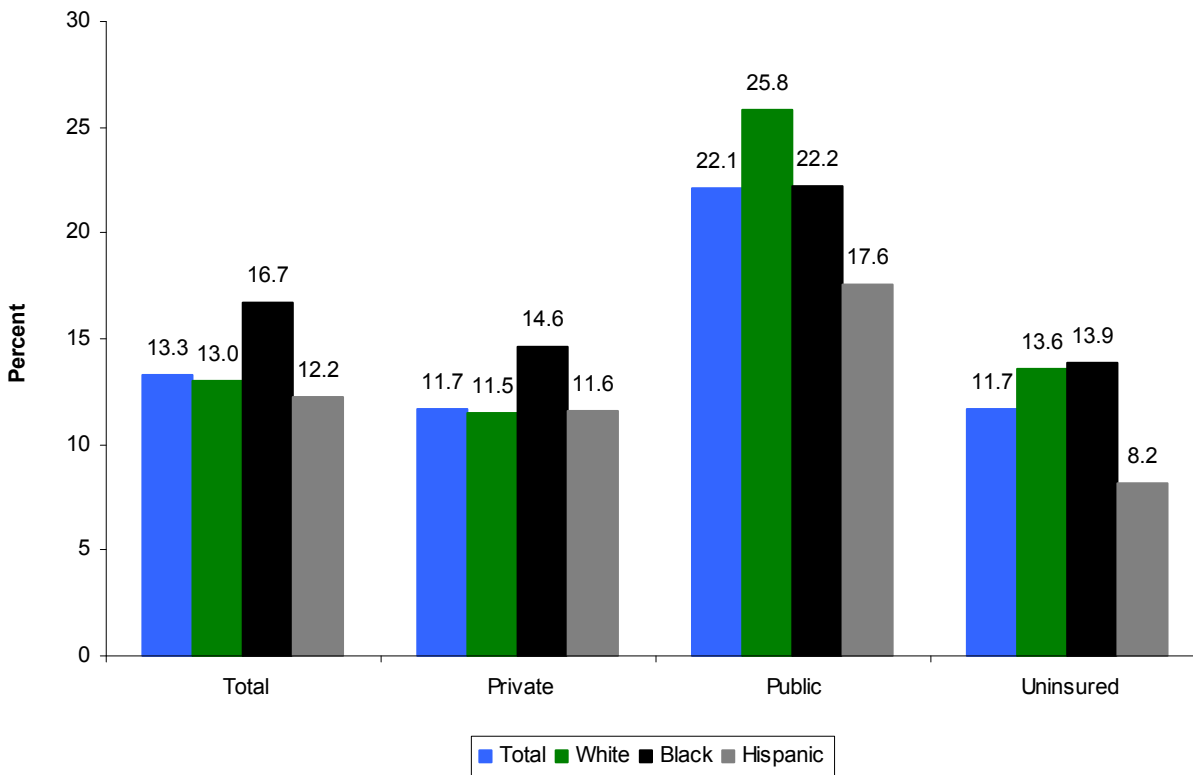
Source: Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey.

- Nearly three-quarters of people under age 65 had an office or outpatient visit. Privately insured individuals were most likely to have visits, followed closely by the publicly insured and distantly by the uninsured.
- Black and Hispanic individuals were less likely to have outpatient visits compared with White individuals; these disparities were present within all insurance types.

Emergency Room 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 3.10. People under age 65 with an emergency room visit, by race/ethnicity, stratified by insurance status, United States, 2003



Note: White and Black are non-Hispanic.

Source: Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, Medical Expenditure Panel Survey.

- Approximately 13 percent of people under age 65 visited the emergency room.
- Publicly insured individuals were more likely than privately insured or uninsured individuals to visit the emergency room. Privately insured and uninsured individuals were equally likely to visit the emergency room.
- Overall, White individuals were less likely than Black individuals, but more likely than Hispanic individuals, to visit the emergency room. Disparities varied by insurance status. Among the privately insured, there were only White-Black disparities, and among the uninsured there were only White-Hispanic disparities. Among the publicly insured, White individuals were more likely to have emergency room visits than both Black and Hispanic individuals.