

Health Care Coverage Analyses of the National Healthcare Quality and Disparities Reports: 2000-2008 Trends

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Highlights from the Coverage Analyses Trends Report

Each year since 2003, the Agency for Healthcare Research and Quality (AHRQ) has reported on the progress and opportunities for improving health care quality and access and reducing health care disparities. These data have been used for the Coverage Analyses Trends Report to observe how quality and access has changed for individuals with private insurance, Medicaid, and no insurance, and to examine racial and ethnic disparities within insurance groups. This Highlights section summarizes the data presented in the Coverage Analyses Trends Report. Appendix 1 lists all measures used in these analyses.

Insurance Disparities

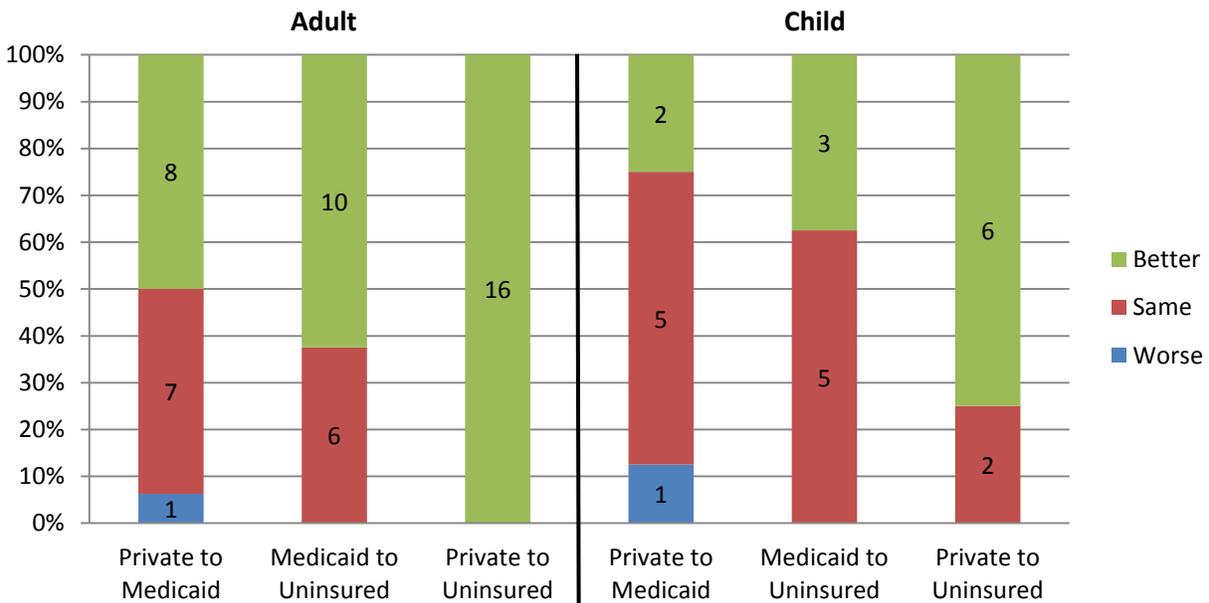
This section addresses the following questions on insurance disparities:

- How does the quality of and access to care in the most recent time period differ based on insurance coverage?
- Has the quality of and access to health care changed over time for people with different insurance? Are the changes different for adults and children?
- Has the number of measures with insurance-based differences changed over time?
- Have the gaps increased or decreased over time for measures with insurance-based differences?

Recent Insurance-Based Differences in Quality of and Access to Care

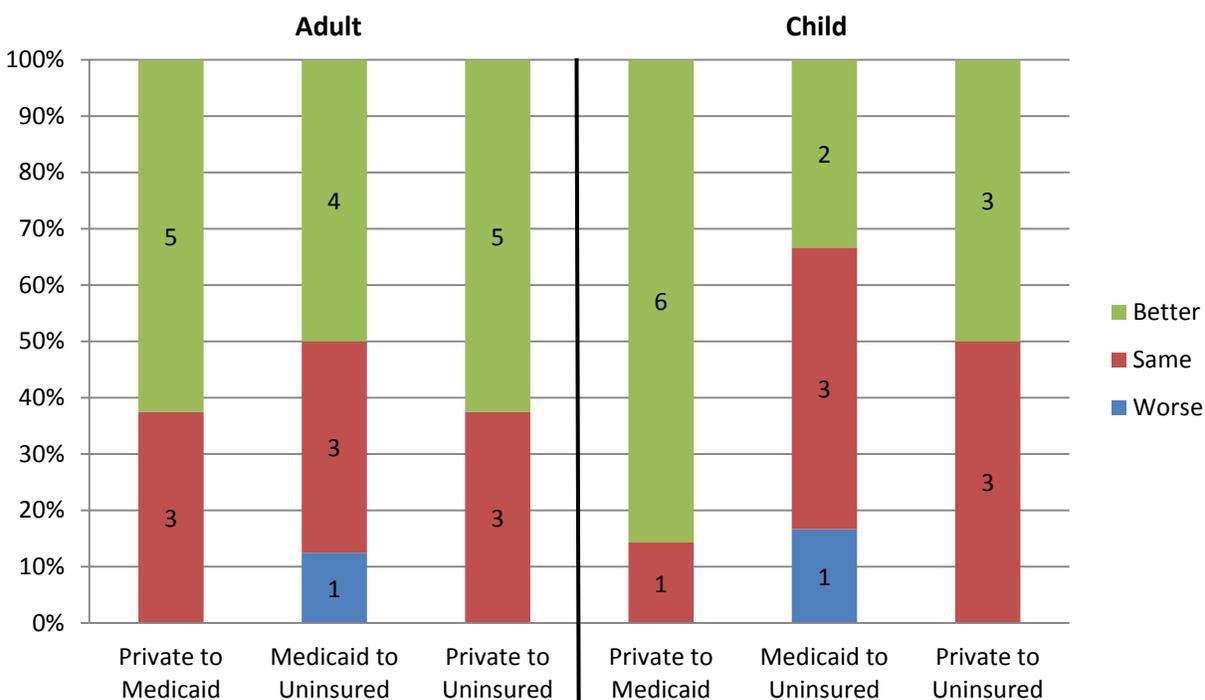
The Coverage Analyses Trends Report compares the quality of and access to care received by adults and children with private insurance, Medicaid, and no insurance in the most recent year for which data were available.

Figure H.1. Insurance comparisons of quality of care, stratified by age



- Overall, privately insured *adults* received better quality of care than individuals with Medicaid or those without insurance, while adults with Medicaid received better quality of care than uninsured adults. Specifically, privately insured adults fared better than adults with Medicaid on 50% of quality of care measures, and adults with Medicaid fared better than uninsured adults on more than 60% of quality measures. Adults with private insurance fared better than uninsured adults on all measures.
- *Children* experienced fewer insurance disparities in quality than *adults*. Privately insured *children* experienced better quality of care than those with Medicaid on 25% of measures, while children with Medicaid fared better than uninsured children on 38% of quality measures. Children with private insurance fared better than uninsured children on three-quarters of measures.

Figure H.2. Insurance comparisons of access to care, stratified by age

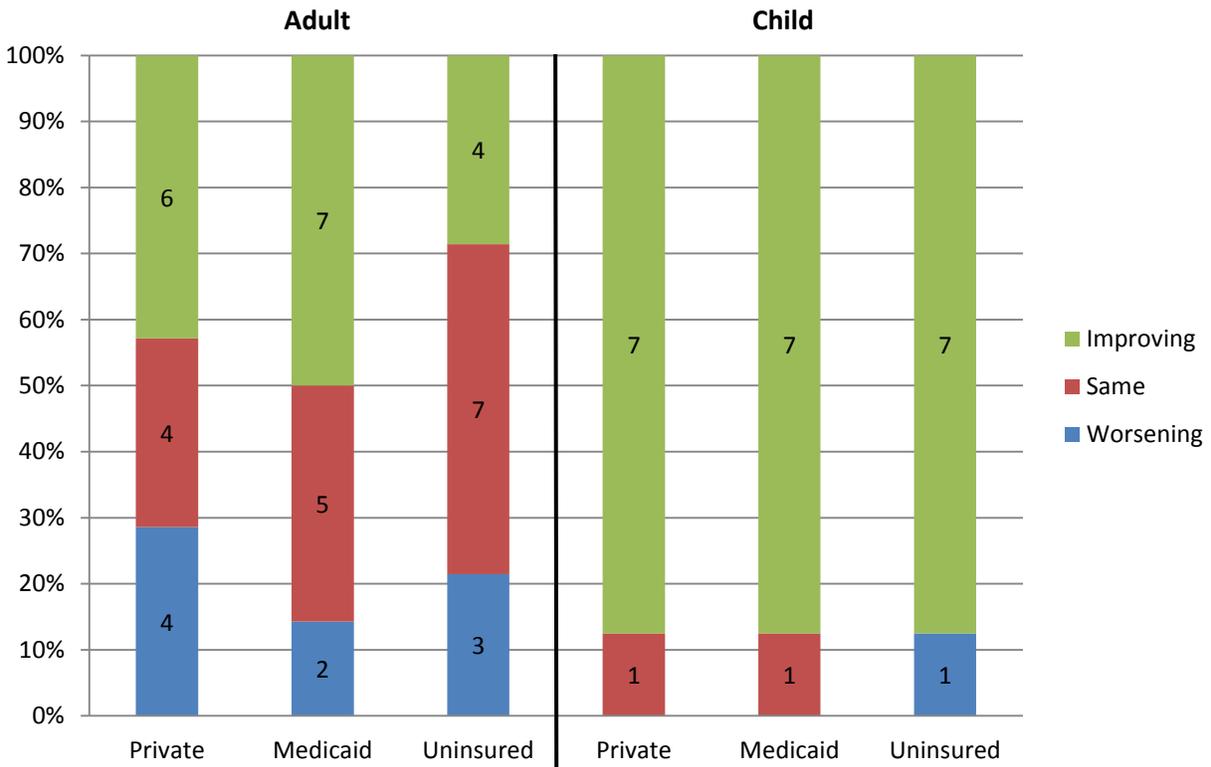


- *Adults* and *children* experienced similar patterns of access to care.
- *Adults* with private insurance had better access to care than those with Medicaid or uninsured adults on 63% of measures.
- Privately insured *children* also fared better than children with Medicaid (86% of measures) and those without insurance (50% of measures). On no measures did privately insured people have worse access than people with Medicaid or uninsured people.
- People with Medicaid had better access to care than uninsured people for one-third (*children*) to one-half (*adults*) of measures. Individuals with Medicaid had worse access than uninsured people on a single measure—people under age 65 who had an emergency hospital room visit in the calendar year.

Changes in Quality of and Access to Care for People with Different Insurance

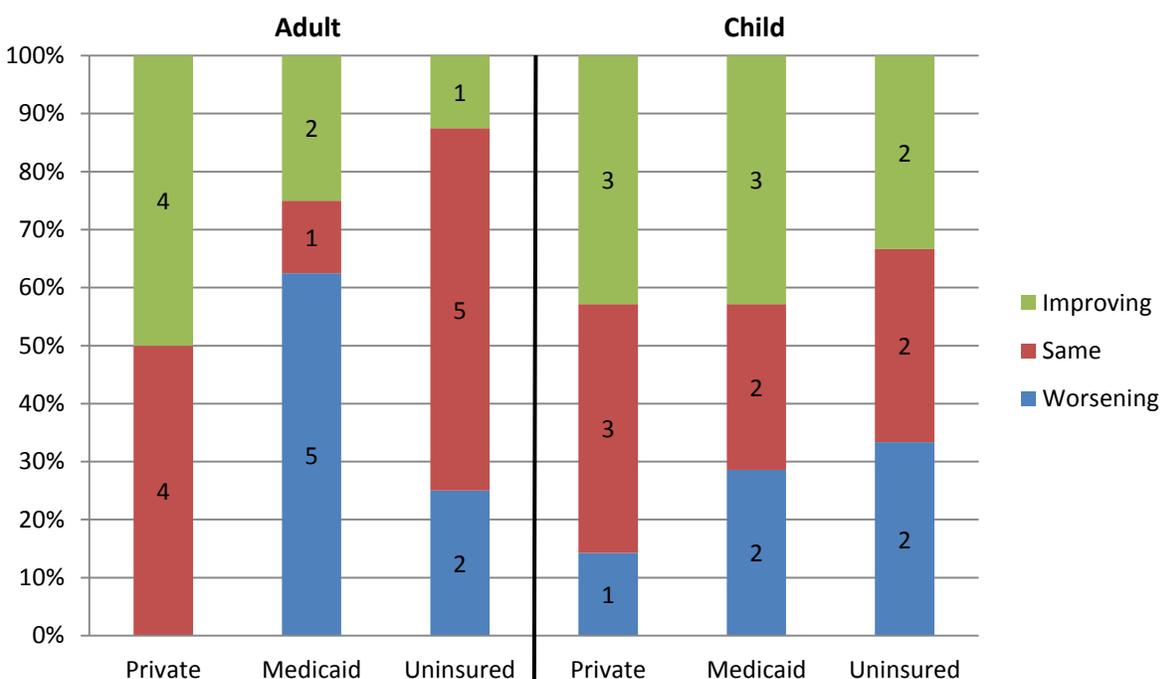
The Coverage Analyses Trends Report examines trends over time, generally between 2000 and 2008 (depending on the measure; see Appendix 1), to see whether quality of and access to health care are improving, staying the same, or worsening.

Figure H.3. Change in quality of care over time, by insurance status, stratified by age



- Improvement in quality of care for *adults* varied by insurance status. Adults with Medicaid experienced improvement on the largest number of measures and experienced the fewest measures where quality worsened. The quality of care for uninsured adults changed the least, with quality remaining the same for 50% of measures.
- *Children*, regardless of insurance, experienced improvement in quality of care for a larger proportion of measures than *adults*.
- Improvement in quality of care was high and similar among *children* of all insurance groups. Children experienced improvement for almost 90% of quality measures.

Figure H.4. Change in access to care over time, by insurance status, stratified by age

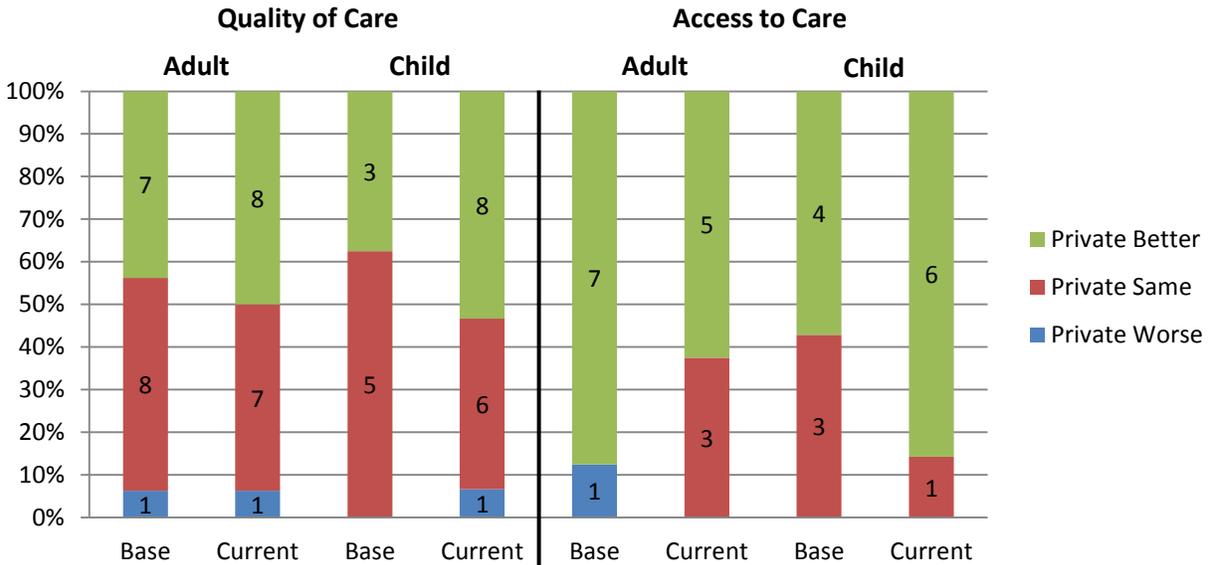


- A smaller proportion of access to care measures than quality measures improved over time.
- Privately insured *adults* experienced improvements in half of access measures and experienced no decreases. Adults with Medicaid experienced fewer improvements and access worsened for 63% of the measures. Uninsured adults experienced the least amount of change, with access remaining the same for 63% of the measures.
- Changes in *children's* access to care measures were similar regardless of insurance status.
- The one access measure that is worsening among privately insured *children*—being unable to get or delayed in getting needed care due to financial or insurance reasons—is also one of the two measures worsening for children with Medicaid. Both uninsured children and those with Medicaid experienced worsening in the access measure of being without a usual source of care.

Changes in Insurance-Based Disparities Over Time

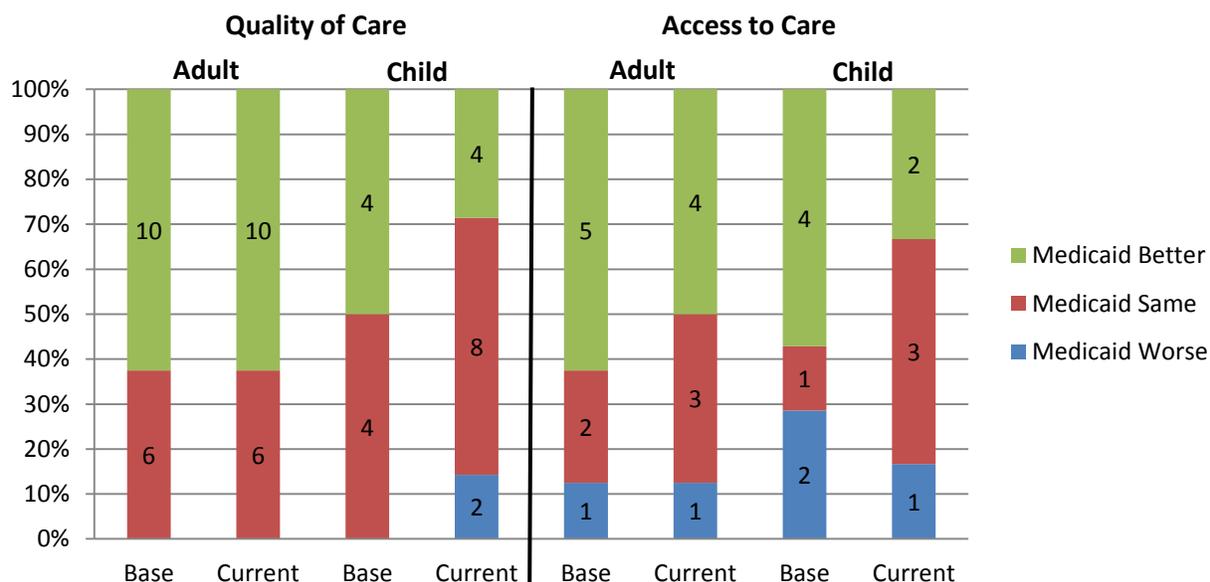
In the previous section we presented data showing that adults and children received different quality of and access to health care depending on what kind of insurance they had and the time period of the measurement. Here we compare the number of measures for which specific insurance disparities existed in the base time period with the most recent period to explore whether the number of measures for which there are disparities has changed over time.

Figure H.5. Comparison of base and most recent periods in quality and access disparities between people with private insurance and Medicaid, stratified by age



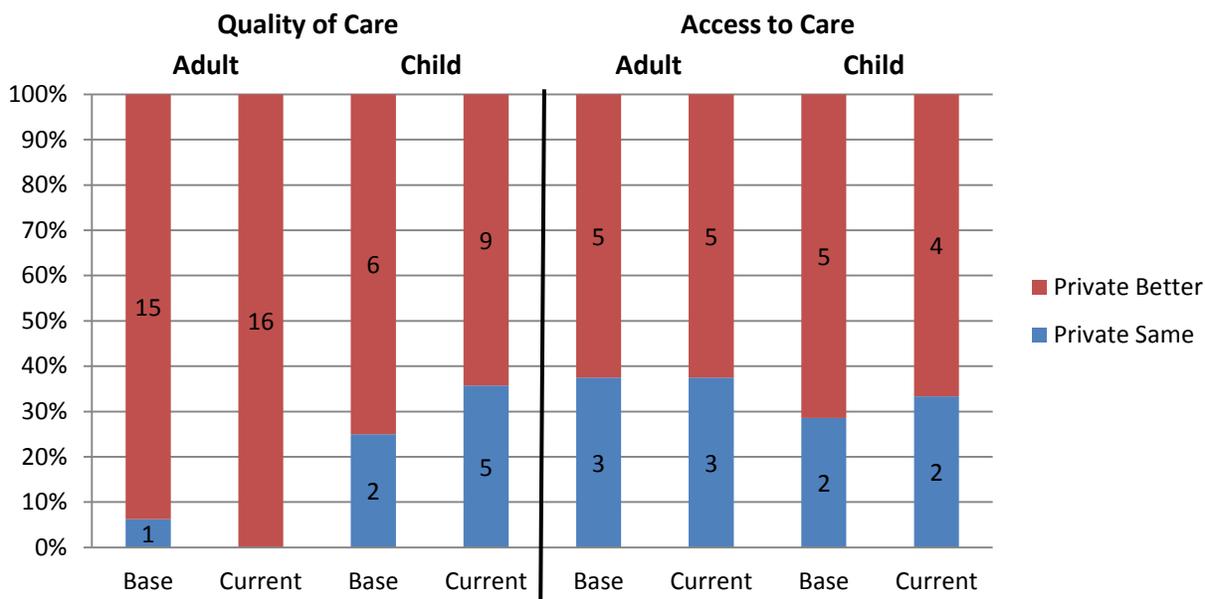
- Disparities in *quality of care* measures between *adults* with private insurance and with Medicaid increased. For adults, the proportion of measures that were better for privately insured adults compared to those with Medicaid increased from 44% in the base period to 50% in the most recent period.
- Insurance disparities in *quality of care* for *children* also increased. In the base period, 38% of quality measures were worse for those with Medicaid than for those with private insurance, compared to 53% in the most recent period.
- In contrast, disparities in *access to care* between *adults* with private insurance and with Medicaid decreased. In the base period, 88% of *access* measures were better for adults with private insurance than those with Medicaid, dropping to 63% of measures in the recent period.
- However, disparities in *access to care* between *children* with Medicaid and those with private insurance increased. Children with Medicaid did worse on 57% of the measures in the base period compared to 86% of the measures in the most recent period.

Figure H.6. Comparison of base and most recent periods in quality and access disparities between people with Medicaid and no insurance, stratified by age



- Disparities in *quality of care* between *adults* with Medicaid and uninsured *adults* did not change between the base and most recent periods. In both periods, adults with Medicaid did better than uninsured adults on 63% of measures.
- Among *children*, the disparities in *quality of care* between those with Medicaid and those who were uninsured decreased. Children with Medicaid experienced better quality of care for 50% of measures in the base period compared to 29% of measures in the most recent period. In fact, children with Medicaid did worse than those without insurance on 2 of 14 (14%) quality of care measures in the most recent period.
- The disparities in *access to care* between *adults* with Medicaid and those without insurance decreased over time, from 63% of measures being better for adults with Medicaid in the base period to 50% of measures being better in the most recent period. In both periods, adults with Medicaid did worse on 1 of 8 (13%) access to care measures than uninsured adults.
- Among *children*, disparities in *access to care* between those with Medicaid and those who were uninsured also decreased. Children with Medicaid experienced better access to care on 57% of access to care measures in the base period compared to 33% in the current period.

Figure H.7. Comparison of base and most recent periods in quality and access disparities between people with private insurance and no insurance, stratified by age

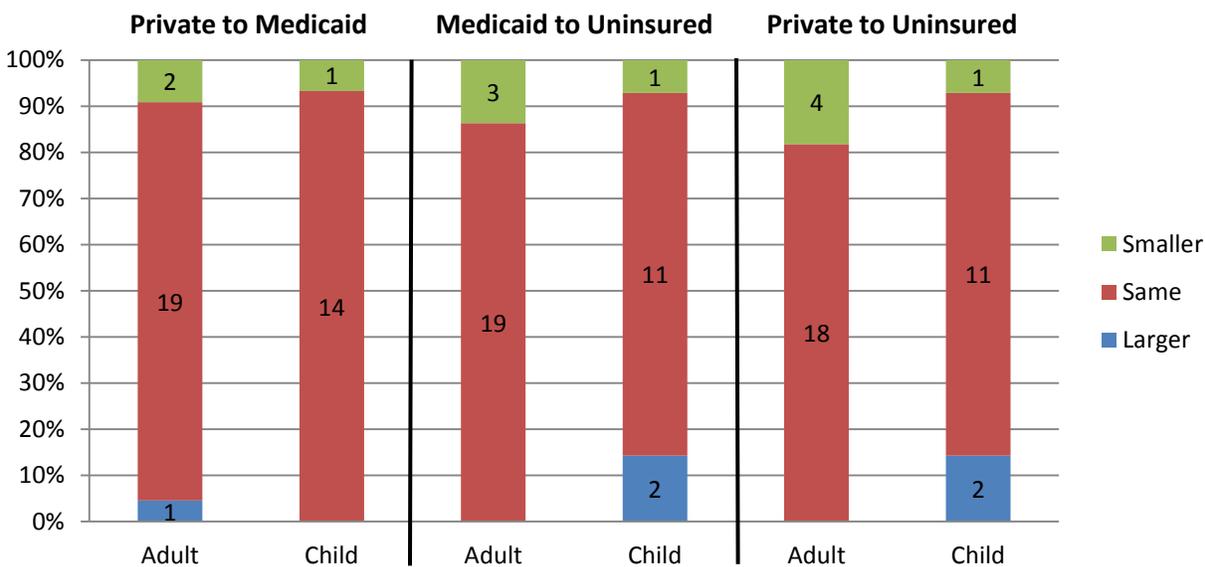


- Disparities between *adults* with private insurance and uninsured *adults* remained relatively stable. In both periods, privately insured adults fared better or the same on all quality and access measures than uninsured adults.
- Among *adults*, there were disparities for a larger proportion of *quality of care* measures than *access to care* measures.

Changes in Disparity Gaps

We looked across quality of care and access to care measures to see whether, for the measures for which there were disparities in the most recent time period, the gaps had gotten smaller, stayed the same, or gotten larger over time. The exact time period, generally between 2000 and 2008, depends on the data available for each measure (see Appendix 1).

Figure H.8. Change in disparity gap by insurance status, stratified by age



- Disparities between insurance groups remained fairly stable over time. The gaps remained the same for the vast majority of measures, with gaps increasing or decreasing for only one or two measures.
- The gap between insurance groups got larger for a greater proportion of *child* measures than *adult* measures.

Racial and Ethnic Disparities

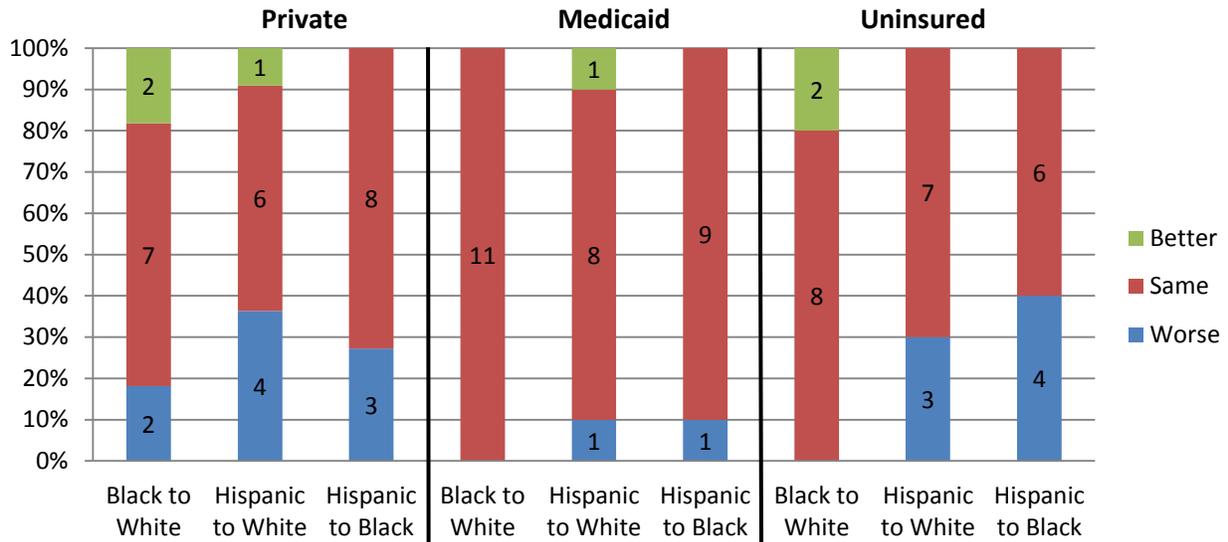
This section addresses the following questions on racial and ethnic disparities:

- Were there racial or ethnic disparities among adults and children with the same insurance in the most recent time period? Were disparities more common among people with a particular insurance status?
- Has the quality of and access to health care changed over time for different racial and ethnic groups within and across different insurance coverage types? Are the changes different for adults and children?
- Has the number of measures exhibiting racial or ethnic disparities among people with the same insurance changed over time?
- For measures exhibiting racial or ethnic disparities among people with the same insurance, has the size of the disparities changed over time?

Recent Race and Ethnicity-Based Differences in Quality of and Access to Care

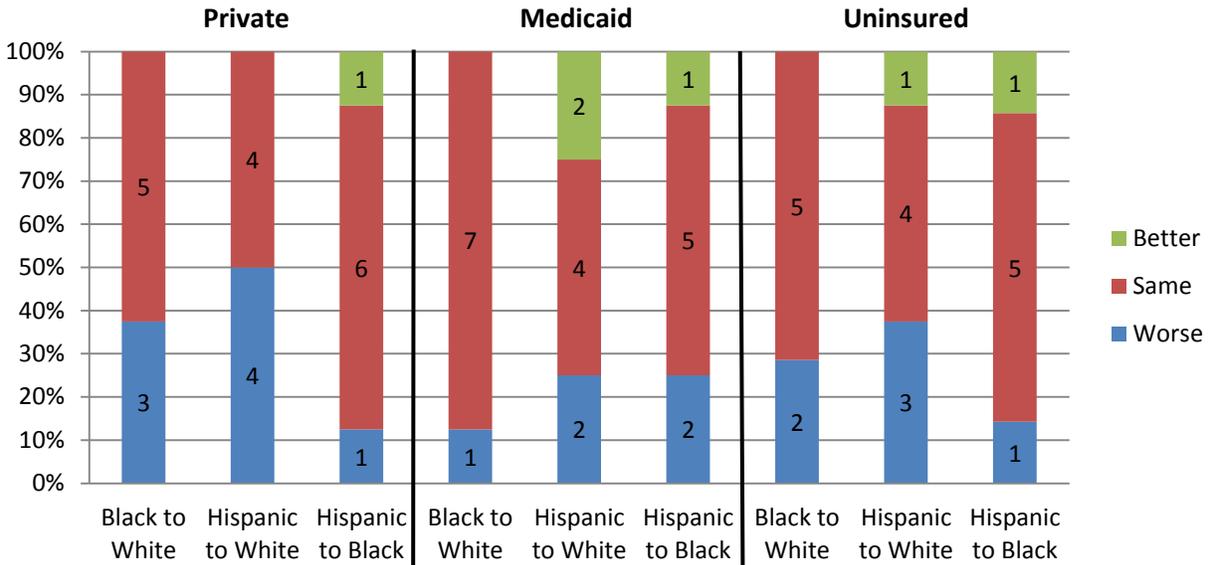
The Coverage Analyses Trends Report compares the quality of and access to care received by White, Black, and Hispanic adults and children with private insurance, Medicaid, and no insurance in the most recent year for which data were available.

Figure H.9. Racial and ethnic disparities in quality of care among adults, stratified by insurance status



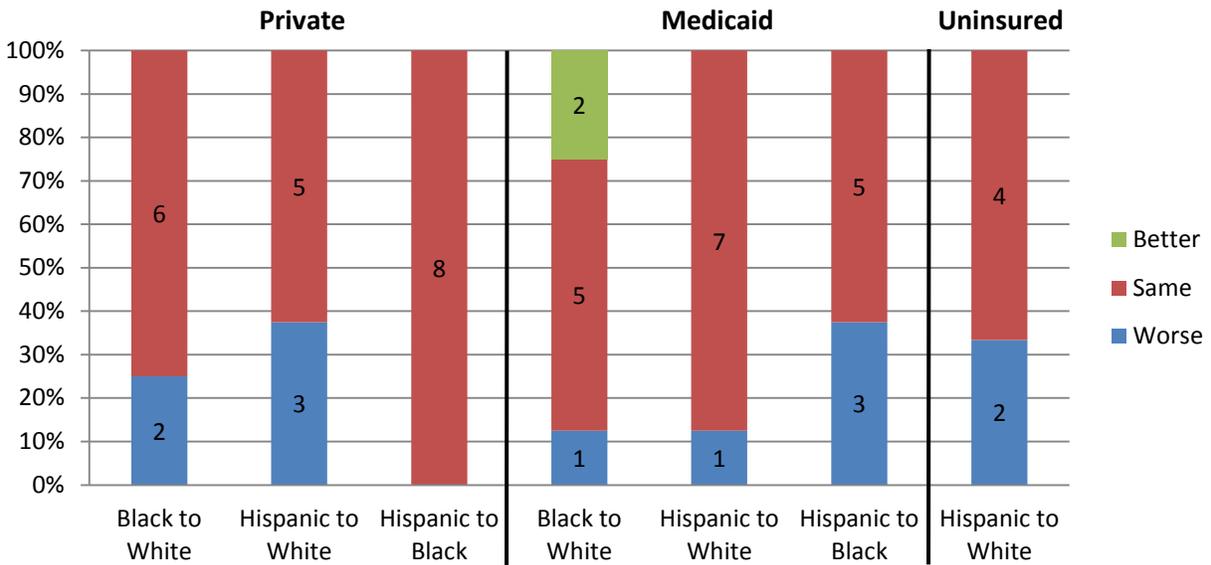
- Adults with Medicaid had few racial and ethnic disparities.
- In contrast, privately insured Blacks and Hispanics fared worse than their White counterparts on several quality measures.
- Hispanics fared the worst on quality of care, particularly among privately insured and uninsured adults.

Figure H.10. Racial and ethnic disparities in access to care among adults, stratified by insurance status



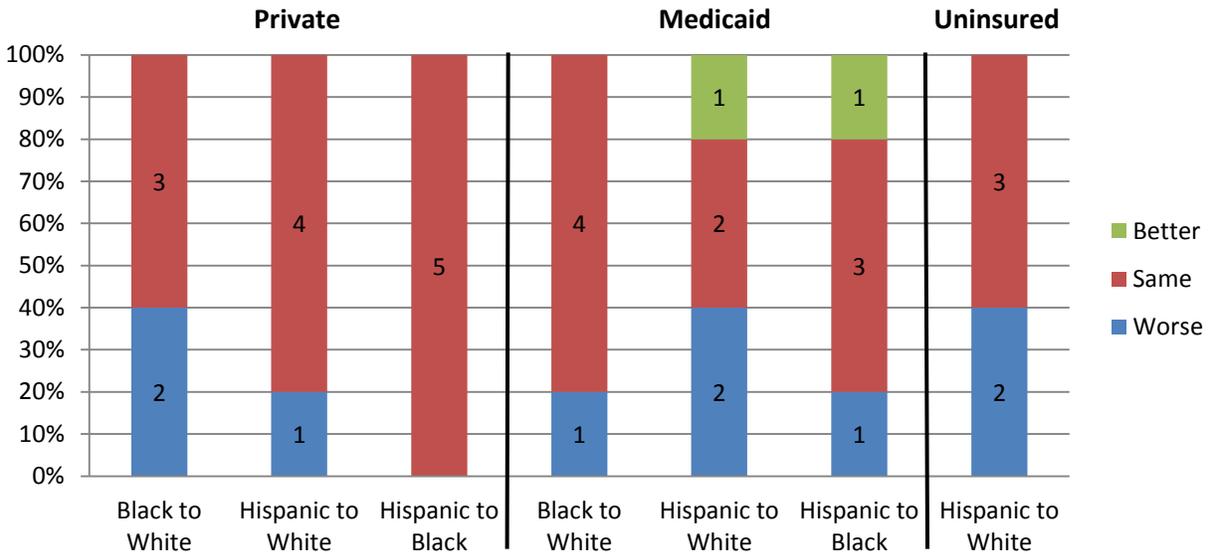
- Black and Hispanic adults with Medicaid fared better compared to Whites with Medicaid than did Blacks and Hispanics with private insurance compared to Whites with private insurance.
- There were somewhat more racial and ethnic disparities in access to care among adults with private insurance than among uninsured adults.

Figure H.11. Racial and ethnic disparities in quality of care among children, stratified by insurance status



- Among Blacks and Hispanics, children with private insurance fared worse than Whites on more quality measures than their counterparts with Medicaid.
- Hispanic children experienced worse quality of care than Whites across all insurance groups.

Figure H.12. Racial and ethnic disparities in access to care among children, stratified by insurance status

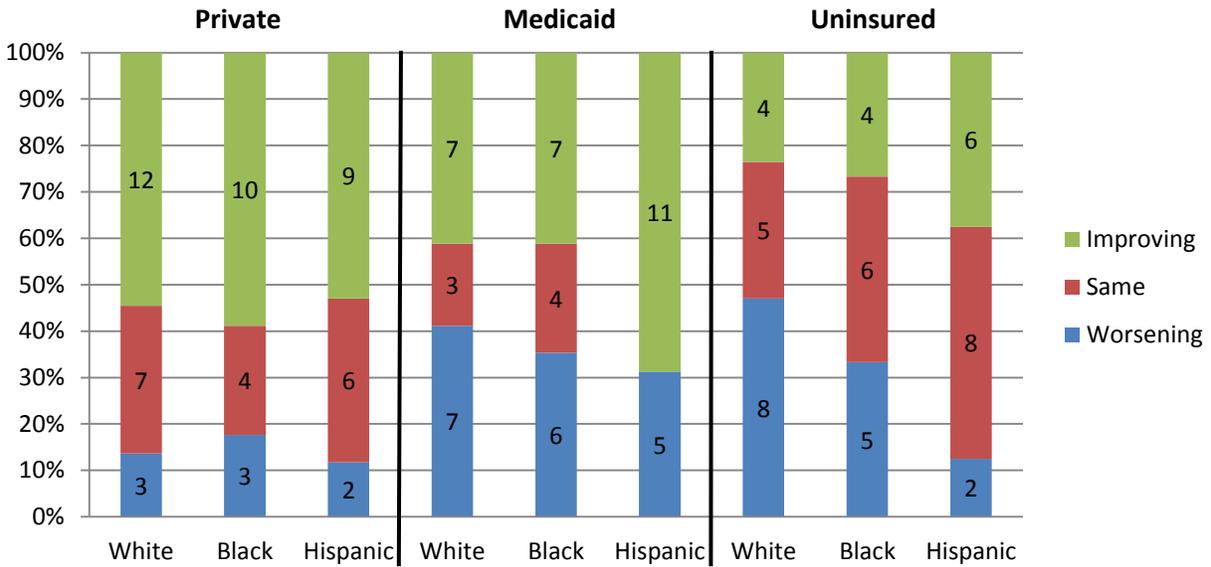


- Hispanic children with private insurance experienced worse access to care than privately insured White children for fewer measures than their counterparts with Medicaid or without insurance.
- Hispanic children experienced worse access to care than Whites across all insurance groups.

Changes in Racial and Ethnic Disparities for People With Different Insurance

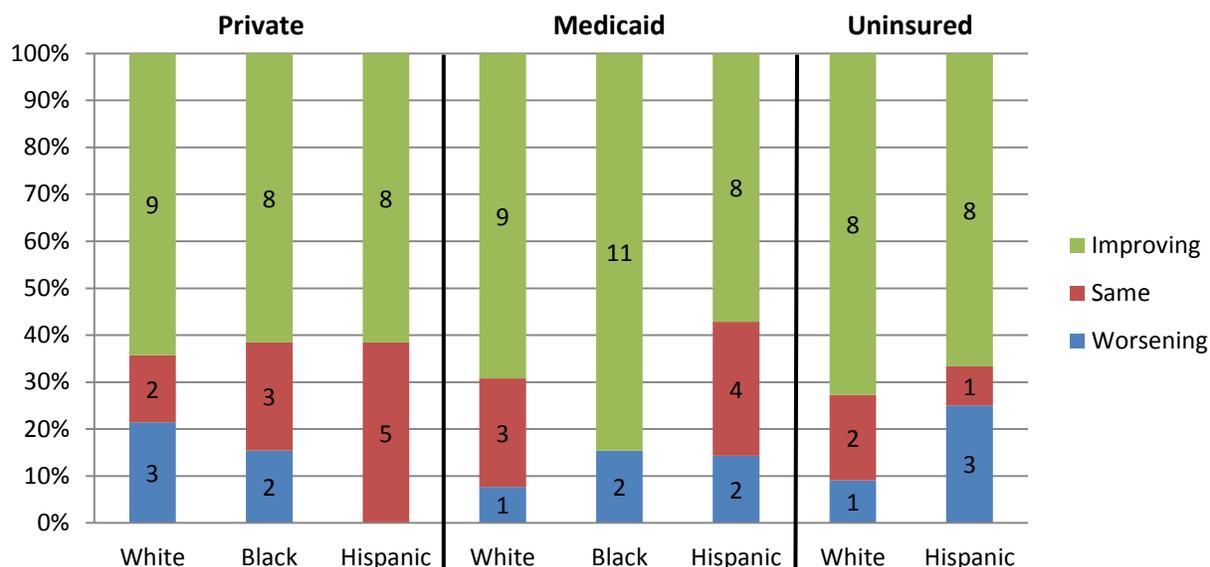
The Coverage Analyses Trends Report examines trends over time, generally between 2000 and 2008 (depending on the measure; see Appendix 1), to see whether quality of and access to health care is improving, staying the same, or worsening based on race/ethnicity among people with different insurance.

Figure H.13. Change in quality of and access to care over time for adults, by race and ethnicity, stratified by insurance status



- Among privately insured adults, Whites, Blacks, and Hispanics experienced similar patterns of improvement in quality and access measures.
- Irrespective of insurance, Hispanic adults saw a worsening in the access measure of people under 65 without a usual source of care.
- Whites and Blacks who were uninsured fared worse than their counterparts with private insurance or Medicaid.

Figure H.14. Change in quality of and access to care over time for children, by race and ethnicity, stratified by insurance status

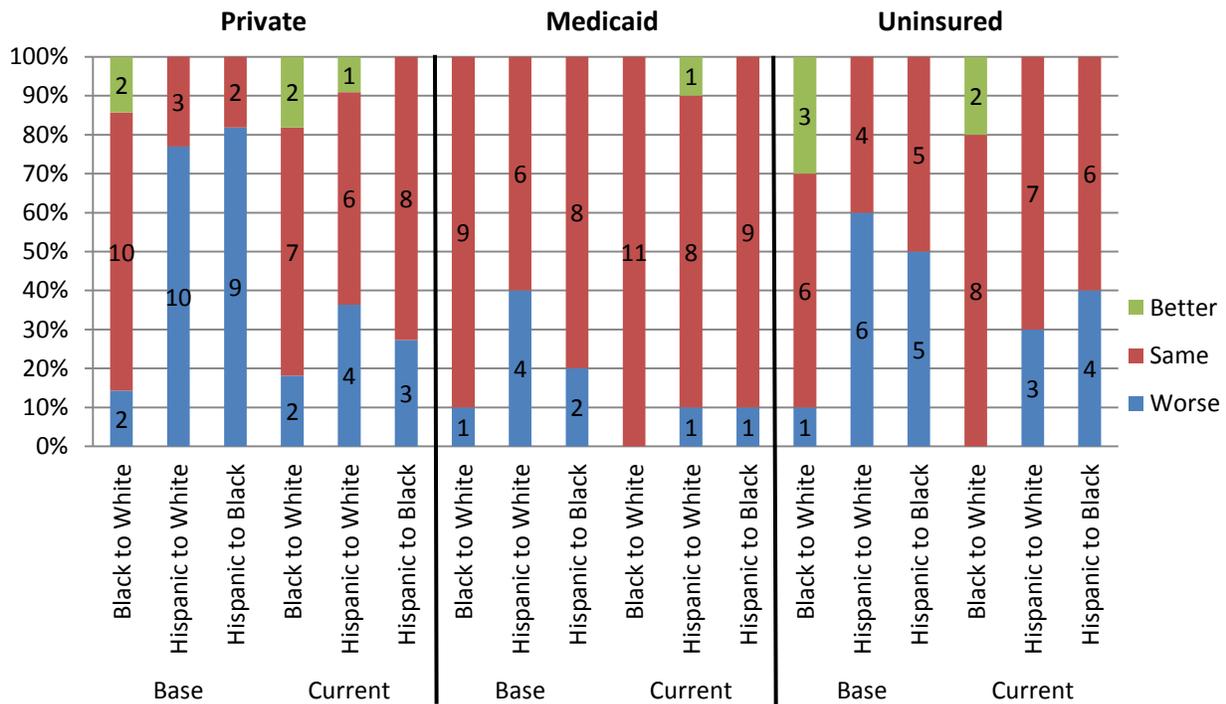


- Fewer quality and access measures worsened for children than for adults.
- Among privately insured Hispanic children, disparities stayed the same or improved for all measures.
- Irrespective of race/ethnicity, children with Medicaid and uninsured children experienced worsening in *access to care* measures only.
- There was no one measure in common that worsened for all children within a given insurance group.

Changes in Racial and Ethnic Disparities Over Time

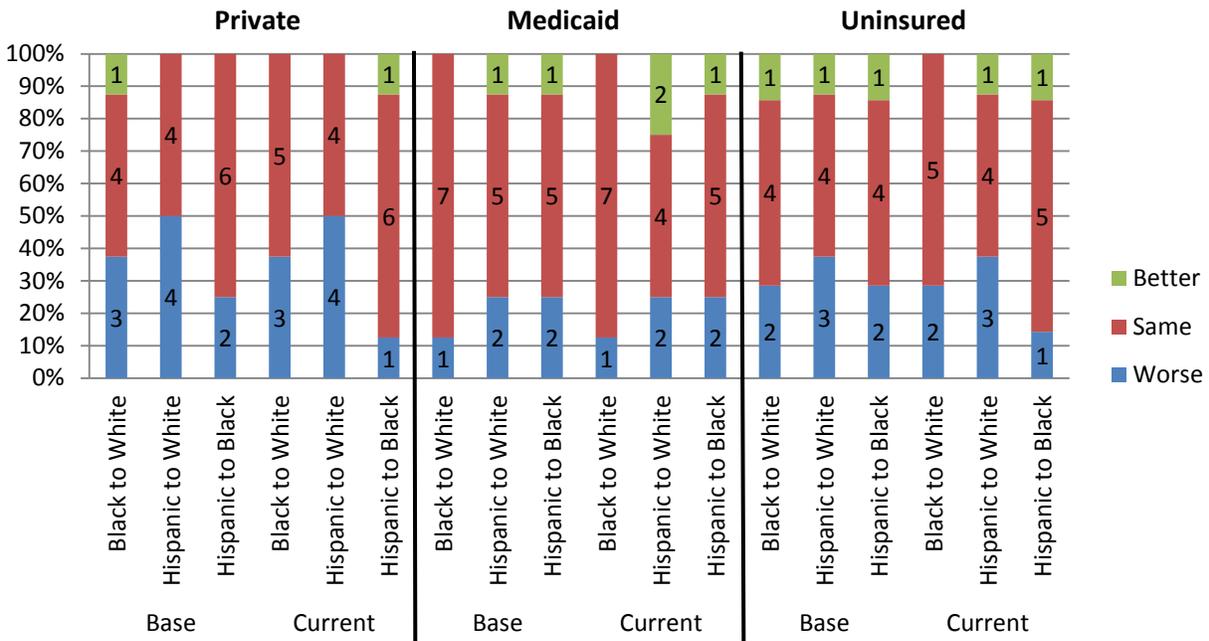
In the previous section we presented data from the most recent time period showing that adults and children received different quality of and access to health care depending on their race and ethnicity. Here we compare the number of measures for which racial and ethnic disparities existed in the base time period with the most recent period to explore whether the number of measures with disparities changed over time. The exact time period, generally between 2000 and 2008, depends on the data available for each measure. (See Appendix 1.)

Figure H.15. Comparison of base and most recent periods in quality of care disparities among adults, by race/ethnicity and insurance status



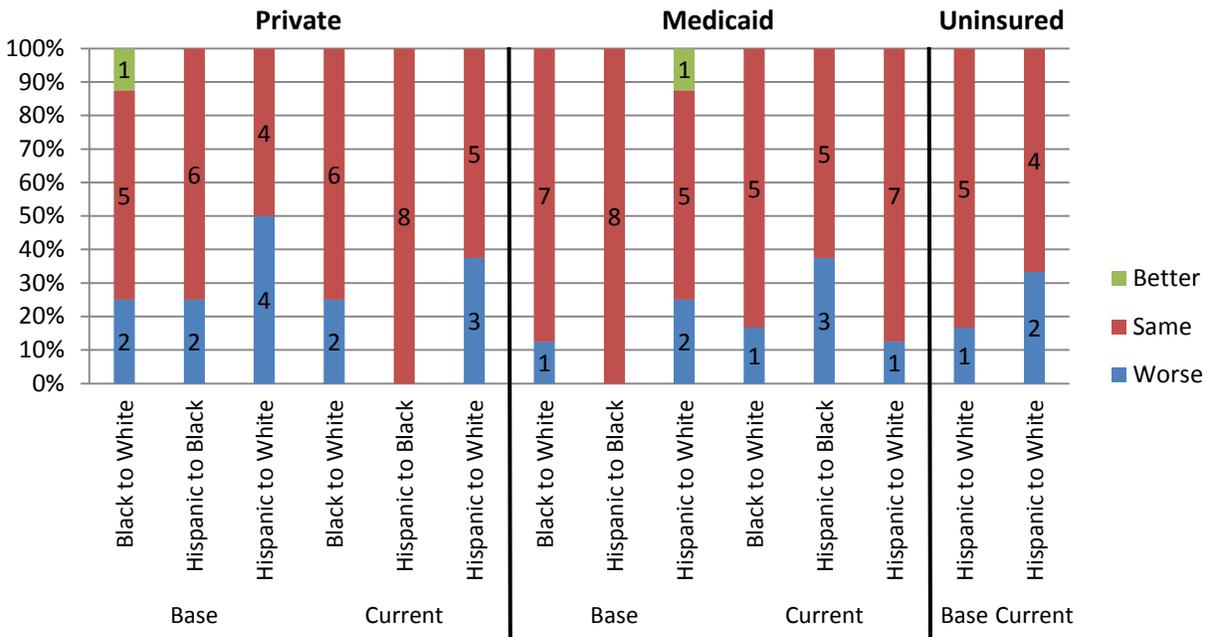
- Among all adults, the percentage of quality of care measures exhibiting disparities decreased over time for nearly every racial and ethnic group. This decline was most notable when comparing Hispanics and Whites and Hispanics and Blacks with private insurance, Hispanics and Whites with Medicaid, and uninsured Blacks and Whites and Hispanics and Whites.
- Except for Hispanics with Medicaid compared to their White counterparts in the current period, Hispanic adults experienced worse quality of care compared to Whites and Blacks.

Figure H.16. Comparison of base and most recent periods in access to care disparities among adults, by race/ethnicity and insurance status



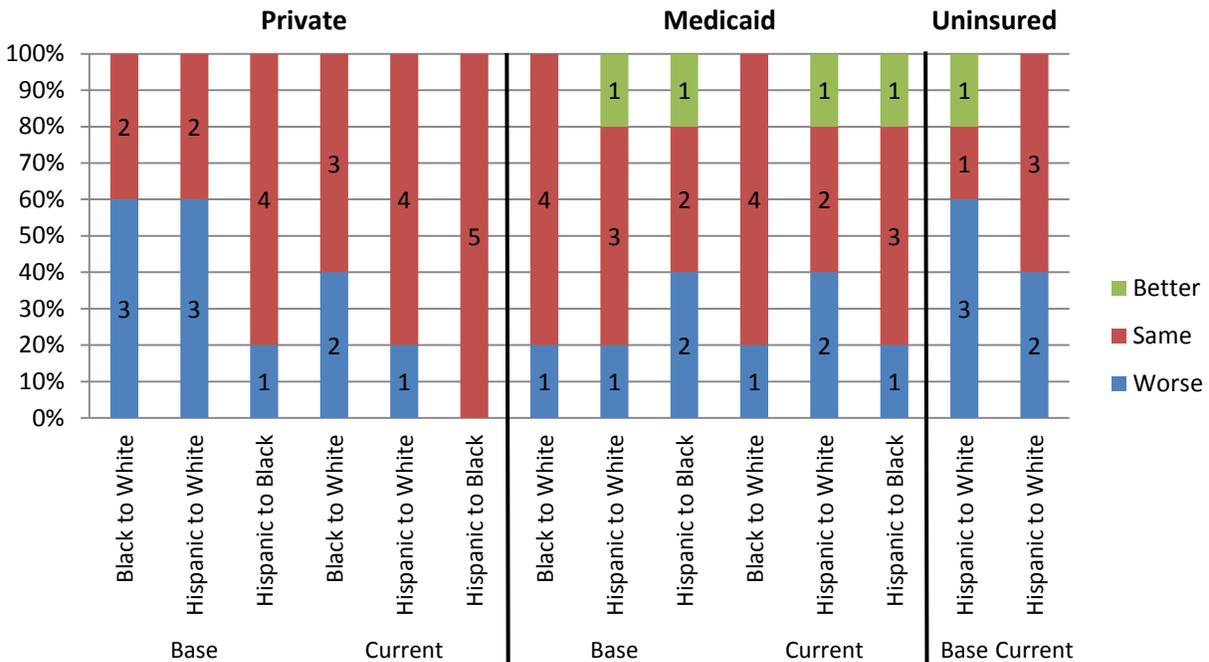
- Among adults, there was little change in the patterns of access to care disparities by race and ethnicity within each insurance category. In both periods, Whites had better access to care than Blacks, who had better access to care than Hispanics.
- In both periods, Black and Hispanic adults with Medicaid had fewer disparities in access to care relative to Whites compared to their privately insured or uninsured counterparts.

Figure H.17. Comparison of base and most recent periods in quality of care disparities among children, by race/ethnicity and insurance status



- Among children with private insurance, racial and ethnic disparities in quality of care stayed the same or decreased slightly between the base and current periods.
- While there were no disparities between Hispanic and Black children with Medicaid in the base period, Hispanic children experienced worse quality of care than Black children for several measures in the current period. Quality of care also decreased for uninsured Hispanic children relative to their White counterparts.

Figure H.18. Comparison of base and most recent periods in access to care disparities among children, by race/ethnicity and insurance status

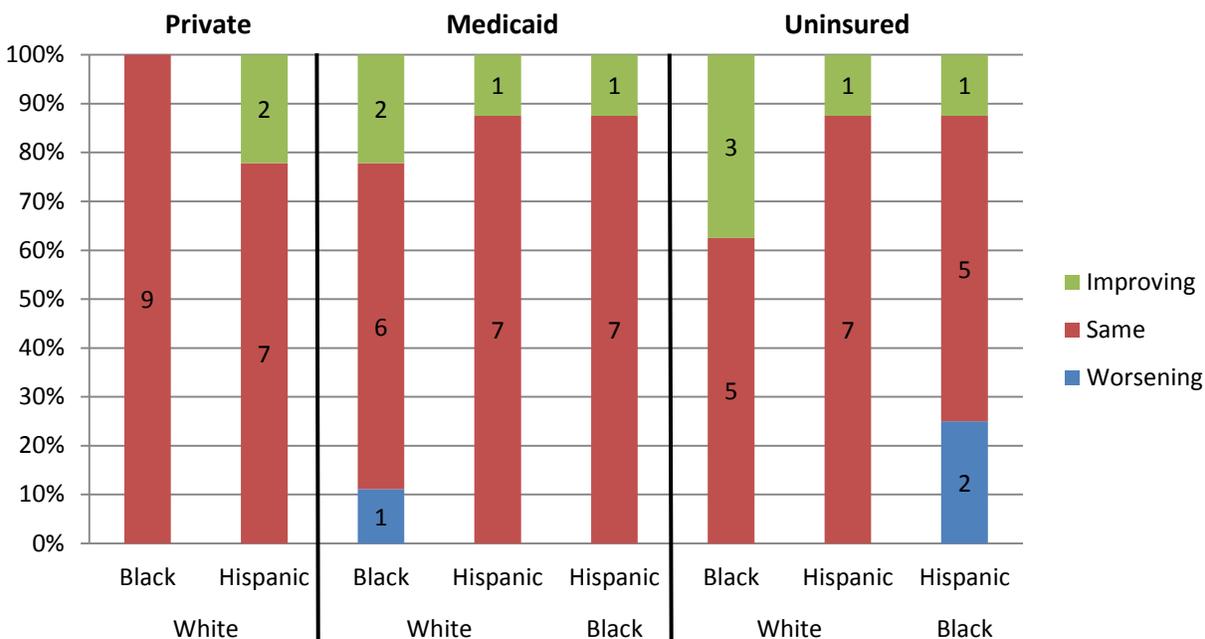


- Disparities in access to care decreased over time among children with private insurance.
- Comparing Hispanic children to White children, only those with Medicaid experienced an increase in access to care disparities over time.

Changes in Disparity Gaps

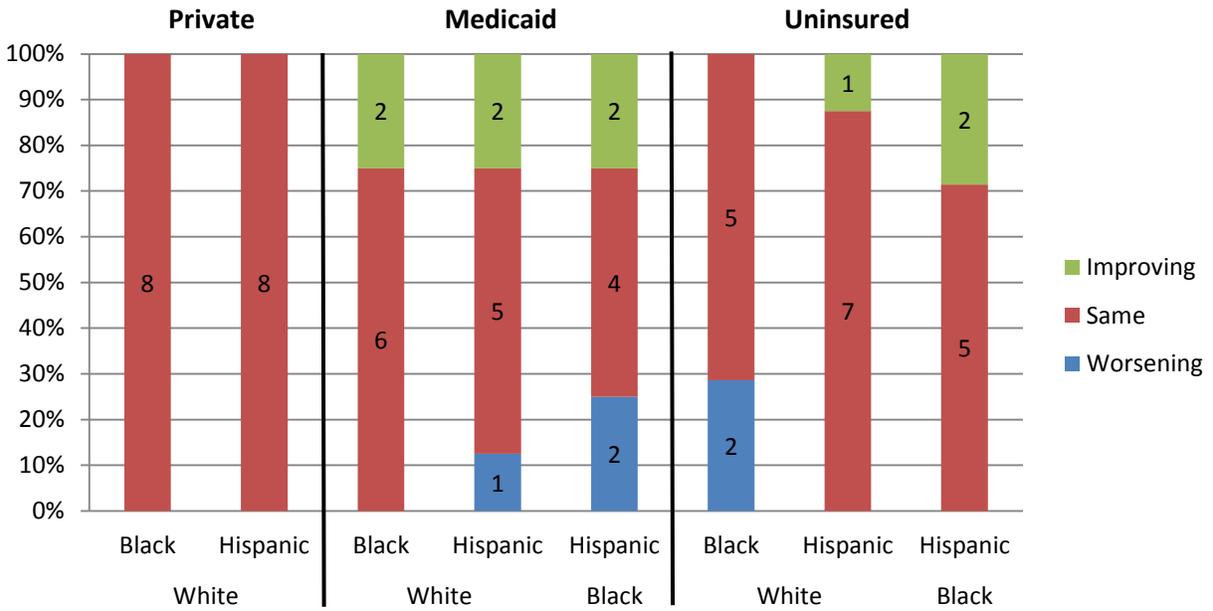
We looked across quality of care and access to care measures to see whether, for the measures for which there were racial and ethnic disparities in the most recent time period, the gaps had gotten smaller, stayed the same, or gotten larger over time. The exact time period, generally between 2000 and 2008, depends on the data available for each measure. (See Appendix 1.)

Figure H.19. Change in quality of care gaps among adults, by race/ethnicity and insurance status



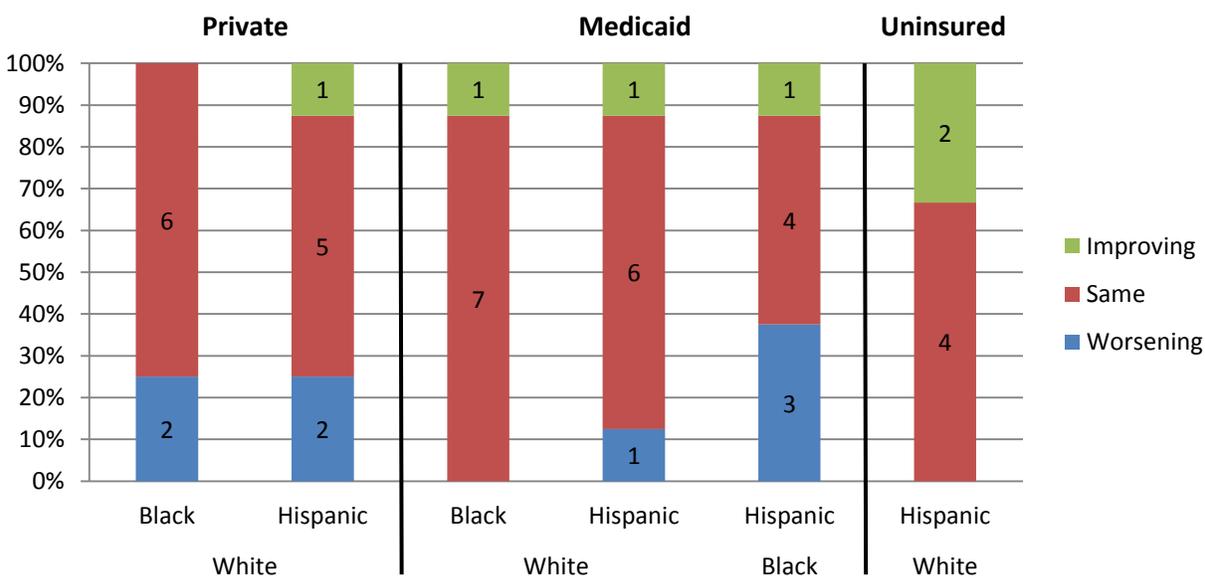
- Among adults with private insurance, the size of quality gaps remained the same (Blacks compared to Whites) or improved (Hispanics compared to Whites).
- For adults with Medicaid, the size of quality gaps between Blacks and Whites worsened on a single quality measure and improved on two quality measures. The size of gaps between Hispanics with Medicaid and their White and Black counterparts stayed the same or improved.
- Among uninsured adults, the size of quality gaps between Blacks and Whites and Hispanics and Whites improved or stayed the same. The size of the quality gap between uninsured Hispanic adults and uninsured Black adults worsened for two measures but improved on a single measure—adults ages 18-64 who had a doctor’s office or clinic visit in the last 12 months whose health providers sometimes or never listened carefully, explained things clearly, respected what they had to say, and spent enough time with them.

Figure H.20. Change in access to care gaps among adults, by race/ethnicity and insurance status



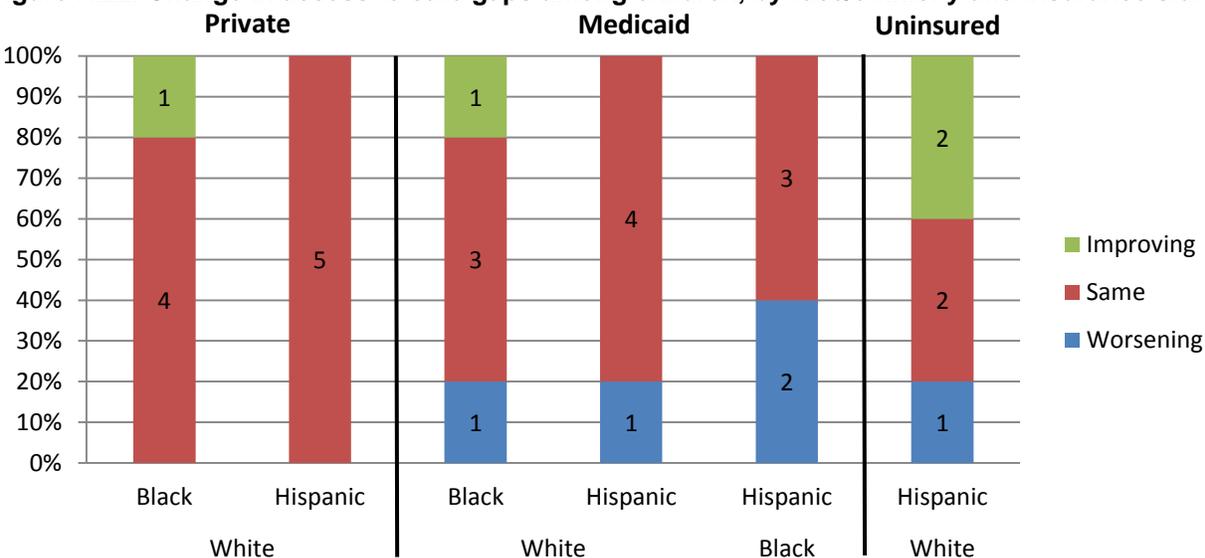
- Among adults with private insurance, the size of racial and ethnic disparity gaps in access to care remained the same for all measures.
- The size of access disparity gaps stayed the same or improved for uninsured Hispanic adults compared to uninsured Whites and Blacks.
- There was more change in the size of access to care disparity gaps—both worsening and improving—for adults with Medicaid than for those with private insurance.

Figure H.21. Change in quality of care gaps among children, by race/ethnicity and insurance status



- The size of quality disparity gaps remained the same or worsened for children with private insurance. For Hispanics, one measure improved—people under age 65 with a usual source of care for whom health providers explained and provided all treatment options.
- Gaps remained the same or improved for Black children with Medicaid and Hispanic uninsured children compared to their White counterparts.

Figure H.22. Change in access to care gaps among children, by race/ethnicity and insurance status



- Among children with private insurance, the size of racial and ethnic disparity gaps in access to care remained the same or improved for all measures.
- There was more change in the size of access to care disparity gaps—both worsening and improving—for children with Medicaid than for those with private insurance.

Appendix 1. Measures Used in Insurance Coverage Analyses

Measure ID	Data Source	Measure Title	Preferred Outcome*	Care Type	Dimension	Base Year	Current Year
10101	NHIS	Women ages 40-64 who received a mammogram in the last 2 years	1	Prevention	Quality of care	2000	2008
10201	NHIS	Women ages 18-64 who received a Pap smear in the last 3 years	1	Prevention	Quality of care	2000	2008
10301	NHIS	Composite measure: Adults ages 50-64 who received colorectal cancer screening (colonoscopy, sigmoidoscopy, proctoscopy, or (in the last 2 years) fecal occult blood test)	1	Prevention	Quality of care	2000	2008
20101	MEPS	Composite measure: Adults ages 40-64 with diagnosed diabetes who received all three recommended services for diabetes in the calendar year (hemoglobin A1c measurement, dilated eye examination, and foot examination)	1	Chronic care	Quality of care	2002	2007
20102	MEPS	Adults ages 40-64 with diagnosed diabetes who received a hemoglobin A1c measurement in the calendar year	1	Chronic care	Quality of care	2002	2007
20103	MEPS	Adults ages 40-64 with diagnosed diabetes who received a dilated eye examination in the calendar year	1	Chronic care	Quality of care	2002, 2006 [†]	2007

* 1 = higher rates are better; -1 = lower rates are better.

† Two base years are shown because measures were reported differently for different insurance groups.

Measure ID	Data Source	Measure Title	Preferred Outcome*	Care Type	Dimension	Base Year	Current Year
20104	MEPS	Adults ages 40-64 with diagnosed diabetes who had their feet checked for sores or irritation in the calendar year	1	Chronic care	Quality of care	2002	2007
20105	MEPS	Adults ages 40-64 with diagnosed diabetes who received an influenza vaccination in the last 12 months	1	Chronic care	Quality of care	2002, 2006 [†]	2007
40101	NHIS	Adults ages 18-64 who received a blood pressure measurement in the last 2 years and can state whether their blood pressure was normal or high	1	Prevention	Quality of care	2003	2008
40103	NHIS	Adults ages 18-64 who received a blood cholesterol measurement in the last 5 years	1	Prevention	Quality of care	2003	2008
60304	NIS	Children ages 19-35 months who received 1 dose of measles-mumps-rubella vaccine	1	Prevention	Quality of care	2001	2008
60306	NIS	Children ages 19-35 months who received 3 doses of hepatitis B vaccine	1	Prevention	Quality of care	2001	2008
60402	MEPS	Children ages 2-17 who had a dental visit in the calendar year	1	Prevention	Quality of care	2002	2007
60405	MEPS	Children ages 2-17 for whom a health provider ever gave advice about the amount and kind of exercise, sports, or physically active hobbies they should have	1	Prevention	Quality of care	2002	2007
60406	MEPS	Children ages 2-17 for whom a health provider ever gave advice about healthy eating	1	Prevention	Quality of care	2002	2007

Measure ID	Data Source	Measure Title	Preferred Outcome*	Care Type	Dimension	Base Year	Current Year
60407	MEPS	Children ages 3-6 who ever had their vision checked by a health provider	1	Prevention	Quality of care	2002	2007
60409	MEPS	Children 0-40 lb for whom a health provider ever gave advice about using child safety seats when riding in a car	1	Prevention	Quality of care	2002	2007
60412	MEPS	Children ages 2-17 for whom a health provider ever gave advice about using a helmet when riding a bicycle or motorcycle	1	Prevention	Quality of care	2002	2007
90101	MEPS	Adult current smokers ages 18-64 with a checkup in the last 12 months who received advice to quit smoking	1	Prevention	Quality of care	2002	2007
90103	MEPS	Adults ages 18-64 with obesity who ever received advice from a health provider to exercise more	1	Prevention	Quality of care	2002	2007
90104	MEPS	Adults ages 18-64 with obesity who ever received advice from a health provider about eating fewer high-fat or high-cholesterol foods	1	Prevention	Quality of care	2002	2007
140101	MEPS	Composite measure: Adults ages 18-64 who had a doctor's office or clinic visit in the last 12 months whose health providers sometimes or never listened carefully, explained things clearly, respected what they had to say, and spent enough time with them	-1	Prevention	Quality of care	2002	2007

Measure ID	Data Source	Measure Title	Preferred Outcome*	Care Type	Dimension	Base Year	Current Year
140114	MEPS	People under age 65 with a usual source of care whose health providers sometimes or never asked for the person's help to make treatment decisions	-1	Prevention	Quality of care	2002	2007
140115	MEPS	People under age 65 with a usual source of care for whom health providers explained and provided all treatment options	1	Prevention	Quality of care	2002	2007
160302	MEPS	People under age 65 without a usual source of care	-1		Access to care	2002	2007
160303	MEPS	People under age 65 with a usual primary care provider	1		Access to care	2002	2007
160306	MEPS	Composite: People under age 65 unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons	-1		Access to care	2002	2007
160405	MEPS	People under age 65 with a usual source of care, excluding hospital emergency rooms, who has office hours nights or weekends	1		Access to care	2002	2007
160406	MEPS	People under age 65 with difficulty contacting their usual source of care over the telephone	-1		Access to care	2002	2007
160407	MEPS	Adults ages 18-64 who did not have problems seeing a specialist they needed to see in the last 12 months	1		Access to care	2002	2007

Measure ID	Data Source	Measure Title	Preferred Outcome*	Care Type	Dimension	Base Year	Current Year
170104	MEPS	People under age 65 who had a hospital emergency room visit in the calendar year	-1		Access to care	2002	2007
170106	MEPS	People under age 65 with physician office and hospital outpatient department visits	1		Access to care	2002	2007

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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 National Healthcare Quality and Disparities Reports: 2000-2008 Trends (Coverage Analyses Trends Report) presents changes over time for quality and racial and ethnic disparity measures by insurance status. Using data submitted for the NHQR and NHDR, the Coverage Analyses Trends Report examines how, over time, the health care experiences of individuals with public insurance, primarily Medicaid, compare with individuals with private insurance and individuals with no insurance. The report also examines racial and ethnic disparities across and within insurance groups.

The Coverage Analyses Trends Report supports a broad number of HHS Secretary Kathleen Sebelius' 2010-2015 Strategic Plan objectives,¹ most specifically:

- Eliminate health disparities;
- Promote prevention and wellness;
- Promote high-value, safe, and effective health care;
- Secure and expand health insurance coverage;
- Accelerate the progress of scientific discovery to improve patient care; and
- Promote program integrity, accountability, and transparency.

The Coverage Analyses Trends Report also supports the Centers for Medicare & Medicaid Services' Center for Medicaid and CHIP Services. State Medicaid and CHIP agencies make their own decisions regarding which measures to collect and, within broad Federal guidelines, which services to cover.

The Coverage Analyses Trends Report is also aligned with the HHS *Action Plan To Reduce Racial and Ethnic Health Disparities* (Disparities Action Plan).² The Disparities Action Plan discusses goals and actions HHS will take to reduce racial and ethnic health disparities. The measures included in this report are matched with the Disparities Action Plan priorities.

Pursuant to the provisions of the Patient Protection and Affordable Care Act of 2010, the Secretary of HHS submitted a report to Congress in 2011 titled *National Strategy for Quality Improvement in Health Care* (National Quality Strategy).³ This report sets priorities to advance three quality improvement aims: better care, healthy people, and affordable care. Six priority areas were identified as a way to achieve the quality improvement aims:

- Making sure care is safer by reducing harm in the delivery of care.
- Ensuring that each person and his or her family members are engaged as partners in their care.
- Promoting effective communication and coordination of care.

Coverage Analyses Trends Report

- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable healthy living.
- Making quality care more affordable for individuals, families, employers, and governments, by developing and spreading new health care delivery models.

The Coverage Analyses Trends Report aligns measures to the National Quality Strategy in an effort to inform policymakers, the public, and other stakeholders of the Nation’s progress in achieving National Quality Strategy aims. Table 1.1 below provides a crosswalk between the National Quality Strategy priorities and the Coverage Analyses Trends Report chapters.

Table 1.1. Relationship of Coverage Analyses Trends to the National Quality Strategy

National Quality Strategy Priorities	Coverage Analyses Trends Chapter
Making care safer by reducing harm in the delivery of care	None
Ensuring that each person and his or her family members are engaged as partners in their care	Chapters 2 & 4 : Quality of Ambulatory Health Care, Patient Centeredness (Adults) Chapters 6 & 8: Quality of Ambulatory Care, Patient Centeredness (Children)
Promoting effective communication and coordination of care	Chapters 2 & 4 : Quality of Ambulatory Health Care, Patient Centeredness (Adults) Chapters 6 & 8: Quality of Ambulatory Care, Patient Centeredness (Children)
Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease	Chapters 2 & 4 : Quality of Ambulatory Health Care, Effectiveness, Heart Disease (Adults)
Working with communities to promote wide use of best practices to enable healthy living	Chapters 2 & 4 : Quality of Ambulatory Health Care, Effectiveness, Heart Disease (Adults) Chapters 6 & 8: Quality of Ambulatory Health Care, Prevention: Advice on Healthy Eating and Physical Activity (Children)
Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models	Chapters 3 & 5: Access to Health Care (Adults) Chapters 7 & 9: Access to Health Care (Children)

How This Report Is Organized

The Coverage Analyses Trends Report follows the structure of the NHQR and 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.
- **Part I: Adult Health** presents information on disparities among adults ages 18-64.

- **Chapter 2: Insurance Disparities in Quality of Ambulatory Health Care** examines insurance (payer) disparities in quality of health care over time. Sections cover two components of health care quality: effectiveness and patient centeredness.
- **Chapter 3: Insurance Disparities in Access to Health Care** examines insurance (payer) disparities in quality of health care over time. Sections cover two components of health care access: barriers and facilitators to health care and health care utilization.
- **Chapter 4: Racial and Ethnic Disparities in Quality of Ambulatory Health Care** examines racial and ethnic disparities, including disparities among those with the same insurance status, in quality of health care over time. Sections cover two components of health care quality: effectiveness and patient centeredness.
- **Chapter 5: Racial and Ethnic Disparities in Access to Health Care** examines racial and ethnic disparities, including disparities among those with the same insurance status, in quality of health care over time. Sections cover two components of health care access: barriers and facilitators to health care and health care utilization.
- **Part II: Child Health** presents information on children ages 0-17.
 - **Chapter 6: Insurance Disparities in Quality of Ambulatory Health Care** examines insurance (payer) disparities in quality of health care over time. Sections cover two components of health care quality: effectiveness and patient centeredness.
 - **Chapter 7: Insurance Disparities in Access to Health Care** examines insurance (payer) disparities in quality of health care over time. Sections cover two components of health care access: barriers and facilitators to health care and health care utilization.
 - **Chapter 8: Racial and Ethnic Disparities in Quality of Ambulatory Health Care** examines racial and ethnic disparities, including disparities among those with the same insurance status, in quality of health care over time. Sections cover two components of health care quality: effectiveness and patient centeredness.
 - **Chapter 9: Racial and Ethnic Disparities in Access to Health Care** examines racial and ethnic disparities, including disparities among those with the same insurance status, in quality of health care over time. Sections cover two components of health care access: barriers and facilitators to health care and health care utilization.

Population Analyzed

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

To approximate the Medicaid population, the Coverage Analyses Trends Report includes data on publicly insured individuals under age 65 only. This group excludes most of the individuals in

the public insurance category who have Medicare only. The Coverage Analyses Trends Report's public insurance data do contain some individuals under age 65 who have Medicare only, but sensitivity analyses revealed that inclusion of these individuals does not significantly change the measures.

In addition to Medicaid and Medicare beneficiaries, the Coverage Analyses Trends Report's public insurance data contain children enrolled in the Children's Health Insurance Program (CHIP), 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). The Coverage Analyses Trends Report categorizes individuals ages 18-21 as adults, while they are categorized as children by Medicaid eligibility criteria. Data on the uninsured population were not available for all measures.

Selection of Measures

Measures for the Coverage Analyses Trends Report 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. In some measures where data were not sufficient for all years, changes over time could not be determined.

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 the Coverage Analyses Trends Report that appeared only in the Data Tables appendix of the NHQR and NHDR.

Unlike the NHQR and NHDR, the Coverage Analyses Trends Report includes only 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 opportunity for Medicaid-driven quality improvement.

All measures included in the Coverage Analyses Trends Report come from self-reported household data provided by an adult. Thus, all data on children are reported by an adult household member.

Categorization

The Coverage Analyses Trends Report 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 uninsured category includes only individuals who were uninsured all year. The public insurance category includes individuals who had public coverage at least part of the year and did not have any private coverage.
- All races of Hispanic individuals are included in the Hispanic category. The White and Black categories include only non-Hispanic individuals.

Analyses

The Coverage Analyses Trends Report 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, these measures do reflect the true experiences of the population that, regardless of cause, are important to consider.

Size of Disparities Across Groups

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 two criteria:

1. The difference between two groups met the standard two-tailed test of statistical significance; there is no more than a 1 in 20 chance that any reported disparities are due to chance; and
2. The relative difference between the comparison group and reference group must be at least 10%.

Annual Rate of Change and Trend Analyses

For all measures for which reliable trend data are available, analyses are conducted to assess the annual rate of change. The Coverage Analyses Trends Report uses regression analysis to estimate average annual rate of change. Regression models were specified as follows:

$$\ln(M) = \beta_0 + \beta_1(Y), \text{ where } \ln(M) = \text{natural logarithm of the value of the measure (M),}$$
$$\beta_0 = \text{intercept or constant, and}$$
$$\beta_1(Y) = \text{coefficient corresponding to year (Y)}$$

Using regression results, the average annual rate of change was calculated as $100 \times (\exp(\beta_1) - 1)$.

Data in the Coverage Analyses Trends Report are unavailable at the person level, and aggregated estimates are used throughout the analyses. The regression-estimated annual rate of change was reported only when at least three data points—or 3 years of aggregated data—were available for a measure. To conclude that a measure was improving or getting worse, the average annual rate of change must be at least 1% per year.

Average annual change was estimated for reference and comparison groups to ascertain the extent to which disparities were increasing, decreasing, or remaining the same over time. Calculation of change in disparities was conducted in a manner similar to that described above, except that a linear regression was used to estimate annual change for each insurance and racial/ethnic subgroup.

Change in disparities was estimated as the difference in the average annual change between the comparison and reference groups. Measures for which the difference between groups was >1 indicate that the disparity is getting larger whereas differences < -1 indicate that the disparity is

getting smaller. Values between -1 and 1 suggest that group differences have not changed over time.

Due to methodological changes over time, changes in data used to construct measures across years, and changes to the measure set, it is not appropriate to compare the annual change or rates of change for measure groups discussed in this report with those from the 2006 Coverage Analyses report.⁴

Measuring Disparities

The Coverage Analyses Trends Report examines disparities of only one of the priority populations covered in the NHQR and 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 because racial and ethnic data by insurance were not always available. In addition, racial and ethnic data were not reported when there was no statistically significant variation across or within payers.

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Part I: Adult Health

Insurance Disparities

Chapter 2: Quality of Ambulatory Health Care

The Coverage Analyses Trends Report examined insurance disparities for each measure. Unless otherwise noted, these measures evaluated adults ages 18-64.

Effectiveness

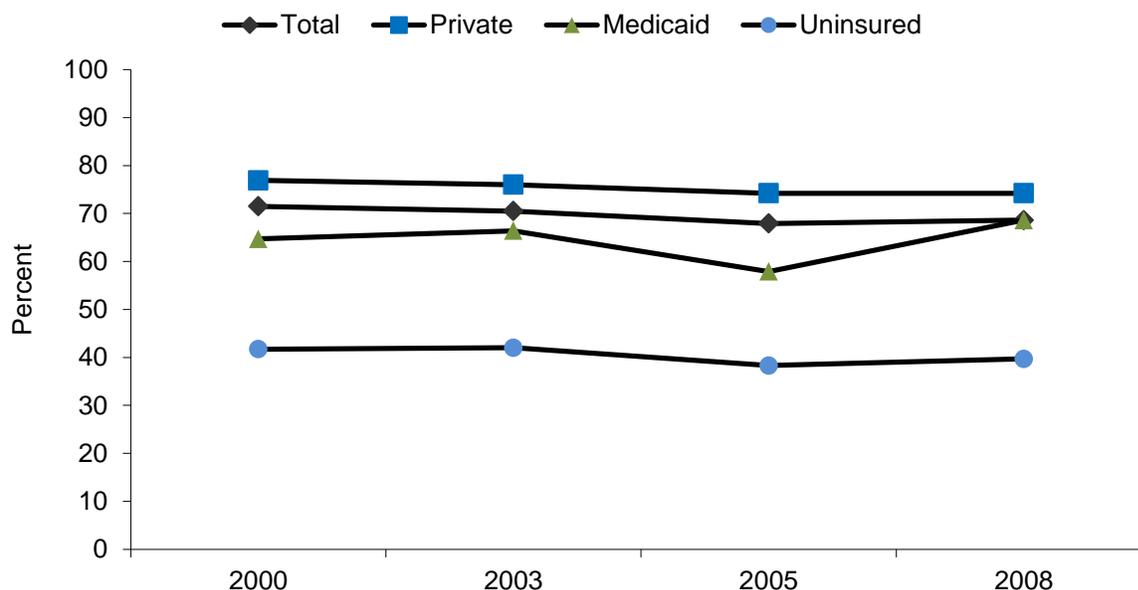
Cancer

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

Early detection of cancer increases treatment options and often improves outcomes. Mammography, the most effective method for detecting breast cancer at its early stages, can identify malignancies before they can be felt and before symptoms develop. For available data years, the U.S. Preventive Services Task Force recommended mammograms every 1 to 2 years for women age 40 and over.

Figure 2.1. Women ages 40-64 who received a mammogram in the last 2 years, by insurance status, 2000-2008



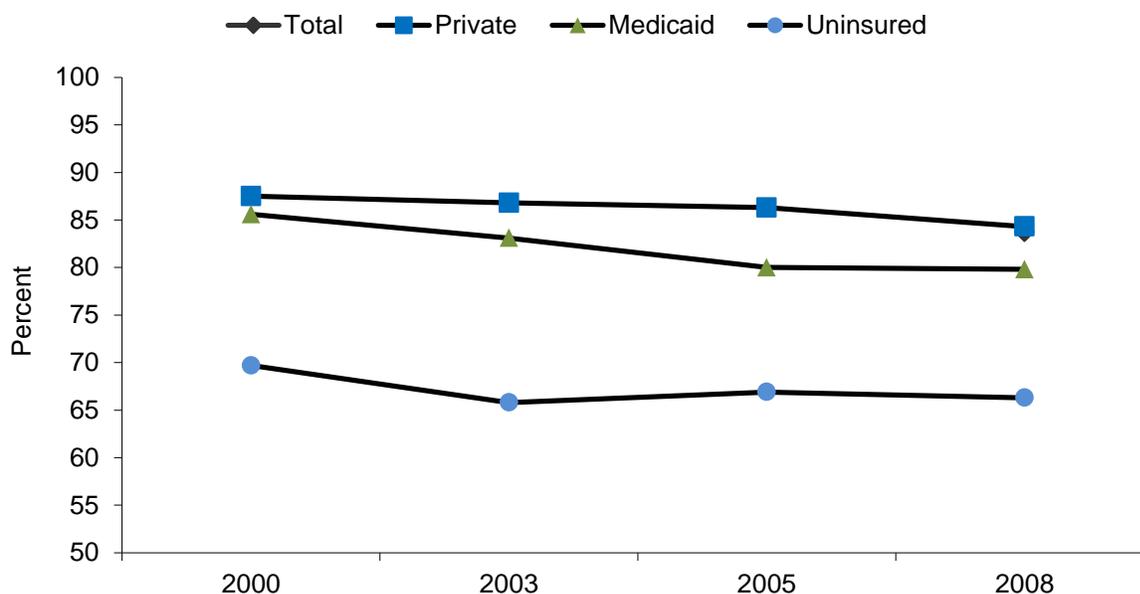
Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2000-2008.

- From 2000 to 2008, the percentage of women ages 40-64 who received a mammogram decreased for women with private insurance, but the percentage was constant for women with Medicaid or no insurance.
- From 2000 to 2008, the percentage of uninsured women ages 40-64 who received a mammogram was significantly lower than the percentage of women with either Medicaid or private insurance who received a mammogram.

Prevention: Pap Smears

The U.S. Preventive 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 strongly recommends that women under age 65 have Pap smears at least every 3 years.

Figure 2.2. Women ages 18-64 who received a Pap smear in the previous 3 years, by insurance status, 2000-2008



Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2000-2008.

Note: Data estimates for the total from 2000 to 2005 are not available.

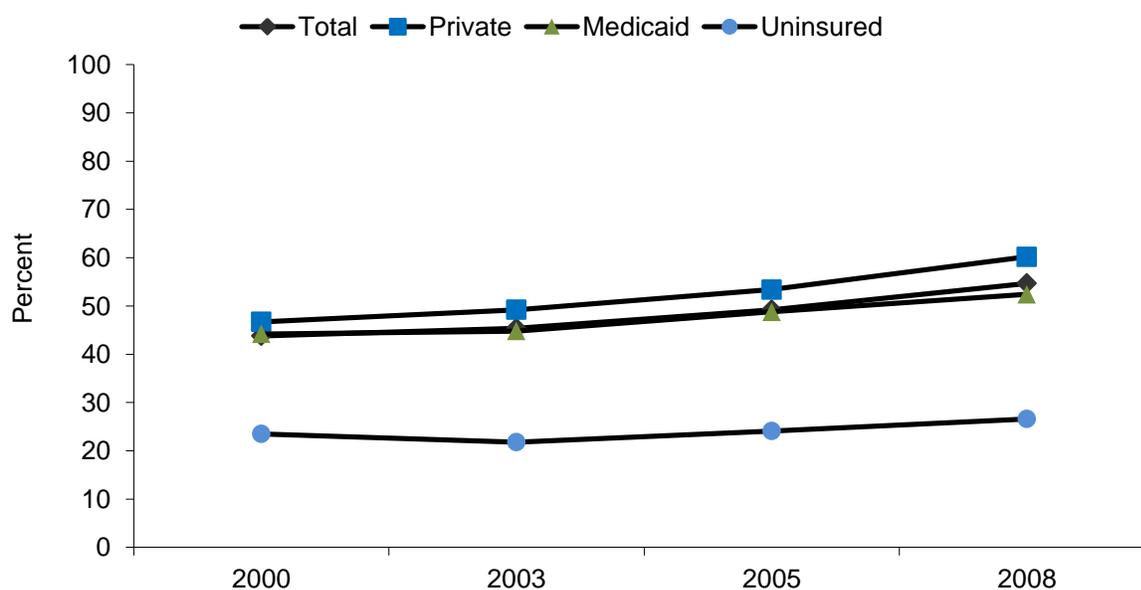
- From 2000 to 2008, the percentage of women who received a Pap smear decreased for all insurance groups.
- From 2000 to 2008, uninsured women ages were least likely and women with private insurance were most likely to receive a Pap smear in the previous 3 years. There was no statistically significant difference between women with Medicaid and women with private insurance in 2000.

Prevention: Screening for Colon Cancer

Colorectal cancer is the third most common cancer in adults. Prevention of colorectal cancer includes modifying risk factors such as weight, physical activity, smoking, and alcohol use, as well as screening for early disease. Screening is important because early stages of colorectal cancer may not present any symptoms, and screening can detect abnormal growths before they develop into cancer.^{1,2} Early detection increases treatment options and the chances for survival.

The U.S. Preventive Services Task Force recommends colorectal cancer screening for men and women age 50 and over. The screening tests for colorectal cancer measured in this report include having a fecal occult blood test in the past 2 years or ever having a colonoscopy, flexible sigmoidoscopy, or proctoscopy.

Figure 2.3. Adults ages 50-64 who reported receiving colorectal cancer screening (received fecal occult blood test in past 2 years or ever received colonoscopy, sigmoidoscopy, or proctoscopy), by insurance status, 2000-2008



Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2000-2008.

- From 2000 to 2008, the percentage of adults ages 50-64 who received colorectal cancer screening increased for adults with Medicaid and adults with private insurance but remained constant for uninsured adults.
- Uninsured adults were less likely to receive colorectal cancer screening than insured adults. The gap between uninsured adults and adults with private insurance ages 50-64 who received colorectal cancer screening increased over time. However, the gap between uninsured adults and adults with Medicaid remained the same over time.
- In 2000, there were no statistically significant differences between adults with private insurance and adults with Medicaid in the percentage ages 50-64 who received colorectal cancer screening. However, in 2008, adults with Medicaid were less likely to receive colorectal cancer screening than adults with private insurance.

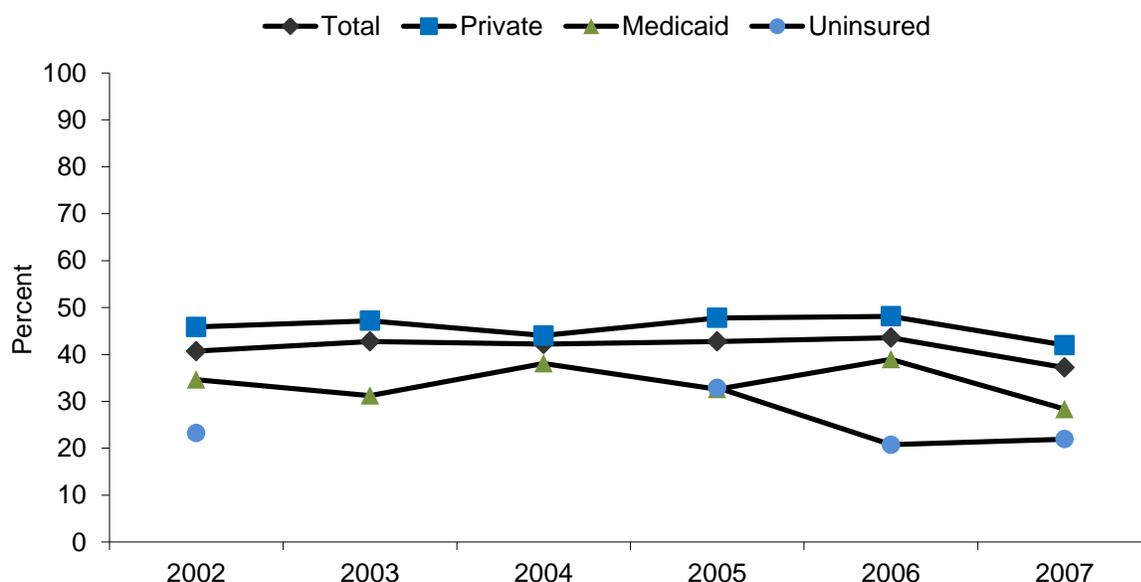
Diabetes

With more than half a million discharges in 2006, diabetes is one of the leading causes of hospitalization in the United States.³ With appropriate and timely ambulatory care, many hospitalizations for diabetes and related complications may be prevented.

Management: Receipt of Recommended Services for Diabetes

Routine monitoring of blood glucose levels with hemoglobin A1c (HbA1c) tests, dilated eye exams, and foot exams have been shown to help prevent or mitigate complications of diabetes, such as diabetic neuropathy, retinopathy, and vascular and kidney disease.⁴

Figure 2.4. Adults ages 40-64 with diagnosed diabetes who received all three recommended services for diabetes in the calendar year (hemoglobin A1c measurement, dilated eye exam, and foot exam), by insurance status, 2002-2007

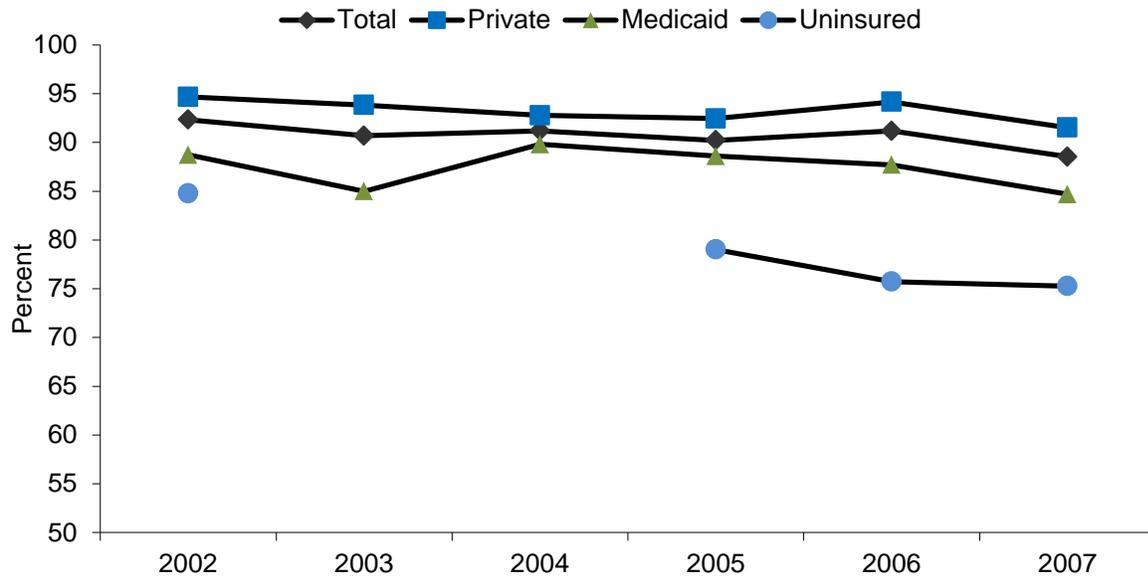


Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.

Note: Data for uninsured people in 2003 and 2004 do not meet the criteria for statistical reliability, data quality, or confidentiality.

- From 2002 to 2007, the percentage of adults ages 40-64 with diagnosed diabetes who received all three recommended services for diabetes in the calendar year did not change for any insurance groups.
- Adults with Medicaid were less likely to receive all three recommended services for diabetes than adults with private insurance from 2002 to 2007. The size of this disparity was constant over time.

Figure 2.5. Adults ages 40-64 with diagnosed diabetes who received a hemoglobin A1c measurement in the calendar year, by insurance status, 2002-2007

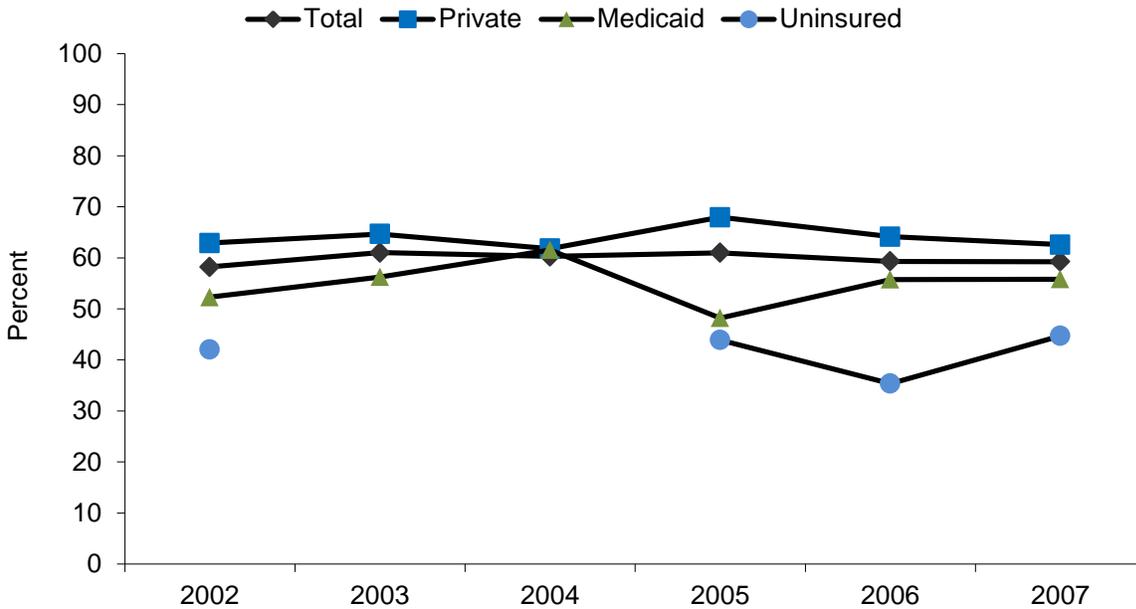


Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.

Note: Data for uninsured people in 2003 and 2004 do not meet the criteria for statistical reliability, data quality, or confidentiality.

- From 2002 to 2007, the percentage of adults ages 40-64 with diagnosed diabetes who received an HbA1c measurement decreased for all insurance groups.
- In 2002, uninsured adults with diagnosed diabetes were less likely to receive an HbA1c measurement than adults with Medicaid or private insurance. However, in 2007, both uninsured adults and adults with Medicaid were less likely to receive an HbA1c measurement than adults with private insurance.

Figure 2.6. Adults ages 40-64 with diagnosed diabetes who received a dilated eye exam in the calendar year, by insurance status, 2002-2007

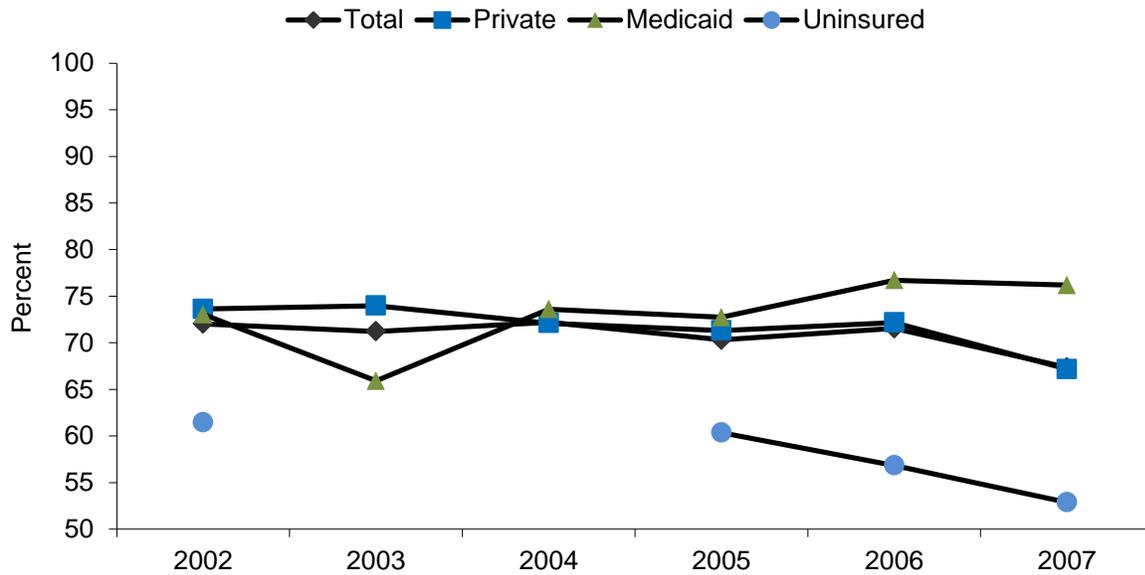


Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.

Note: Data for uninsured people in 2003 and 2004 do not meet the criteria for statistical reliability, data quality, or confidentiality.

- From 2002 to 2007, the percentage of adults ages 40-64 with diagnosed diabetes who received a dilated eye exam in the calendar year did not change for any insurance group.
- In 2002 and 2007, uninsured adults were less likely to receive a dilated eye exam than adults with private insurance.

Figure 2.7. Adults ages 40-64 with diagnosed diabetes who had their feet checked for sores or irritation in the calendar year, by insurance status, 2002-2007

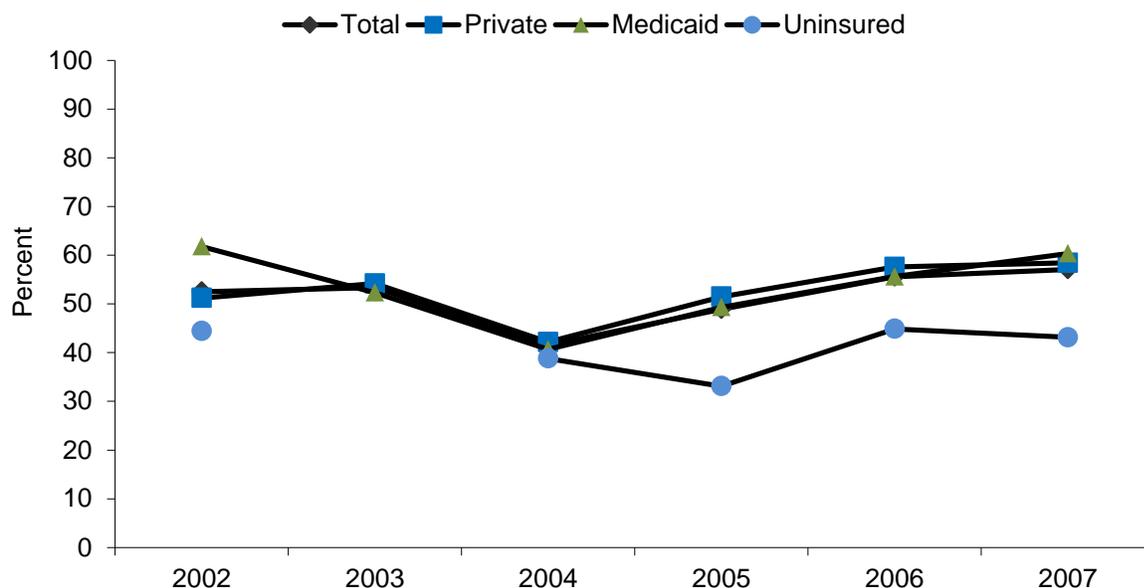


Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.

Note: Data for uninsured people in 2003 and 2004 do not meet the criteria for statistical reliability, data quality, or confidentiality.

- From 2002 to 2007, the percentage of adults ages 40-64 with diagnosed diabetes who had their feet checked for sores or irritation decreased for privately insured and uninsured adults. However, over the same period, the percentage increased for adults with Medicaid.
- In 2002, uninsured adults were less likely to have their feet checked than adults with private insurance. In 2007, however, uninsured adults were less likely to have their feet checked than either adults with Medicaid or adults with private insurance.

Figure 2.8. Adults ages 40-64 with diagnosed diabetes who received an influenza vaccination in the last 12 months, by insurance status, 2002-2007



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

Note: Data for uninsured people in 2003 and 2004 do not meet the criteria for statistical reliability, data quality, or confidentiality.

- From 2002 to 2007, the percentage of adults ages 40-64 with diagnosed diabetes who received an influenza vaccination increased for privately insured adults and did not change for uninsured adults and adults with Medicaid.
- In 2002, privately insured adults ages 40-64 with diagnosed diabetes were less likely to receive an influenza vaccination than adults with Medicaid, but there were no statistically significant differences between the two in 2007.
- In 2002, uninsured adults with diagnosed diabetes were less likely to receive an influenza vaccination than adults with Medicaid. In 2007, uninsured adults with diagnosed diabetes were less likely to receive an influenza vaccination than adults with Medicaid and adults with private insurance.

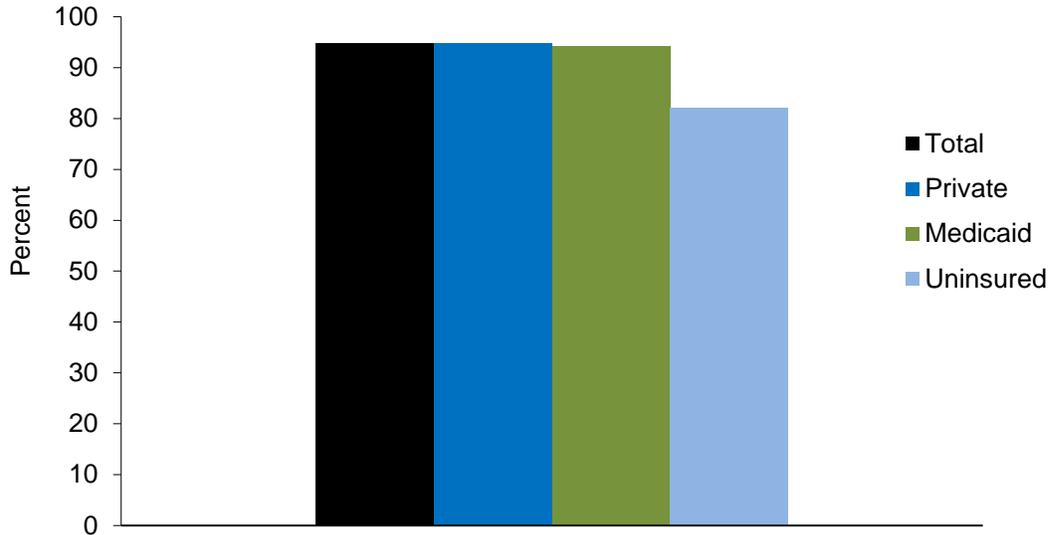
Heart Disease

Prevention: Blood Pressure and Cholesterol Checks

High cholesterol and blood pressure are major factors for heart disease. Awareness and control can help reduce the risk of heart attack.

The 2002-2007 sample sizes were not sufficient to reliably compare insurance subgroups, so trend data are not available for these measures.

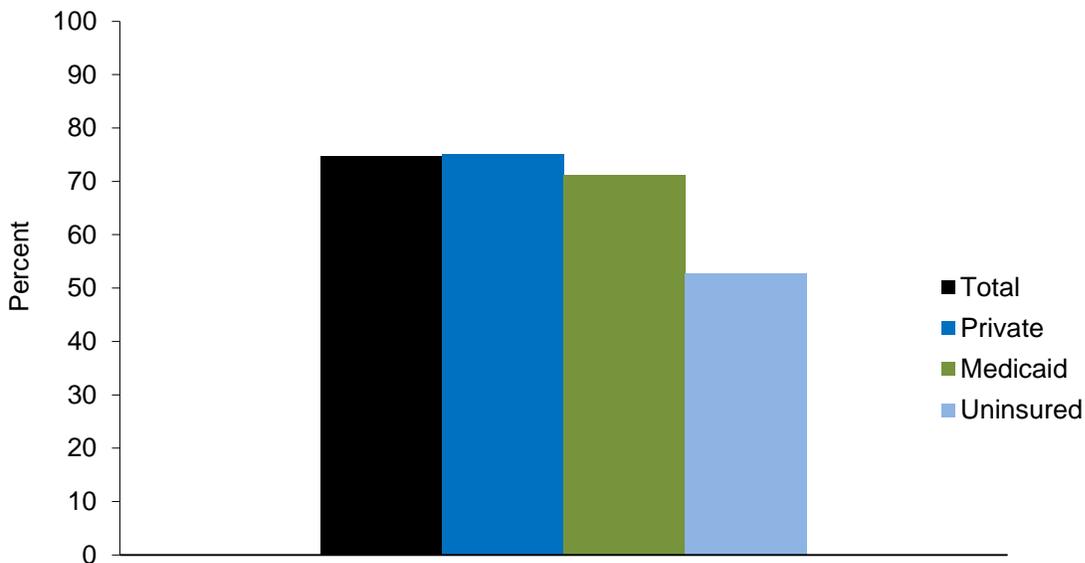
Figure 2.9. Adults ages 18-64 who received a blood pressure measurement in the last 2 years and can state whether their blood pressure was normal or high, by insurance status, 2008



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2008.

- In 2008, nearly 95% of privately insured adults and adults with Medicaid and 82% of uninsured adults received a blood pressure measurement in the last 2 years and could state whether their blood pressure was normal or high.
- In 2008, uninsured adults were less likely to receive a blood pressure measurement than adults with either Medicaid or private insurance.

Figure 2.10. Adults ages 18-64 who received a blood cholesterol measurement in the last 5 years, by insurance status, 2008



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2008.

- In 2008, three-quarters of privately insured adults, more than 70% of adults with Medicaid, and more than half of uninsured adults received a blood cholesterol measurement in the last 5 years.
- In 2008, uninsured adults were less likely to receive a blood cholesterol measurement than adults with either Medicaid or private insurance.

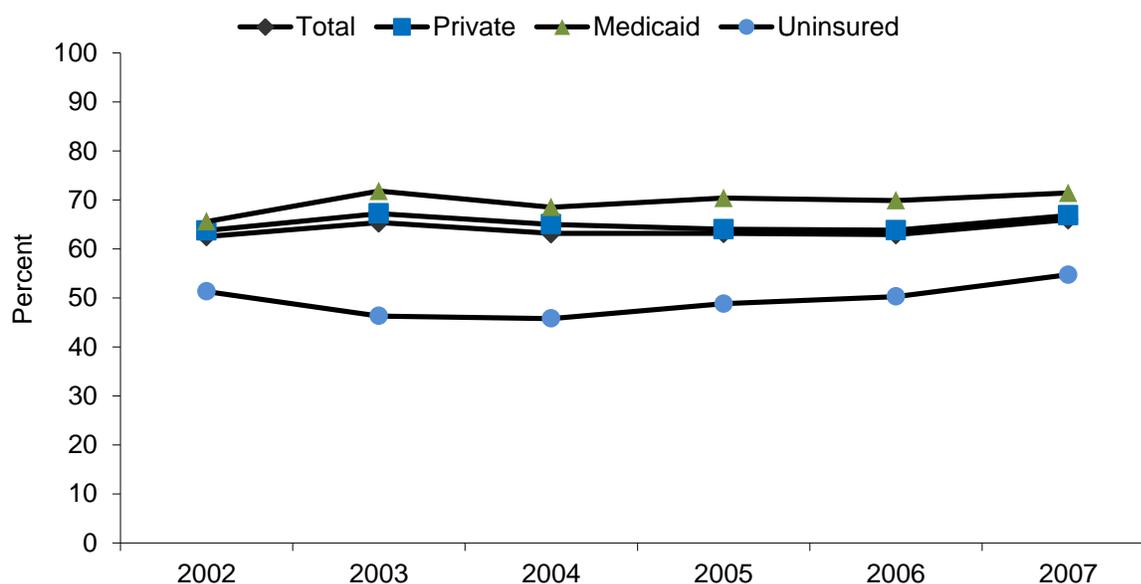
Lifestyle Modification

Prevention: Counseling Smokers To Quit Smoking

Smoking harms nearly every organ of the body and causes or exacerbates many diseases. Smoking causes more than 80% of deaths from lung cancer and more than 90% of deaths from chronic obstructive pulmonary disease.⁵ Heart disease is the leading cause of death in the United States for both men and women.⁶ Approximately 443,000 annual deaths are due to smoking.⁷

Quitting smoking has immediate and long-term health benefits. The risk of developing coronary heart disease attributed to smoking can be decreased by 50% after one year of cessation.⁸ Smoking may be the single most important modifiable risk factor for heart disease, and providers can encourage patients to quit smoking.

Figure 2.11. Adult current smokers ages 18-64 with a checkup in the last 12 months who received advice from a doctor to quit smoking, by insurance status, 2002-2007



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

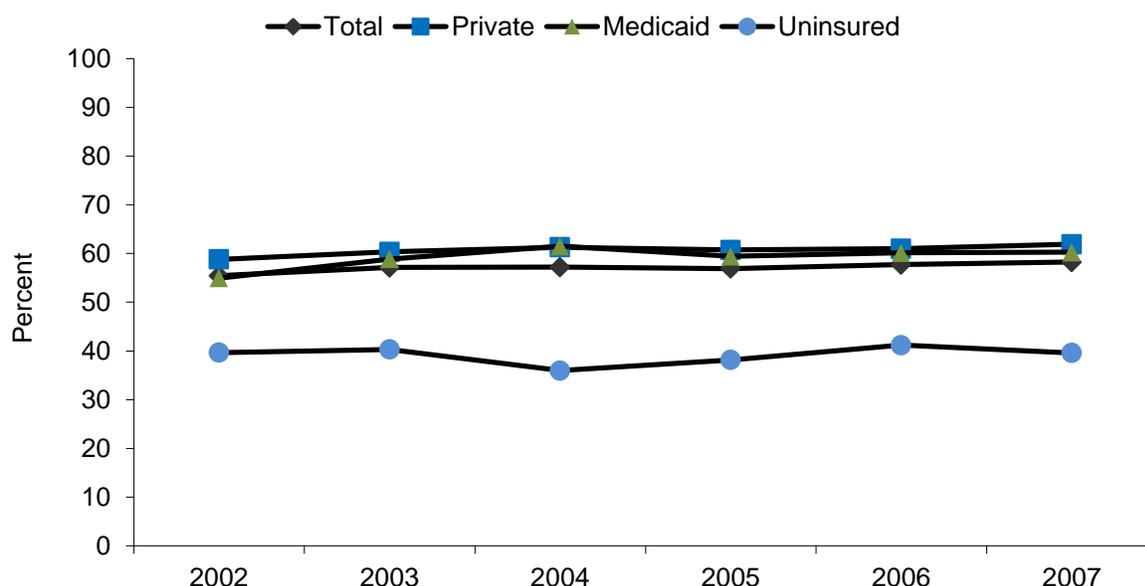
- From 2002 to 2007, the percentage of adult current smokers who received advice from a doctor to quit smoking increased for uninsured adults and for adults with Medicaid but was constant did not change for adults with private insurance.
- From 2002 to 2007, adult smokers with no insurance were less likely to receive advice from a doctor to quit smoking than adults with Medicaid or adults with private insurance.

Prevention: Counseling Obese Adults About Exercise and Diet

More than one-third of adults age 20 and over in the United States are obese (defined as having a body mass index of 30 or higher).⁹ Obesity puts them at increased risk for many chronic, often deadly conditions, such as hypertension, cancer, diabetes, and coronary heart disease.¹⁰ Although clinical guidelines recommend that health providers screen all adult patients for obesity,¹¹ obesity remains underdiagnosed among U.S. adults.¹²

Provider-based exercise counseling is an important component of effective weight loss interventions,¹¹ and has been shown to produce increased levels of physical activity among sedentary patients.¹³ Although every obese person may not need counseling about exercise and diet, many would likely benefit from improvements in these activities. Regular exercise and a healthy diet aid in maintaining normal blood cholesterol levels, weight, and blood pressure, reducing the risk of heart disease, stroke, diabetes, and other comorbidities of obesity.

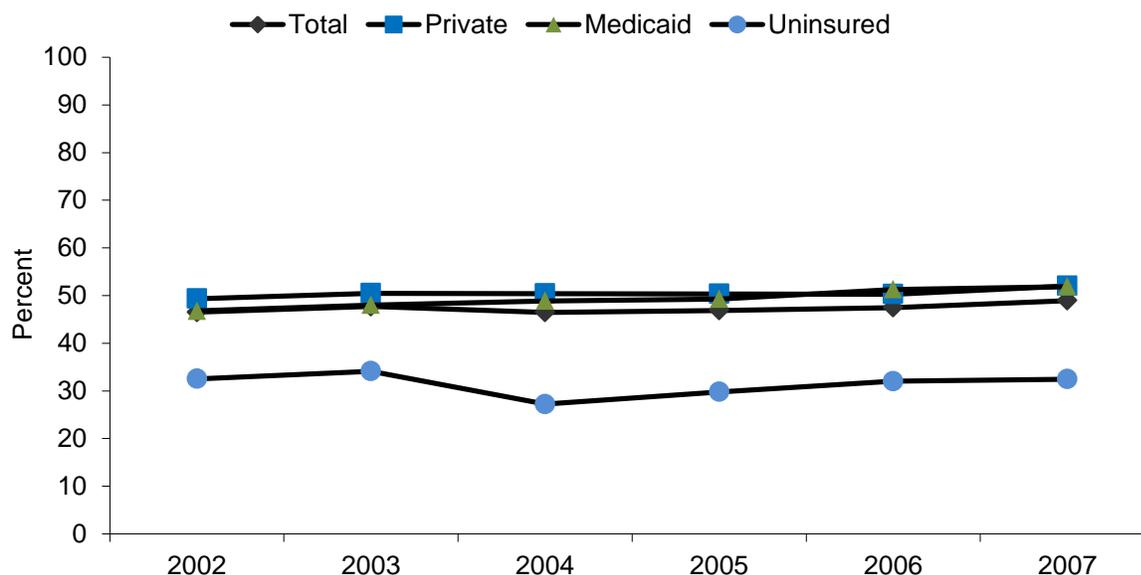
Figure 2.12. Adults ages 18-64 with obesity who ever received advice from a health provider to exercise more, by insurance status, 2002-2007



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

- From 2002 to 2007, the percentage of obese adults who received advice from a health provider to exercise more increased for those with private insurance or Medicaid, but the percentage did not change for uninsured adults.
- Uninsured adults with obesity were less likely than those with Medicaid or private insurance to receive advice from a health provider to exercise more.

Figure 2.13. Adults ages 18-64 with obesity who ever received advice from a health provider about eating fewer high-fat or high-cholesterol foods, by insurance status, 2002-2007



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

- From 2002 to 2007, the percentage of obese adults who received advice from a health provider about eating fewer high-fat or high-cholesterol foods increased for those with Medicaid but did not change for uninsured adults or those with private insurance.
- During this time, uninsured adults with obesity were less likely than those with Medicaid or private insurance to receive advice about eating fewer high-fat or high-cholesterol foods.

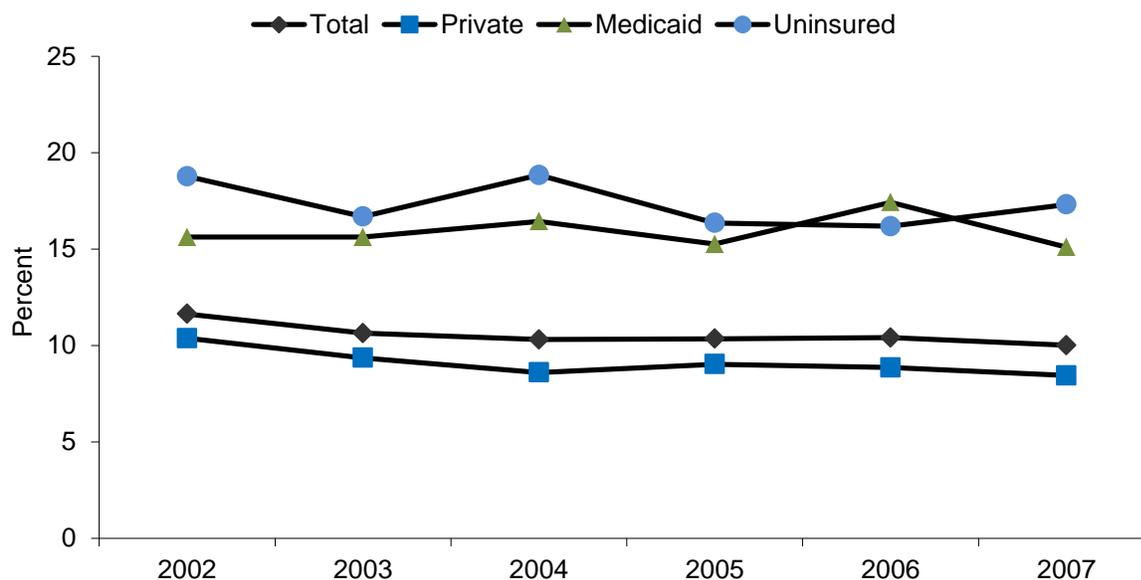
Patient Centeredness

Patient-centered care is supported by good provider-patient communication so that patients' needs and wants are understood and addressed and patients understand and participate in their own care. This style of care has been shown to improve patients' health and health care. Unfortunately, many barriers exist to good communication.

Patient Experiences of Care

Optimal health care requires good communication between patients and providers, yet barriers to provider-patient communication are common. To provide all patients with the best possible care, providers need to understand patients' diverse health care needs and preferences and communicate clearly with patients about their care.

Figure 2.14. Adults ages 18-64 who reported poor communication with health providers, by insurance status, 2002-2007



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

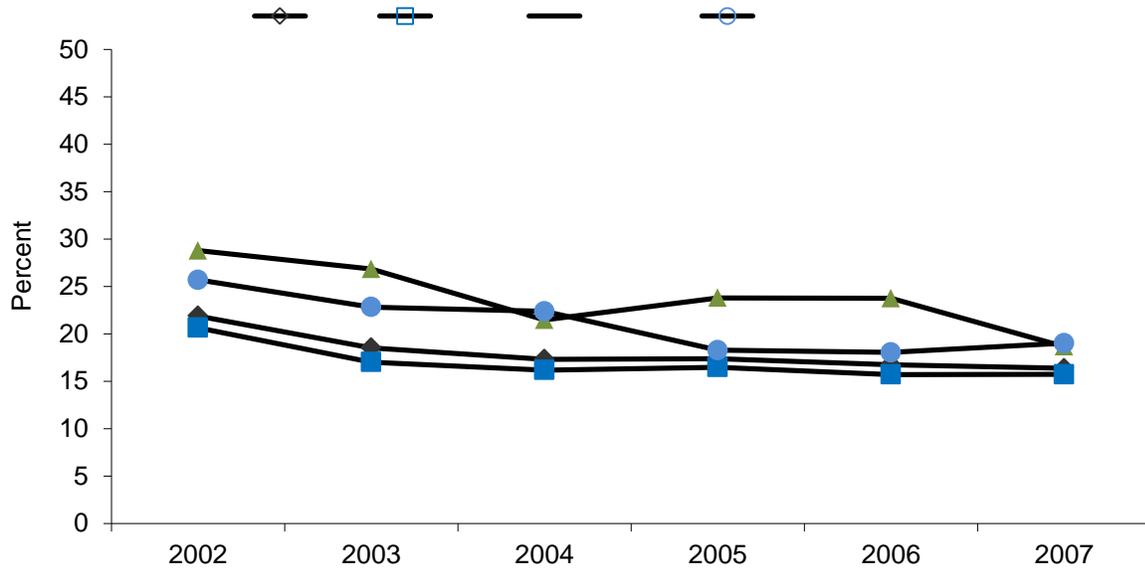
Note: For this measure, lower rates are better. Patients who report that their health providers sometimes or never listened carefully, explained things clearly, showed respect for what they had to say, or spent enough time with them are considered to have poor communication.

- From 2002 to 2007, the percentage of adults reporting poor communication with health providers decreased for those with private insurance and for uninsured adults but did not change for adults with Medicaid.
- In 2002, uninsured adults were the most likely to report poor communication. However, in 2007, there were no statistically significant differences between uninsured adults and adults with Medicaid. In addition, both were more likely than adults with private insurance to report poor communication with health providers.

Providers Asking Patients To Assist in Making Treatment Decisions

The high prevalence of chronic disease has placed more responsibility on patients. Conditions such as diabetes and hypertension require self-management by patients. It is vital that patients are provided with information that allows them to make informed decisions and feel engaged in their treatment and that it incorporates their values and preferences.

Figure 2.15. Adults ages 18-64 with a usual source of care whose health provider sometimes or never asked for the person’s help to make treatment decisions, by insurance status, 2002-2007

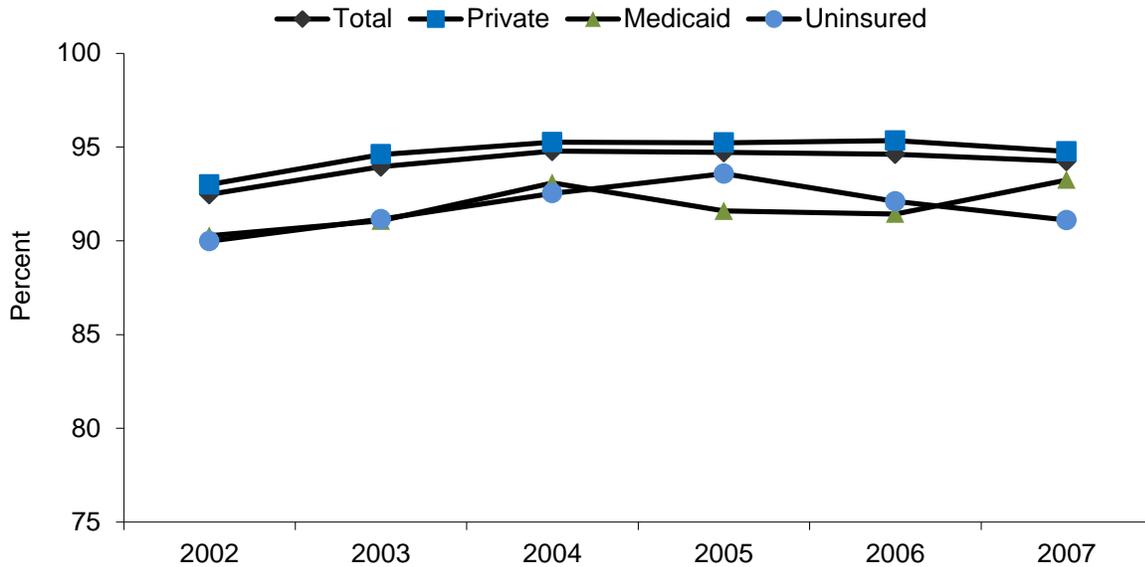


Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.

Note: For this measure, lower rates are better.

- From 2002 to 2007, the percentage of health providers who sometimes or never asked for the patient’s help to make treatment decisions decreased for all insurance groups.
- From 2002 to 2007, the percentage of adults whose health providers sometimes or never asked for their help to make treatment decisions was higher for uninsured adults and adults with Medicaid than for adults with private insurance.

Figure 2.16. Adults ages 18-64 with a usual source of care whose health provider explained and provided all treatment options, by insurance status, 2002-2007



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

- From 2002 to 2007, the percentage of adults whose health providers explained and provided all treatment options increased for all insurance groups.
- In 2002, uninsured adults and adults with Medicaid were less likely to have health providers explain and provide all treatment options than adults with private insurance.
- In 2007, uninsured adults were less likely to have providers explain all treatment options than adults with private insurance, but there were no statistically significant differences between adults with Medicaid and those with private insurance.

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Insurance Disparities

Chapter 3: Access to Health Care

Many Americans have good access to health care that enables them to benefit fully from the Nation’s health care system. 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) are disproportionately represented among those with access problems.

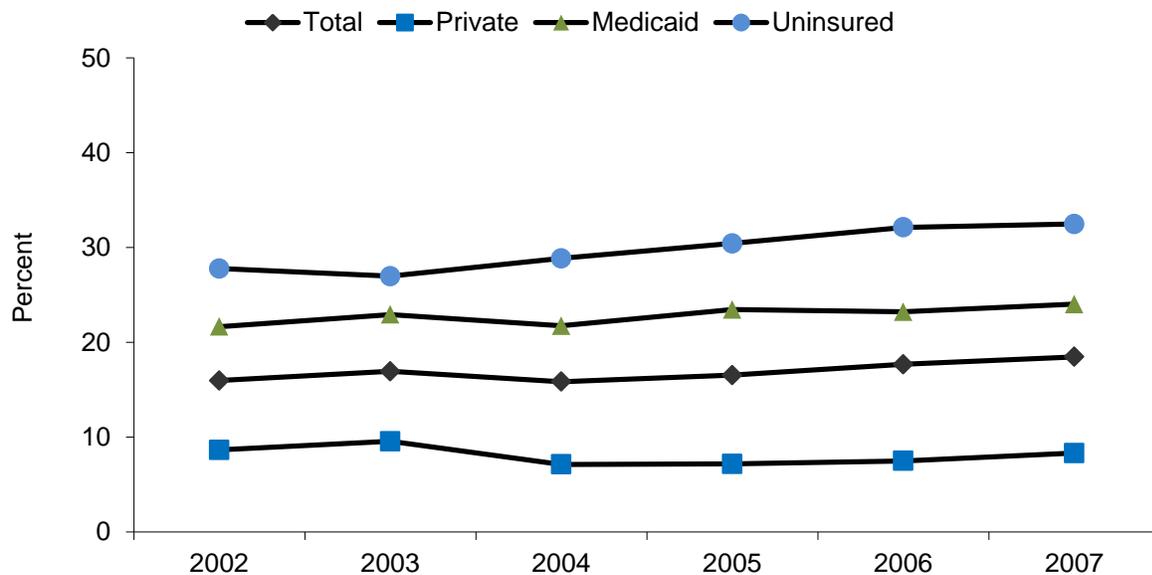
Facilitators and Barriers to Health Care

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

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 disparities¹ and costs.² Evidence suggests that the effect on quality of the combination of health insurance and a usual source of care is additive.³ In addition, people with a usual source of care are more likely to receive preventive health services.⁴

Figure 3.1. Adults ages 18-64 without a usual source of care, by insurance status, 2002-2007



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

Note: For this measure, lower rates are better.

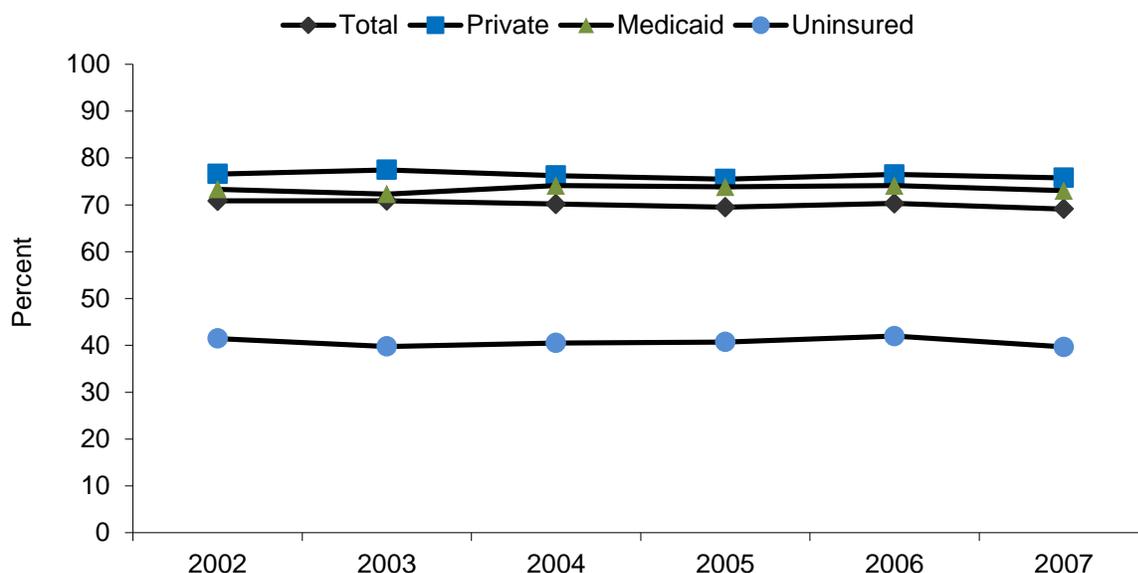
- From 2002 to 2007, the percentage of adults without a usual source of care increased for uninsured adults and for adults with Medicaid and decreased for adults with private insurance.

- Privately insured adults were the least likely and uninsured adults were the most likely to lack a usual source of care.
- The disparity between uninsured adults and adults with private insurance without a usual source of care increased over time.

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 provider⁵ and with good provider-patient communication. These factors increase the likelihood that patients receive appropriate care.⁶ 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.⁷ Having a usual primary care provider correlates with receipt of higher quality care.^{8,9}

Figure 3.2. Adults ages 18-64 with a usual primary care provider, by insurance status, 2002-2007



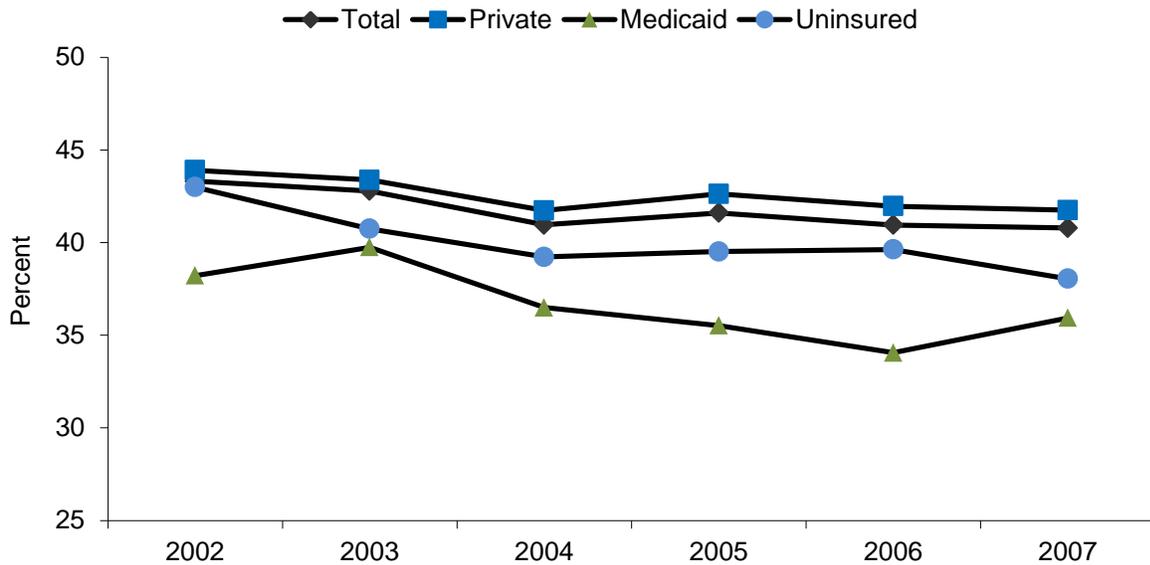
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.

- From 2002 to 2007, there was no statistically significant change for any insurance group in the percentage of adults with a usual primary care provider.
- From 2002 to 2007, adults with Medicaid and adults with private insurance were more likely to have a usual primary care provider than uninsured adults.

Provider With Night or Weekend Hours

The health care delivery system's structure and organization are critical factors for 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 and helping people who cannot afford time off from work to see their doctor after hours.

Figure 3.3. Adults ages 18-64 with a usual source of care, excluding hospital emergency rooms, who has office hours nights or weekends, by insurance status, 2002-2007



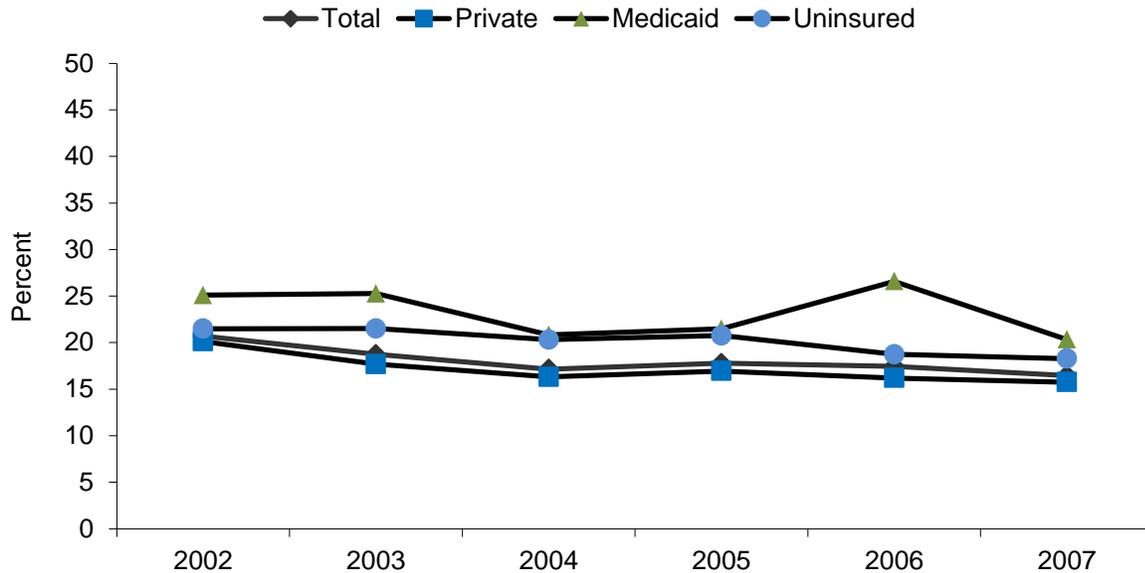
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.

- From 2002 to 2007, the percentage of adults with a usual source of care with office hours nights or weekends decreased for uninsured adults and adults with Medicaid. There were no statistically significant changes over time for adults with private insurance.
- There were no statistically significant differences over time between insurance groups in the percentage who had a usual source of care with office hours nights or weekends.

Difficulty Contacting Provider by Telephone

Patients cannot always meet a health provider in person. Ensuring health provider availability via telephone facilitates access by increasing convenience and making providers available to patients who cannot travel to providers’ offices.

Figure 3.4. Adults ages 18-64 with difficulty contacting their usual source of care over the telephone, by insurance status, 2002-2007



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

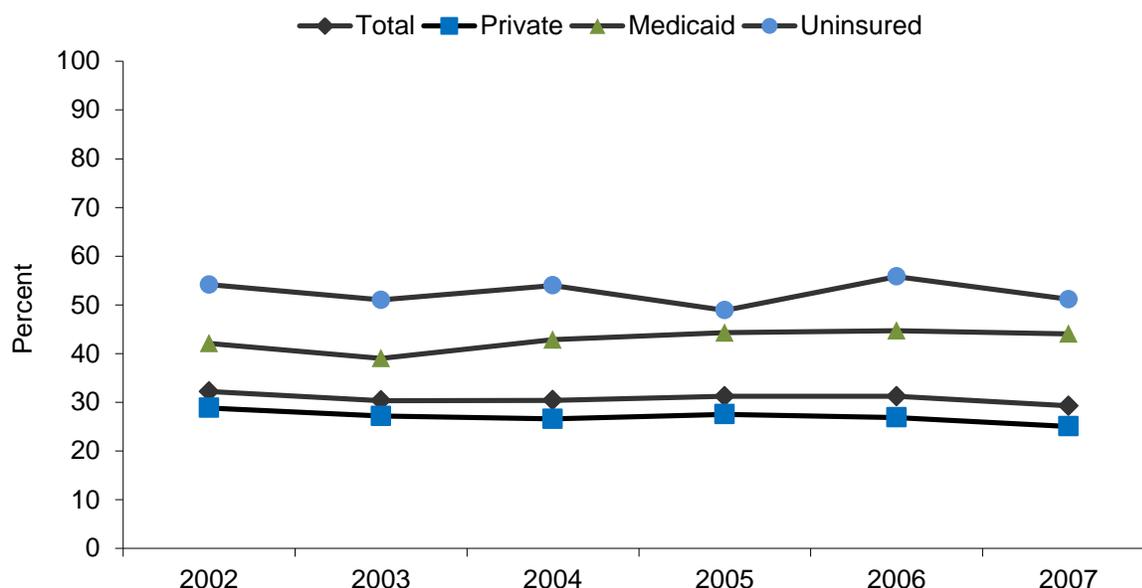
Note: For this measure, lower rates are better.

- From 2002 to 2007, the percentage of adults who had difficulty contacting their usual source of care over the telephone decreased for all insurance groups.
- From 2002 to 2007, adults with Medicaid were more likely to have difficulty contacting their usual source of care over the telephone than privately insured adults.

Problems Seeing a Specialist

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 3.5. Adults ages 18-64 who had problems seeing a specialist they needed to see in the last 12 months, by insurance status, 2002-2007



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

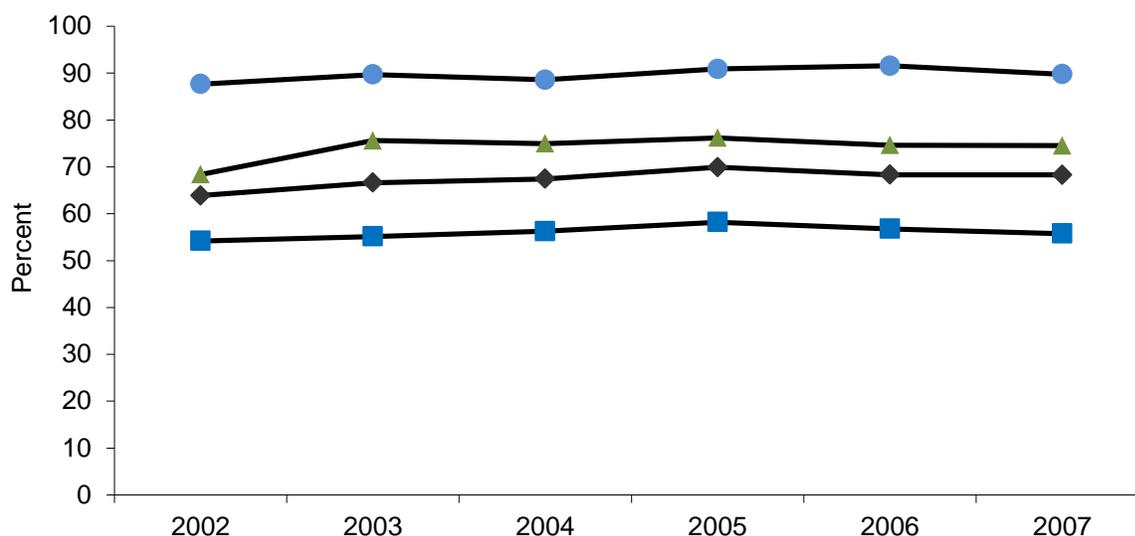
Note: For this measure, lower rates are better.

- From 2002 to 2007, the percentage of adults who had problems seeing a needed specialist increased for adults with Medicaid and decreased for adults with private insurance.
- In 2002, adults with private insurance were the least likely and uninsured adults were the most likely to have problems seeing a specialist they needed to see in the last 12 months.
- In 2007, adults with private insurance were still the least likely to have problems seeing a specialist, but there were no statistically significant differences between adults with Medicaid and uninsured adults. The disparity between adults with Medicaid and adults with private insurance increased over time.

Financial Burden of Health Care

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.¹⁰ High premiums and out-of-pocket payments can be a significant barrier to accessing needed medical treatment and preventive care.¹¹ Some patients have 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 3.6. Adults ages 18-64 unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons, by insurance status, 2002-2007



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

Note: For this measure, lower rates are better.

- From 2002 to 2007, the percentage of adults unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons increased for adults with Medicaid and was unchanged over time for uninsured adults and adults with private insurance.
- From 2002 to 2007, the percentage of adults unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons was highest for uninsured adults and lowest for adults with private insurance.

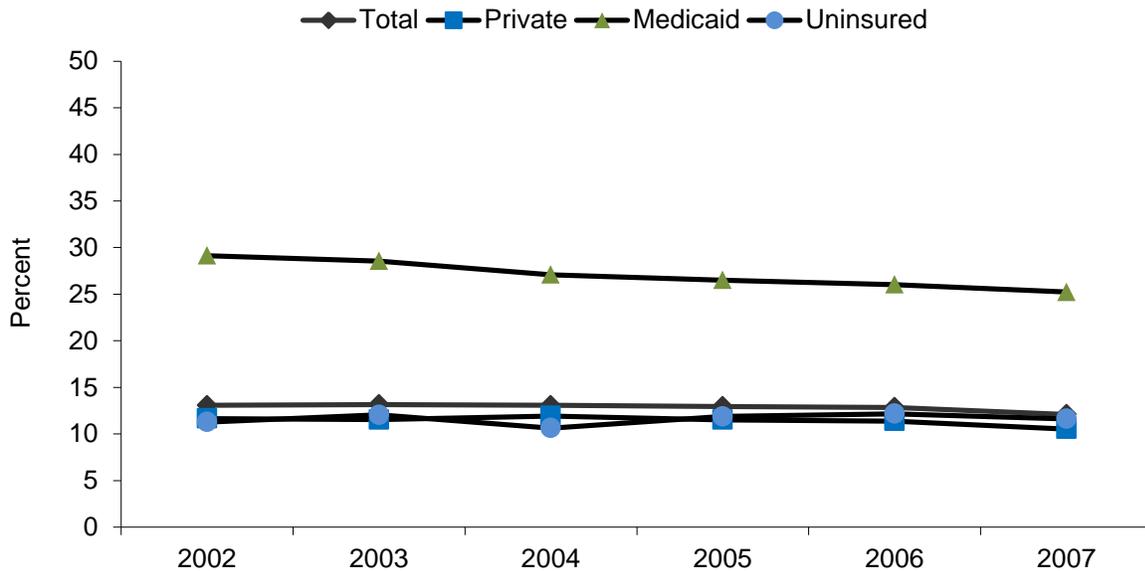
Utilization

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 medical care is important for preserving health and functioning, while high rates of emergency department use suggest lack of access to routine care and other avenues of treatment.

Emergency Room Visits

Without good access to health care, people sometimes resort to using the emergency department when care is needed. Delaying care until care is urgent often results in poorer health outcomes and increased health care costs.

Figure 3.7. Adults ages 18-64 who had a hospital emergency room visit in the calendar year, by insurance status, 2002-2007



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

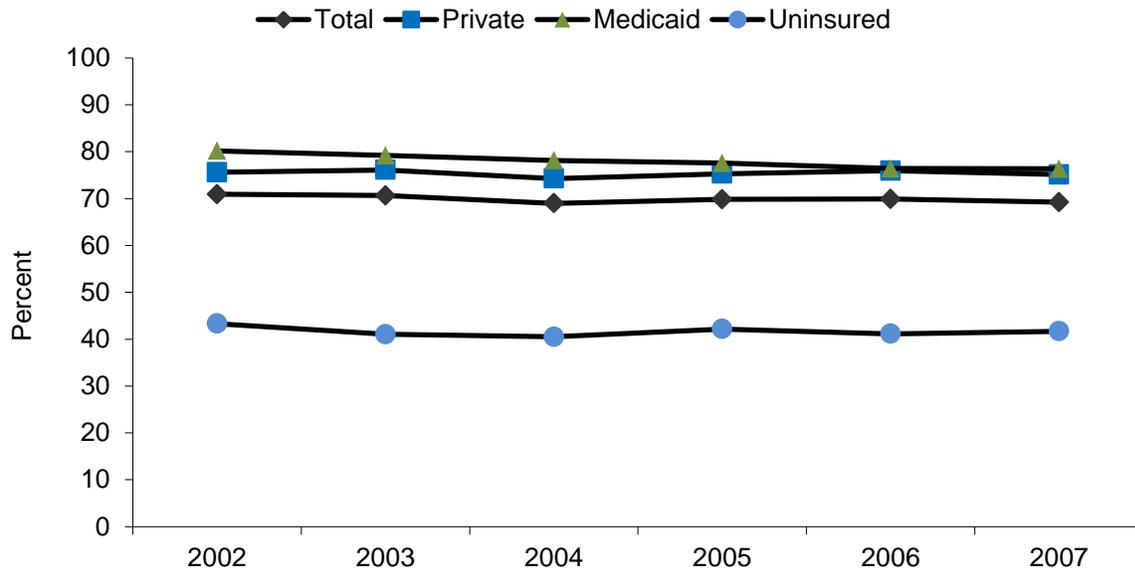
Note: For this measure, lower rates are better.

- From 2002 to 2007, the percentage of adults with an emergency room visit in the calendar year decreased for adults with private insurance and adults with Medicaid but was unchanged for uninsured adults.
- Adults with Medicaid were more likely to have an emergency room visit than uninsured adults and privately insured adults from 2002 to 2007.

Outpatient Visits

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

Figure 3.8. Adults ages 18-64 who had a physician office or hospital outpatient department visit, by insurance status, 2002-2007



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

- From 2002 to 2007, the percentage of adults with a physician office or hospital outpatient department visit decreased for adults with Medicaid but was unchanged over time for uninsured adults and adults with private insurance.
- In 2002, adults with Medicaid were the most likely and uninsured adults were the least likely to have a physician office or hospital outpatient department visit. In 2007, however, uninsured adults were the least likely to have visits and there were no statistically significant differences between adults with Medicaid and adults with private insurance.

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Racial and Ethnic Disparities

Chapter 4: Quality of Ambulatory Health Care

The Coverage Analyses Trends Report examined racial and ethnic disparities for each measure, including disparities among those with the same insurance status. Unless otherwise noted, these measures evaluated adults ages 18-64.

Effectiveness

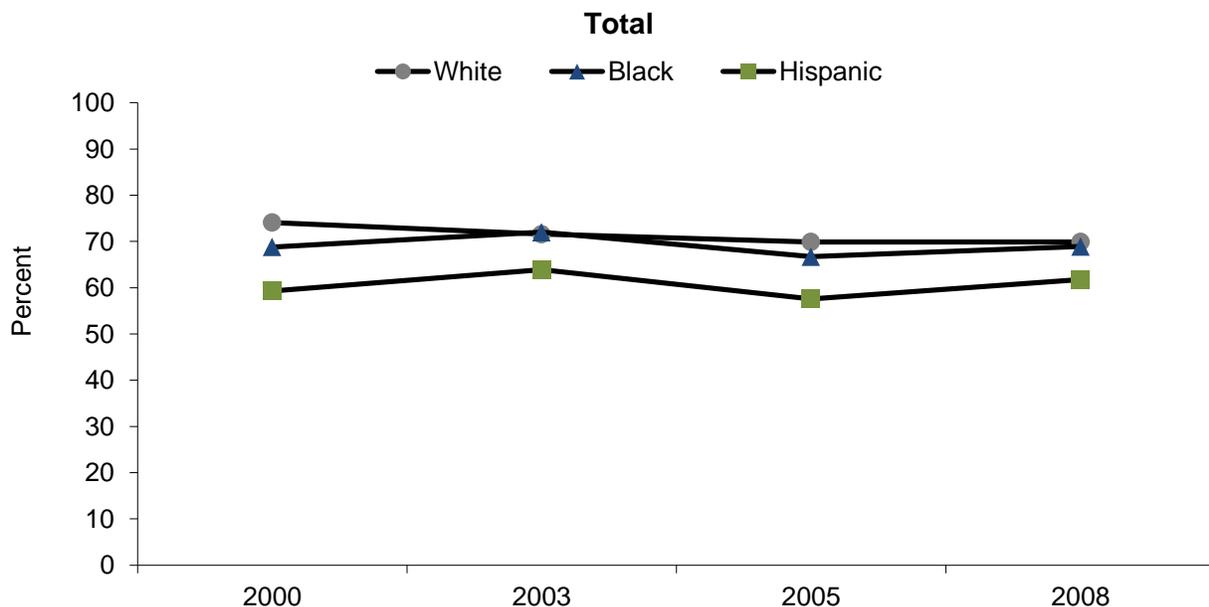
Cancer

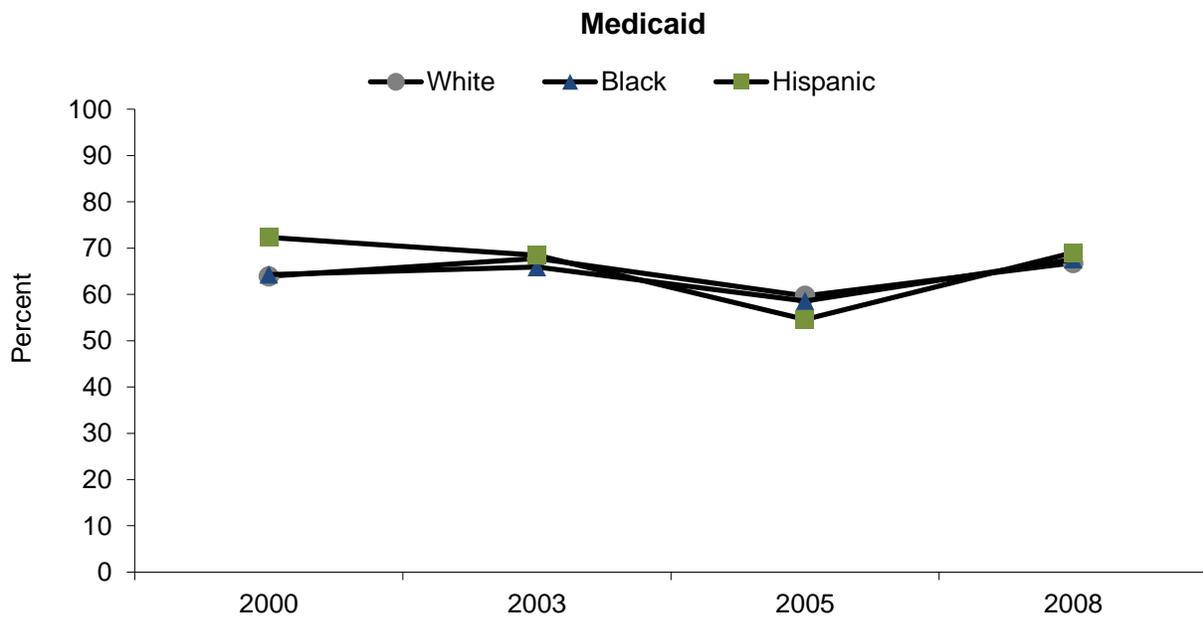
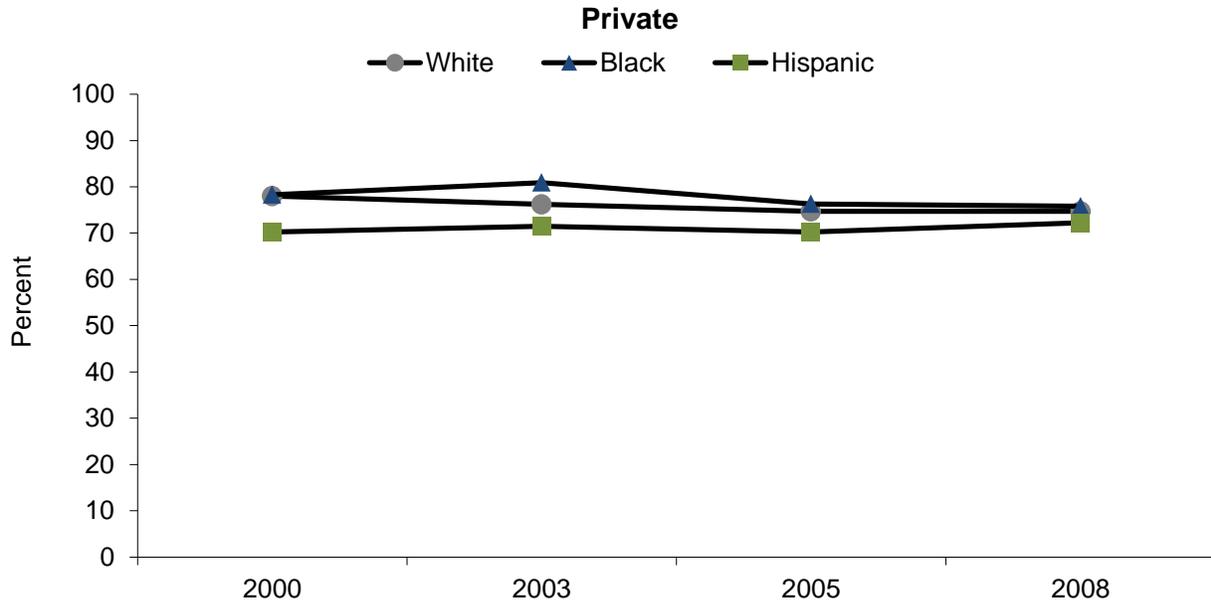
Ensuring that all populations have access to appropriate cancer screening services is a core element of reducing cancer morbidity, mortality, and disparities. Evidence-based consensus defining good quality care and how to measure it currently exists for only a few cancers and aspects of care.

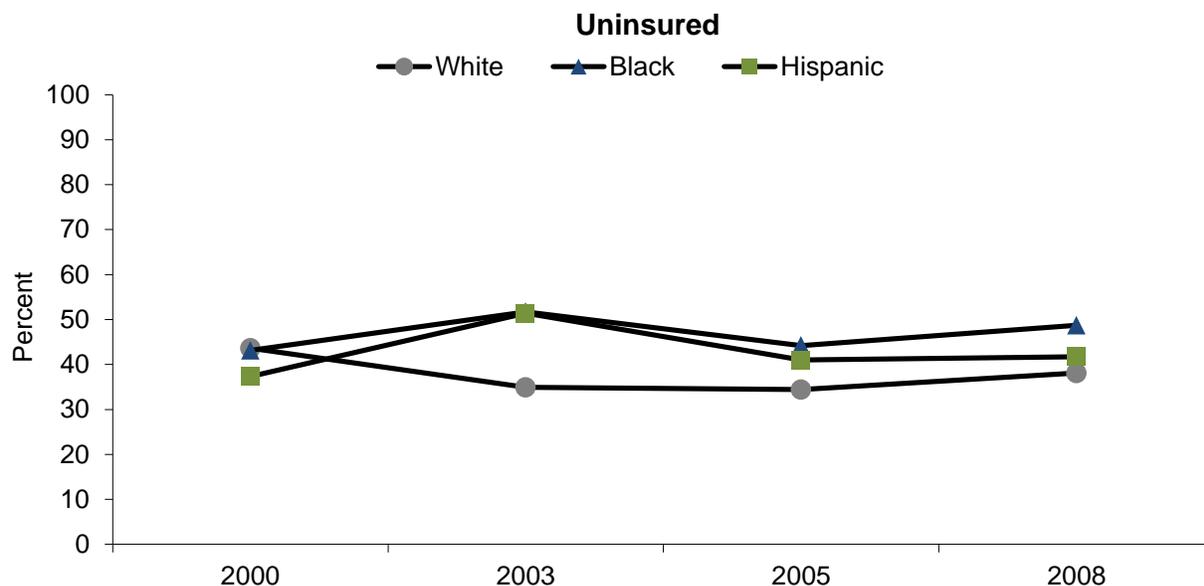
Prevention: Mammograms

Early detection of cancer increases treatment options and often improves outcomes. Mammography, the most effective method for detecting breast cancer at its early stages, can identify malignancies before they can be felt and before symptoms develop. For available data years, the U.S. Preventive Services Task Force recommended mammograms every 1 to 2 years for women age 40 and over.

Figure 4.1. Women ages 40-64 who received a mammogram in the last 2 years, by race/ethnicity, stratified by insurance status, 2000-2008







Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2000-2008.

- Overall, from 2000 to 2008, White and Black women ages 40-64 were more likely than Hispanic women to receive a mammogram in the previous 2 years.
- The percentage of White and Black women ages 40-64 with private insurance who received a mammogram decreased from 2000 to 2008. Among privately insured women, the percentage who received a mammogram was higher for White and Black women than for Hispanic women in 2000 but not in 2008.
- Over time, the percentage of Hispanic women with Medicaid who received a mammogram decreased, while the percentage was relatively unchanged over time for Black and White women with Medicaid.
- There were no statistically significant racial or ethnic differences for uninsured women from 2000 to 2008.

Prevention: Pap Smears

The U.S. Preventive 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 strongly recommends that women under age 65 have Pap smears at least every 3 years.

Pap smear data for all women combined (ages 18-64, all insurance groups totaled) is not available by race/ethnicity. Thus, data on the pap smears are presented separately for women ages 18-44 and women ages 45-64 for the total, and for all women ages 18-64 for each insurance category.

Figure 4.2. Women ages 18-44 who received a Pap smear in the previous 3 years, by race/ethnicity, stratified by insurance status, 2000-2008

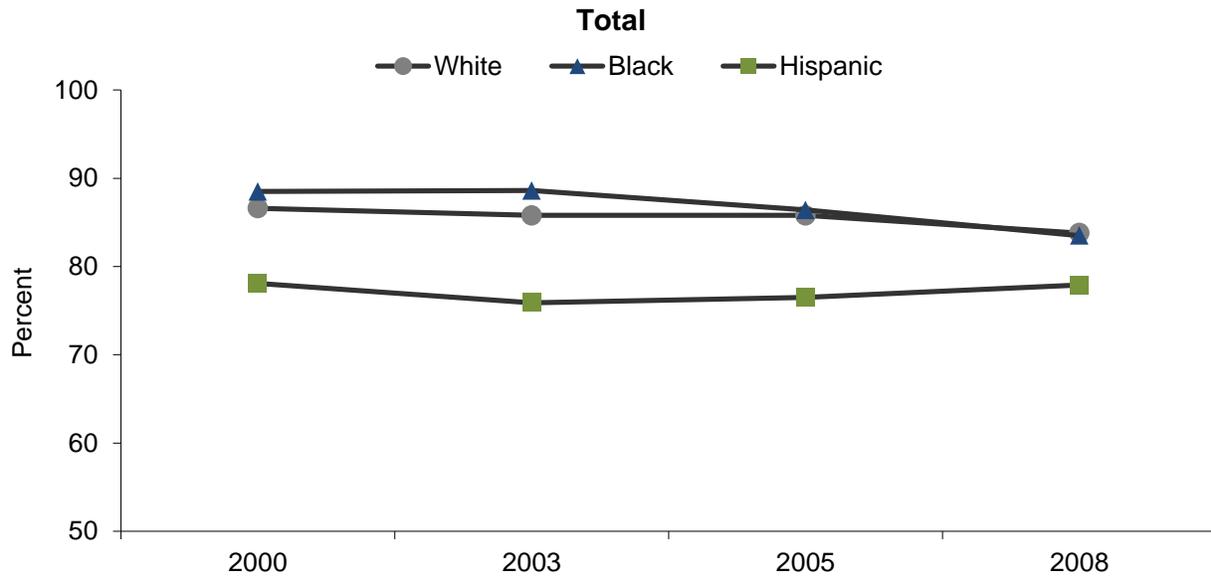


Figure 4.3. Women ages 45-64 who received a Pap smear in the previous 3 years, by race/ethnicity, stratified by insurance status, 2000-2008

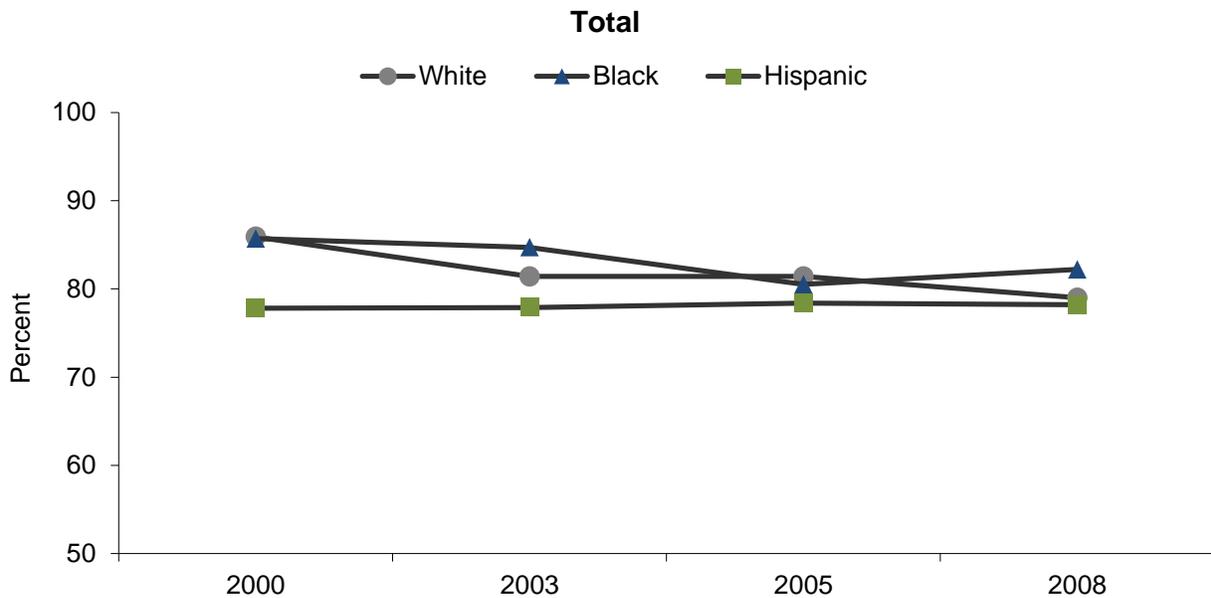
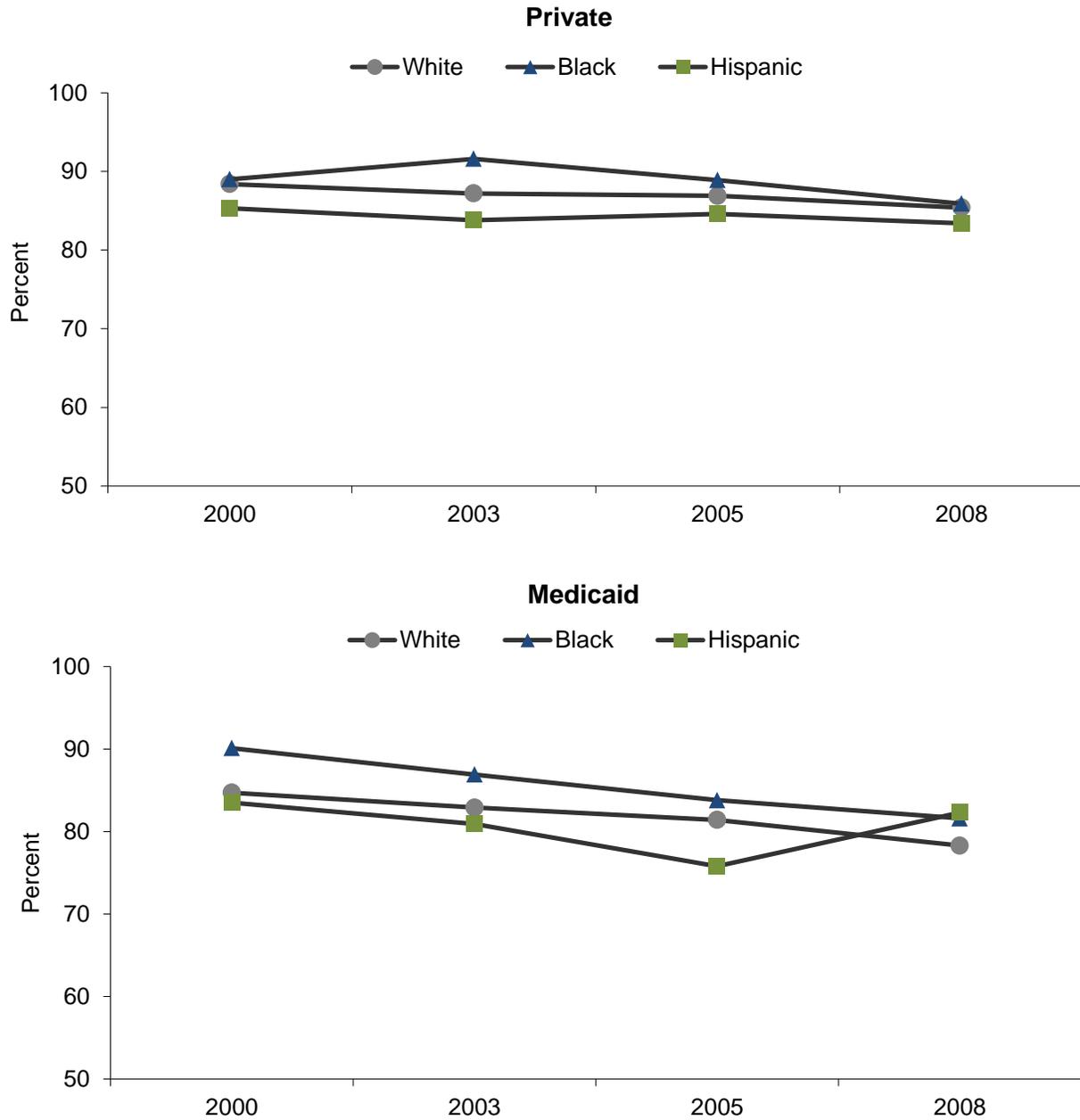
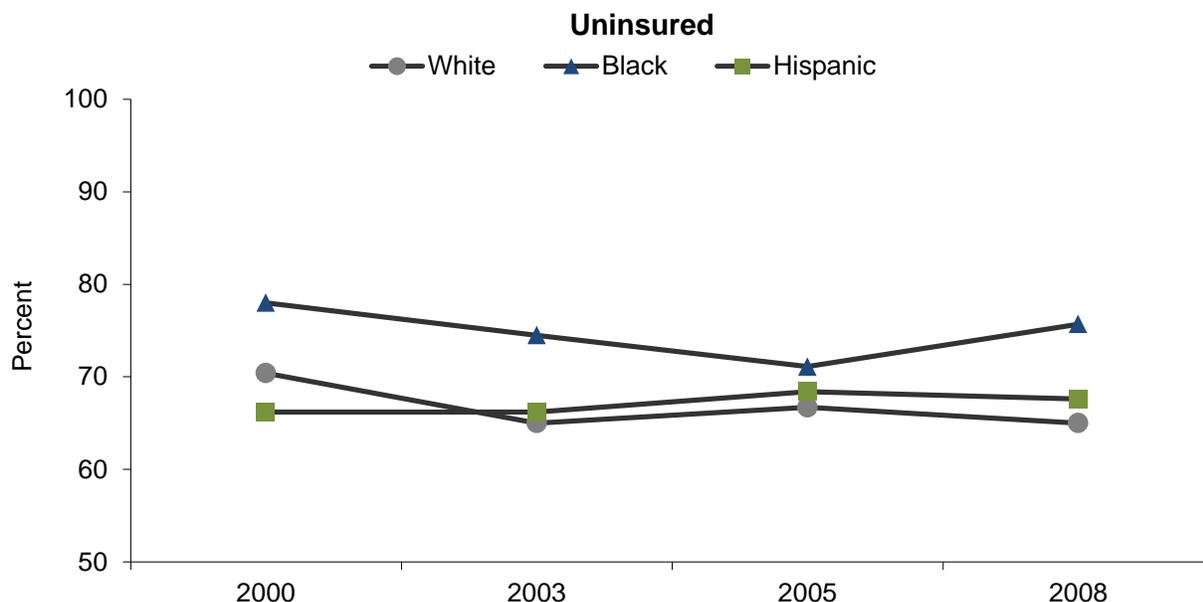


Figure 4.4. Women ages 18-64 who received a Pap smear in the previous 3 years, by race/ethnicity, stratified by insurance status, 2000-2008





Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2000-2008.

- From 2000 to 2008, the percentage of White and Black women who received a Pap smear decreased for women ages 18-44 and 45-64 but remained stable for Hispanic women ages 18-44.
- Overall, in 2000, the percentage of women ages 18-44 who received a Pap smear in the previous 3 years was higher for Blacks and Whites than for Hispanics. In 2008, the percentage was higher among Black and White women ages 18-44 compared with Hispanic women, but there were no statistically significant differences for women ages 45-64.
- In 2000, among women with Medicaid, Blacks ages 18-64 were more likely than Whites and Hispanics to receive a Pap smear, but there were no statistically significant differences in 2008.
- The percentage of White, Black, and Hispanic women with Medicaid who received a Pap smear decreased from 2000 to 2008.
- In 2000 and 2008, Black uninsured women were more likely to have received a Pap smear than White uninsured women.

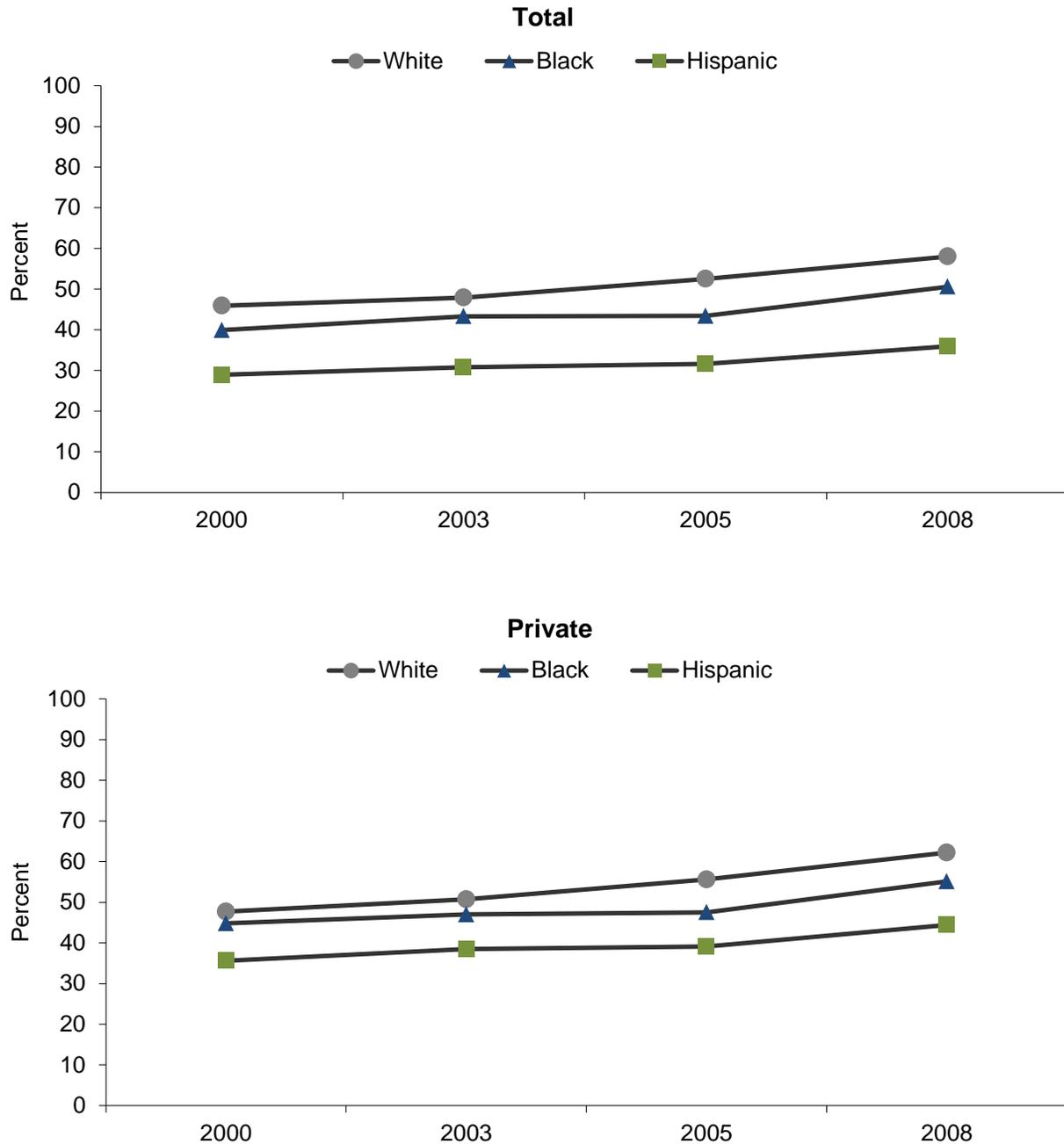
Prevention: Screening for Colon Cancer

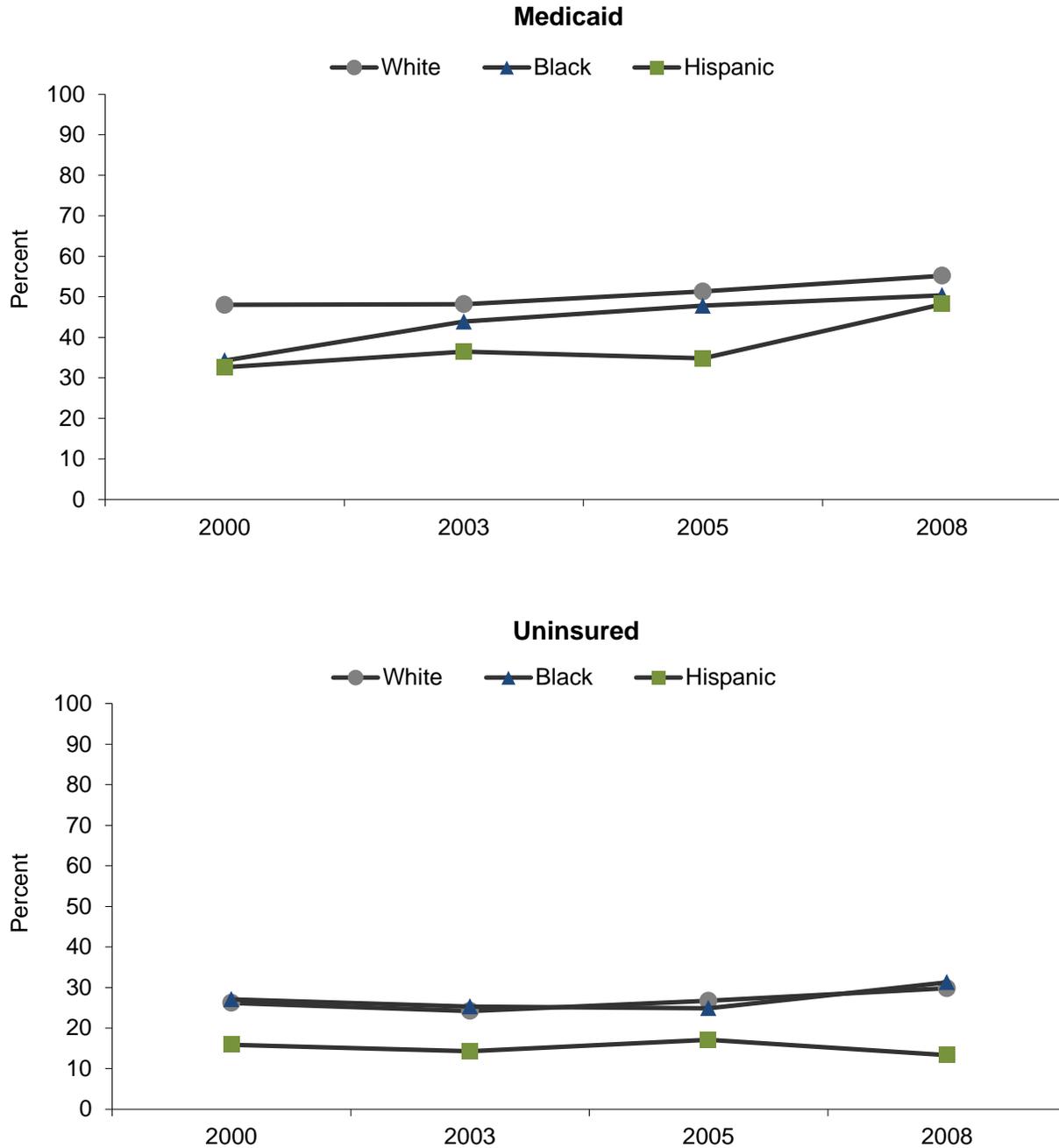
Colorectal cancer is the third most common cancer in adults. Prevention of colorectal cancer includes modifying risk factors such as weight, physical activity, smoking, and alcohol use, as well as screening for early disease. Screening is important because early stages of colorectal cancer may not present any symptoms, and screening tests can detect abnormal growths before they develop into cancer.^{1,2} Early detection of colorectal cancer increases treatment options and chances for survival.

The U.S. Preventive Services Task Force recommends that adults age 50 and over be screened for colorectal cancer. The screening tests for colorectal cancer measured in this report include:

having a fecal occult blood test in the past 2 years or ever having a colonoscopy, flexible sigmoidoscopy, or proctoscopy.

Figure 4.5. Adults ages 50-64 who reported receiving colorectal cancer screening (received fecal occult blood test in past 2 years or ever received colonoscopy, sigmoidoscopy, or proctoscopy), by race/ethnicity, stratified by insurance status, 2000-2008





Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2000-2008.

- From 2000 to 2008, White adults ages 50-64 were the most likely and Hispanic adults were the least likely to receive colorectal cancer screening.
- The percentage of adults who received colorectal cancer screening increased over time for all racial and ethnic groups. The disparities between White, Black, and Hispanic adults stayed the same over time.
- Among adults with private insurance, the percentage who received colorectal cancer screening increased over time for all racial and ethnic groups. Hispanics were the least

likely to receive screening in both 2000 and 2008, while Blacks were less likely to receive screening than Whites only in 2000.

- In 2000, White adults with Medicaid were more likely to receive colorectal cancer screening than Black and Hispanic adults; however, there were no statistically differences in 2008.
- From 2000 to 2008, uninsured Black and White adults were equally likely to receive colorectal cancer screening. Uninsured Hispanic adults were the least likely to receive cancer screening.

Diabetes

The 2002-2007 sample sizes were not large enough to reliably compare racial and ethnic subgroups, so diabetes analyses are not presented.

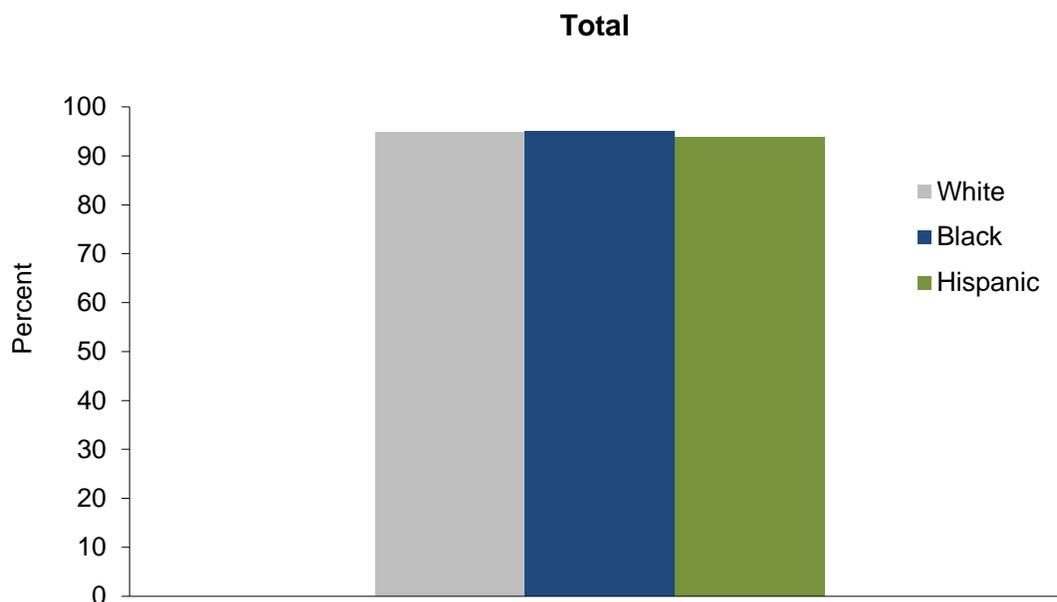
Heart Disease

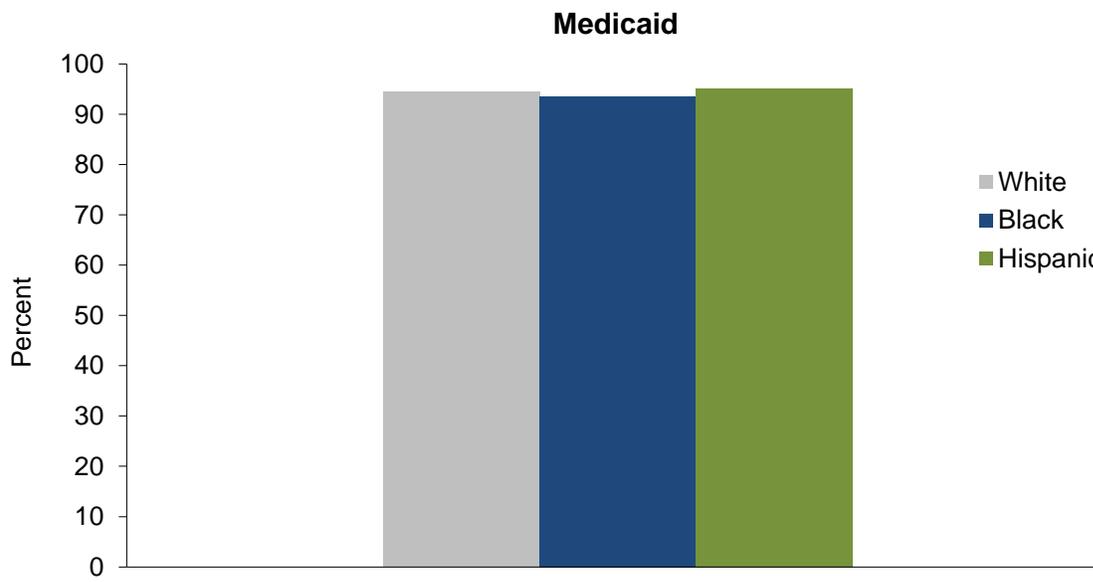
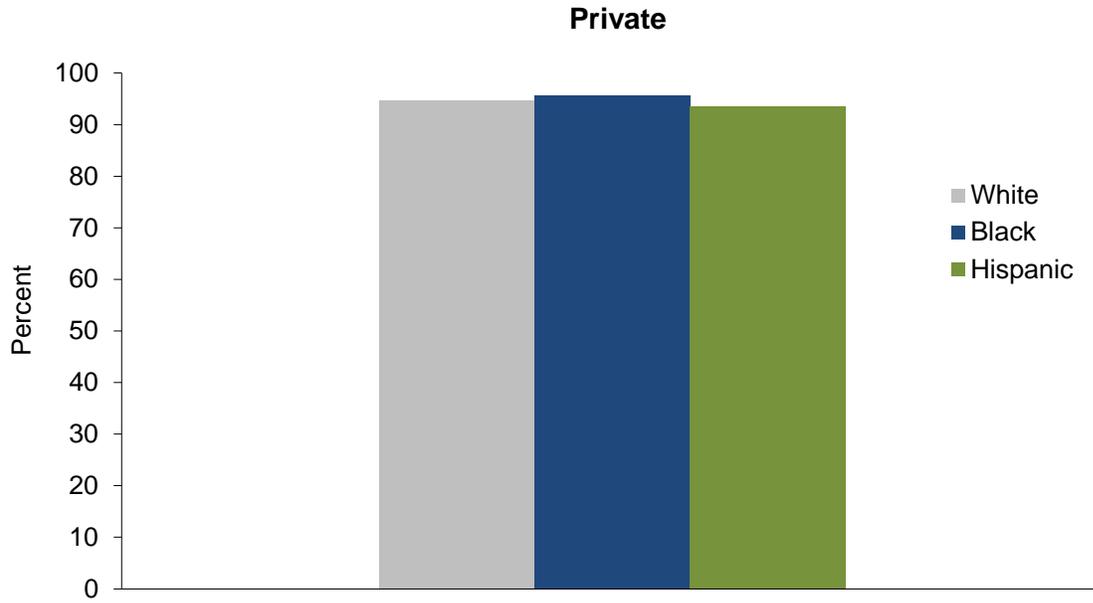
Prevention: Blood Pressure and Cholesterol Checks

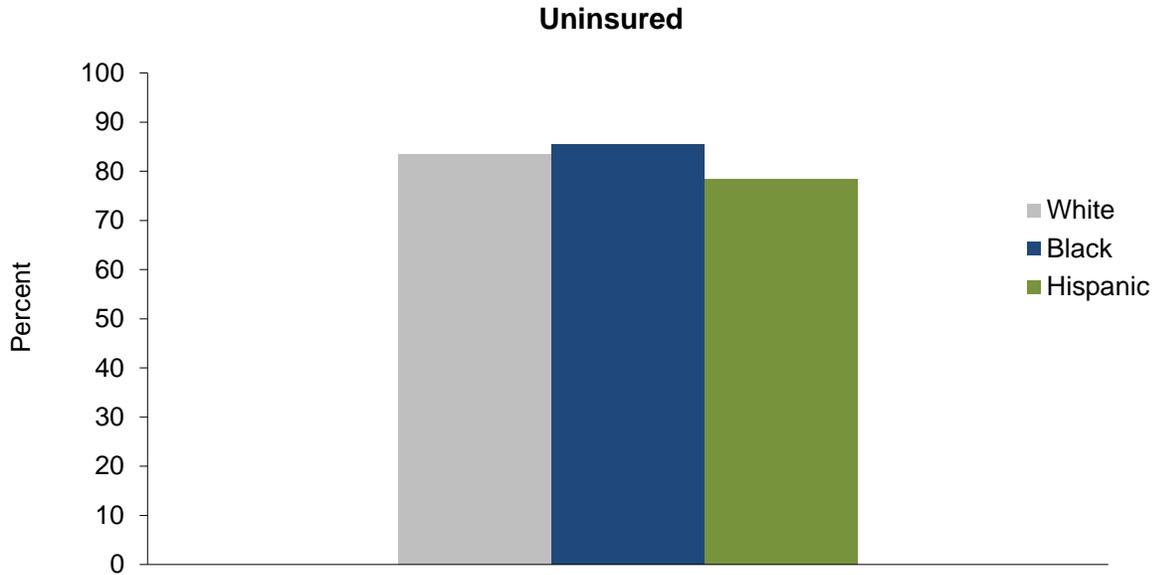
High cholesterol and blood pressure are major factors for heart disease. Awareness and control can help reduce the risk of heart attack.

The 2002-2007 sample sizes were not sufficient to reliably compare racial and ethnic or insurance subgroups, so trend data are not available for these measures.

Figure 4.6. Adults ages 18-64 who received a blood pressure measurement in the last 2 years and can state whether their blood pressure was normal or high, by race/ethnicity, stratified by insurance status, 2008



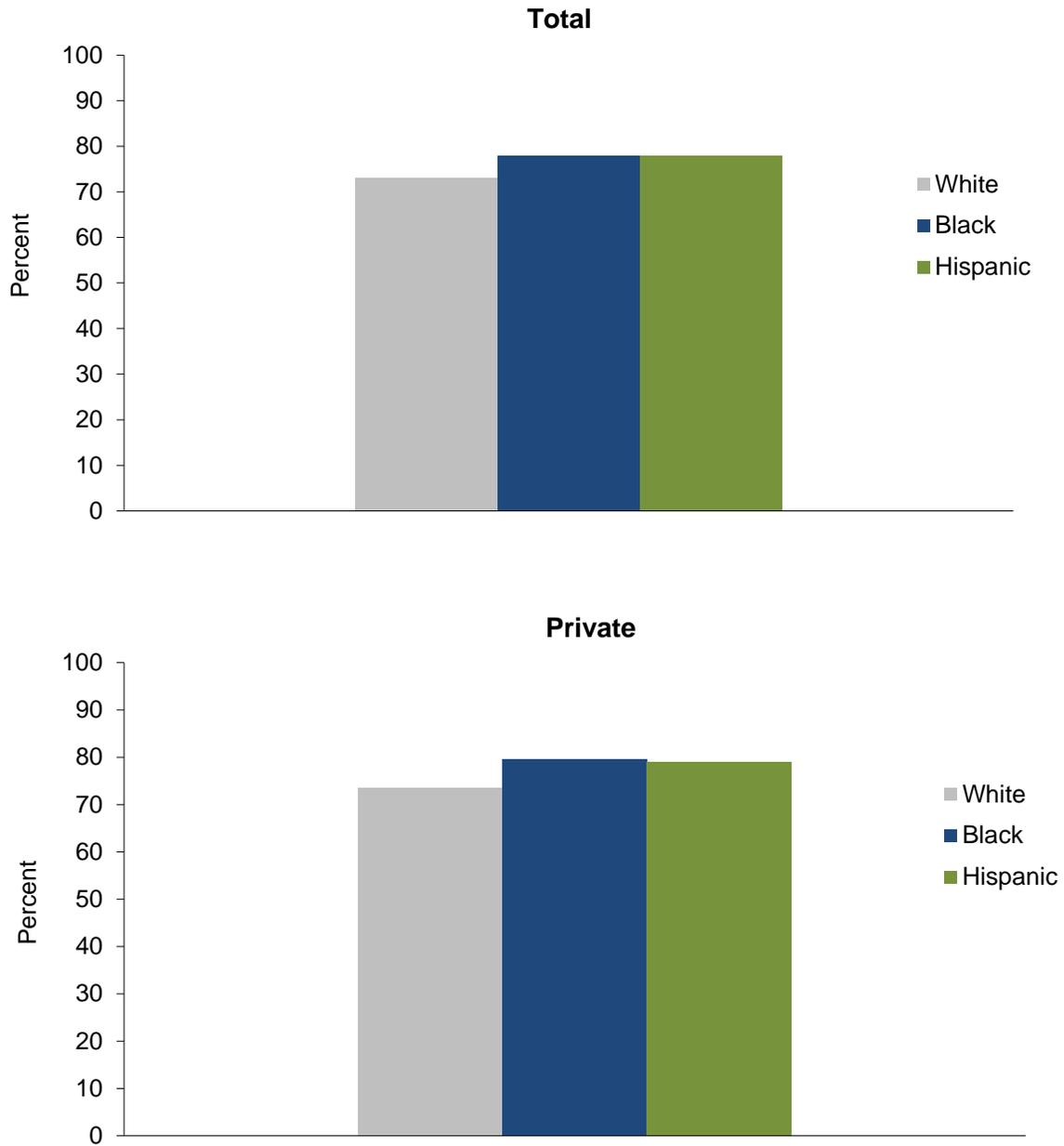


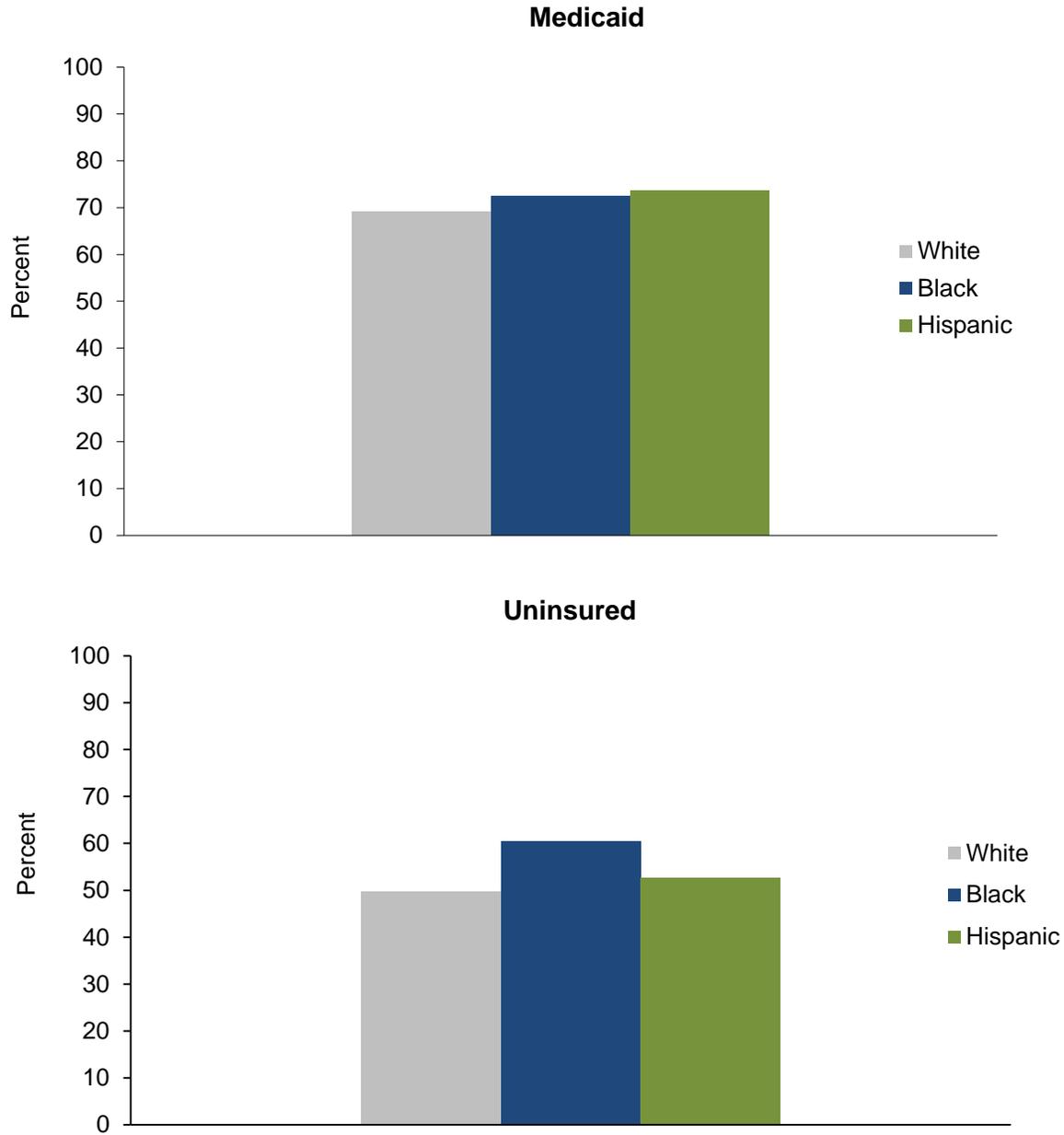


Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2008.

- In 2008, there were no statistically significant differences between racial and ethnic groups in the percentage who received a blood pressure measurement in the last 2 years and could state whether their blood pressure was normal or high.
- Also in 2008, Hispanic adults with private insurance were less likely than Black adults with private insurance to receive a blood pressure measurement and be able to state whether their blood pressure was normal or high.
- In 2008, there were no statistically significant differences between racial and ethnic groups with Medicaid.
- In 2008, uninsured Hispanic adults were less likely than uninsured White and Black adults to receive a blood pressure measurement.

Figure 4.7. Adults ages 18-64 who received a blood cholesterol measurement in the last 5 years, by race/ethnicity, stratified by insurance status, 2008





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

- In 2008, overall, White adults were less likely than both Black and Hispanic adults to have had a blood cholesterol measurement. The same was true of adults with private insurance.
- Also in 2008, there were no statistically significant differences between racial and ethnic groups with Medicaid in the percentage who received a blood cholesterol measurement.
- In 2008, White and Hispanic uninsured adults were less likely than Black uninsured adults to have had a cholesterol measurement.

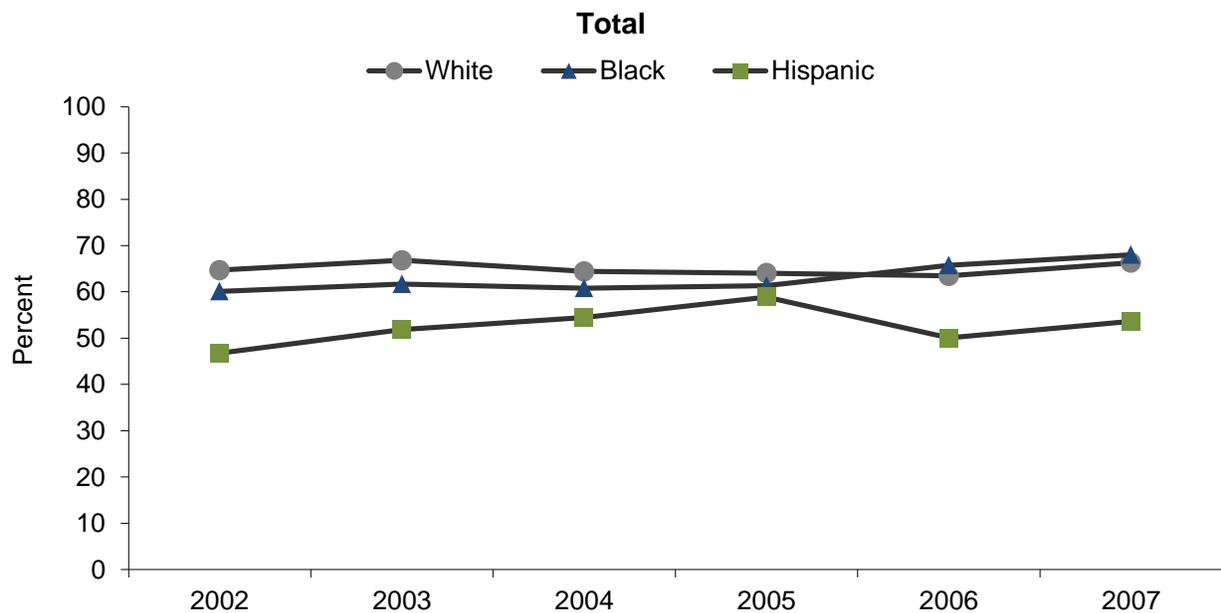
Lifestyle Modification

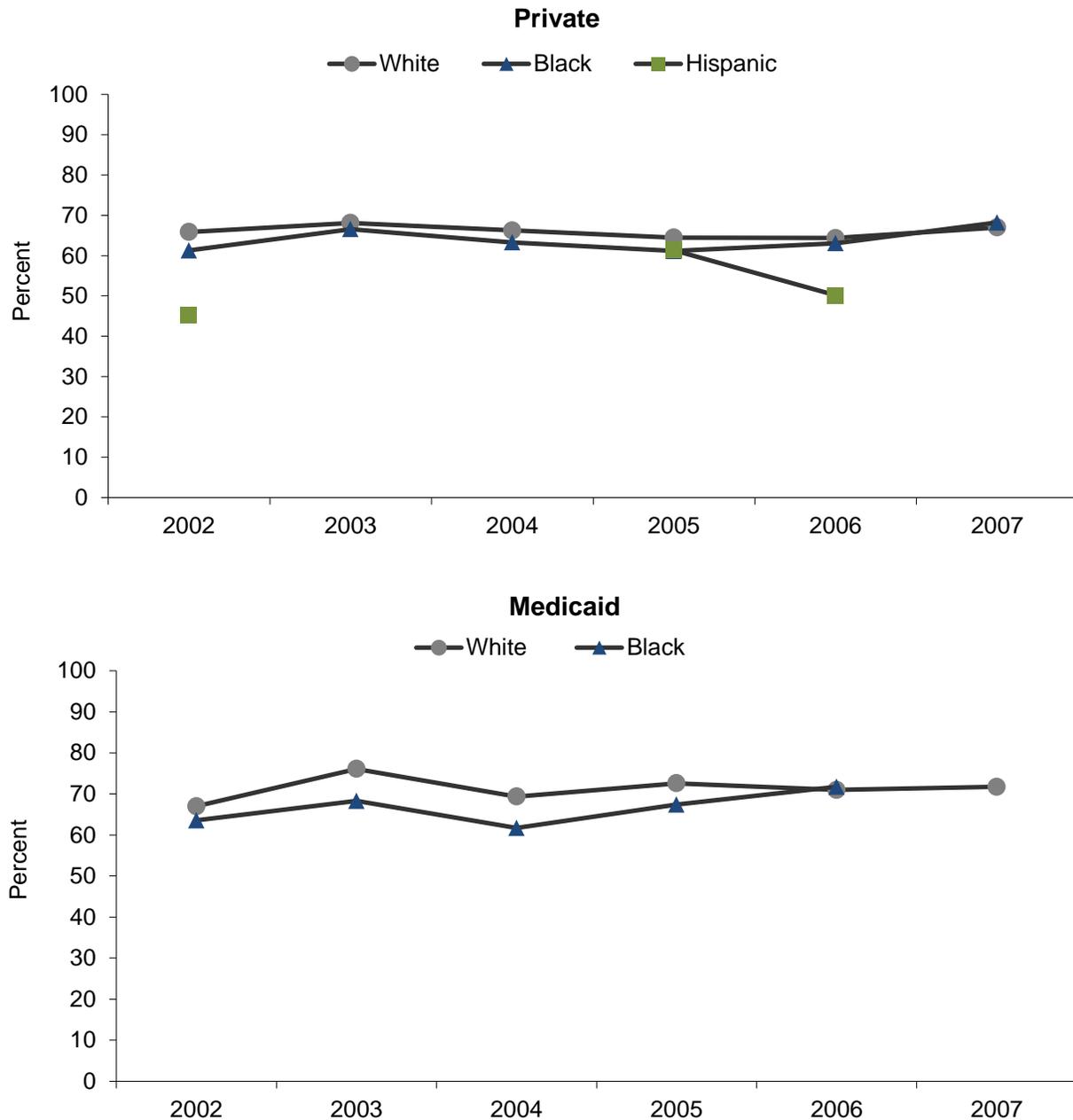
Prevention: Counseling Smokers to Quit Smoking

Smoking harms nearly every organ of the body and causes or exacerbates many diseases. Smoking causes more than 80% of deaths from lung cancer and more than 90% of deaths from chronic obstructive pulmonary disease.³ Heart disease is the leading cause of death in the United States for both men and women.⁴ Approximately 443,000 annual deaths are due to smoking.⁵

Quitting smoking has immediate and long-term health benefits. The risk of developing coronary heart disease attributed to smoking can be decreased by 50% after one year of cessation.⁶ Smoking may be the single most important modifiable risk factor for heart disease, and providers can encourage patients to quit smoking.

Figure 4.8. Adult current smokers ages 18-64 with a checkup in the last 12 months who received advice from a doctor to quit smoking, by race/ethnicity, stratified by insurance status, 2002-2007





Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.
Note: Data for privately insured Hispanics in 2003, 2004, and 2007; Hispanic adults with Medicaid from 2002 to 2007; Black adults with Medicaid in 2007; and uninsured Blacks and Hispanics from 2002 to 2007 do not meet the criteria for statistical reliability, data quality, or confidentiality.

- From 2002 to 2007, Hispanic adult current smokers ages 18-64 with a checkup in the last 12 months were less likely to receive advice from a doctor to quit smoking than Black and White adults, who were equally likely to receive advice.
- There were no statistically significant differences between White and Black adult current smokers with private insurance who received advice from a doctor to quit smoking. Among privately insured adult current smokers, Hispanics were less likely than Whites

and Blacks in 2002 and less likely than Whites in 2006 to receive advice from a doctor to quit smoking.

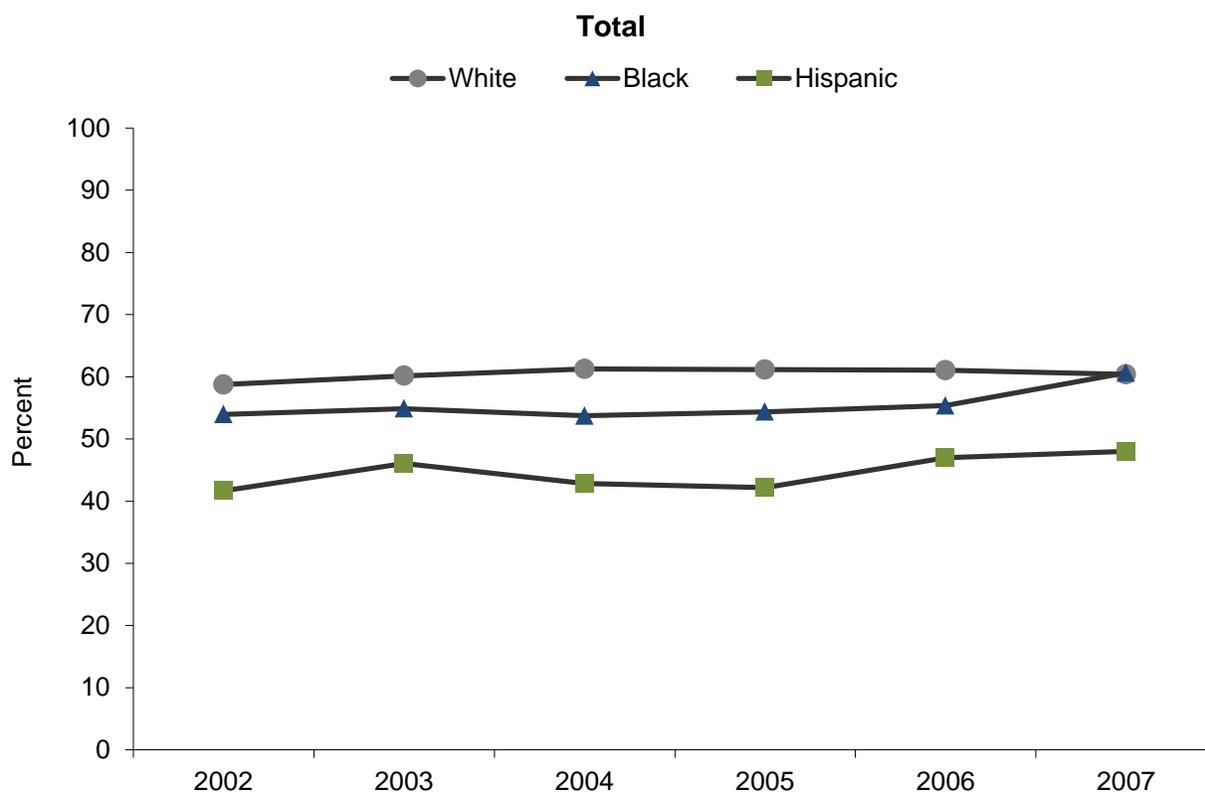
- From 2002 to 2006, there were no statistically significant differences between Whites and Blacks with Medicaid who received advice from a doctor to quit smoking.

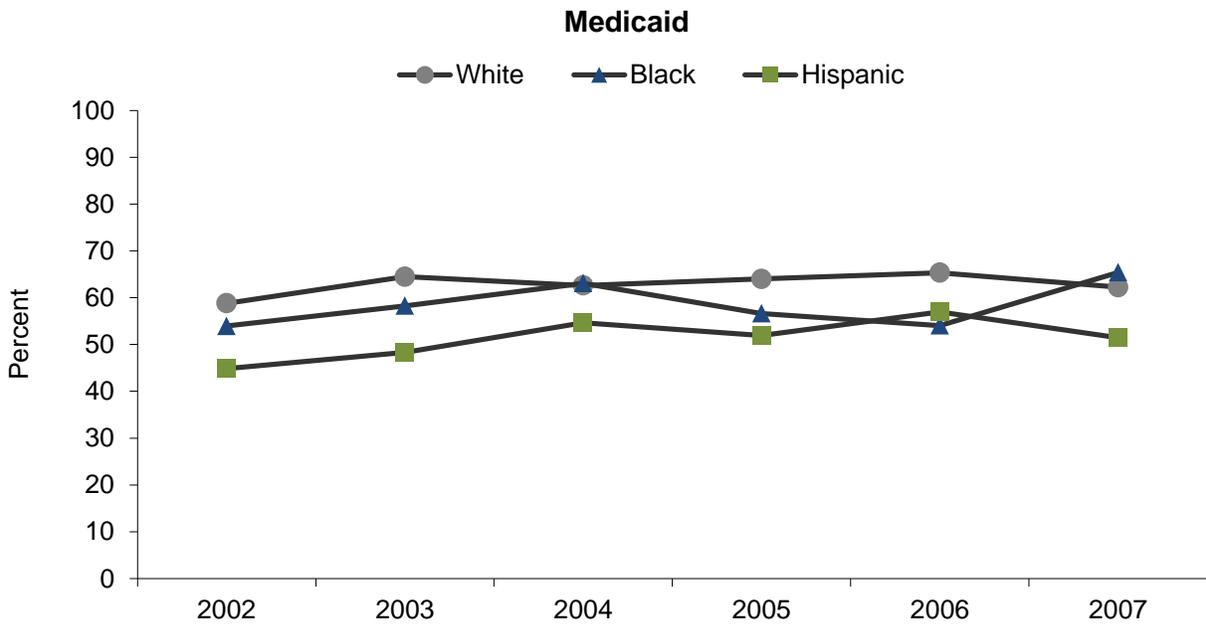
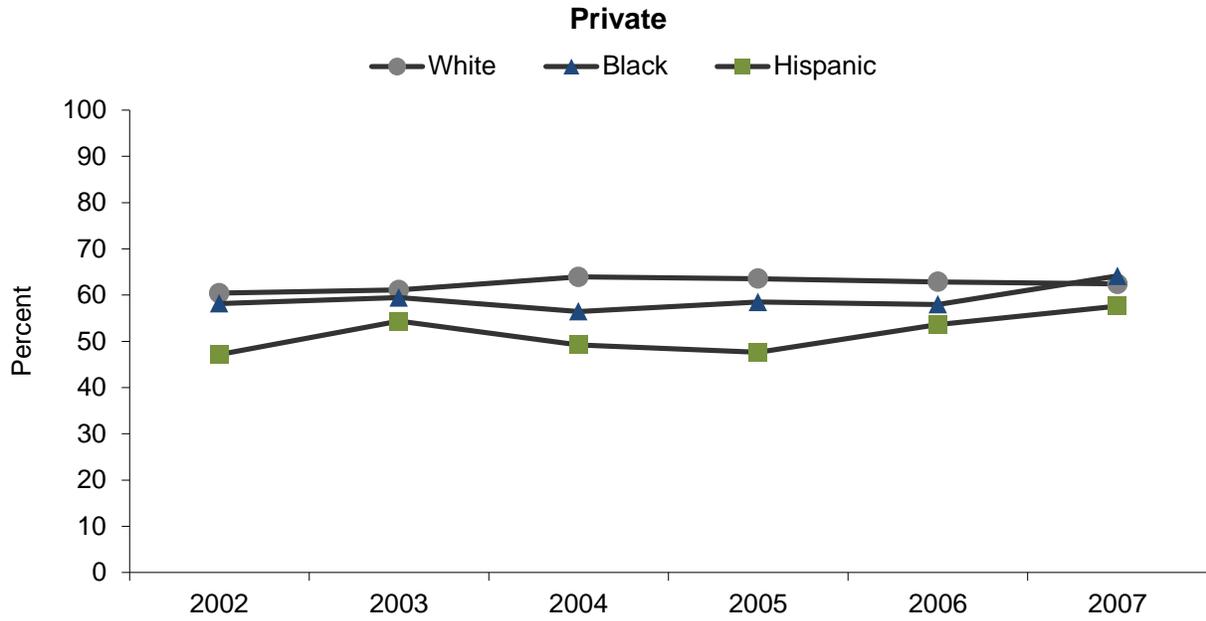
Prevention: Counseling Obese Adults About Exercise and Diet

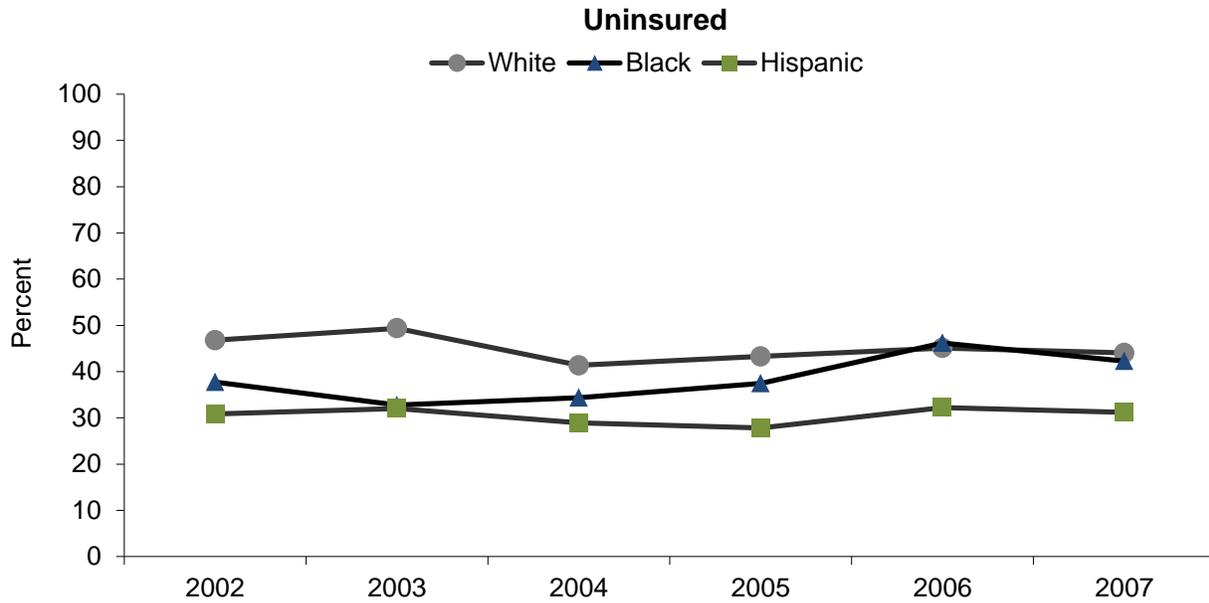
More than one-third of adults age 20 and over in the United States are obese (defined as having a body mass index [BMI] of 30 or higher).⁷ Obesity puts them at increased risk for many chronic, often deadly conditions, such as hypertension, cancer, diabetes, and coronary heart disease.⁸ Although clinical guidelines recommend that health care providers screen all adult patients for obesity,⁹ obesity remains underdiagnosed among U.S. adults.¹⁰

Provider-based exercise counseling is an important component of effective weight loss interventions,⁹ and has been shown to produce increased levels of physical activity among sedentary patients.¹¹ Although every obese person may not need counseling about exercise and diet, many would likely benefit from improvements in these activities. Regular exercise and a healthy diet aid in maintaining normal blood cholesterol levels, weight, and blood pressure, reducing the risk of heart disease, stroke, diabetes, and other comorbidities of obesity.

Figure 4.9. Adults ages 18-64 with obesity who ever received advice from a health provider to exercise more, by race/ethnicity, stratified by insurance status, 2002-2007



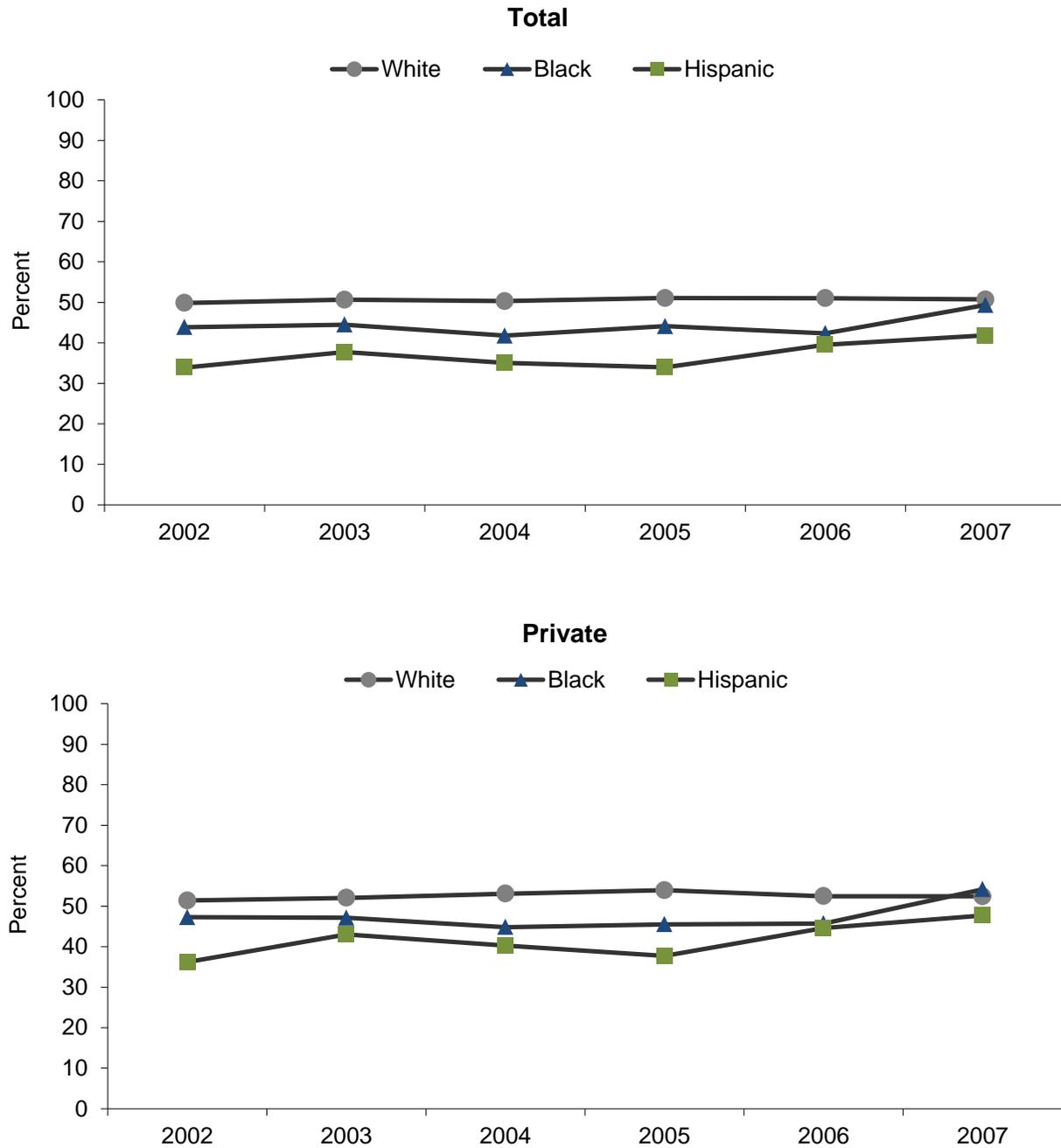


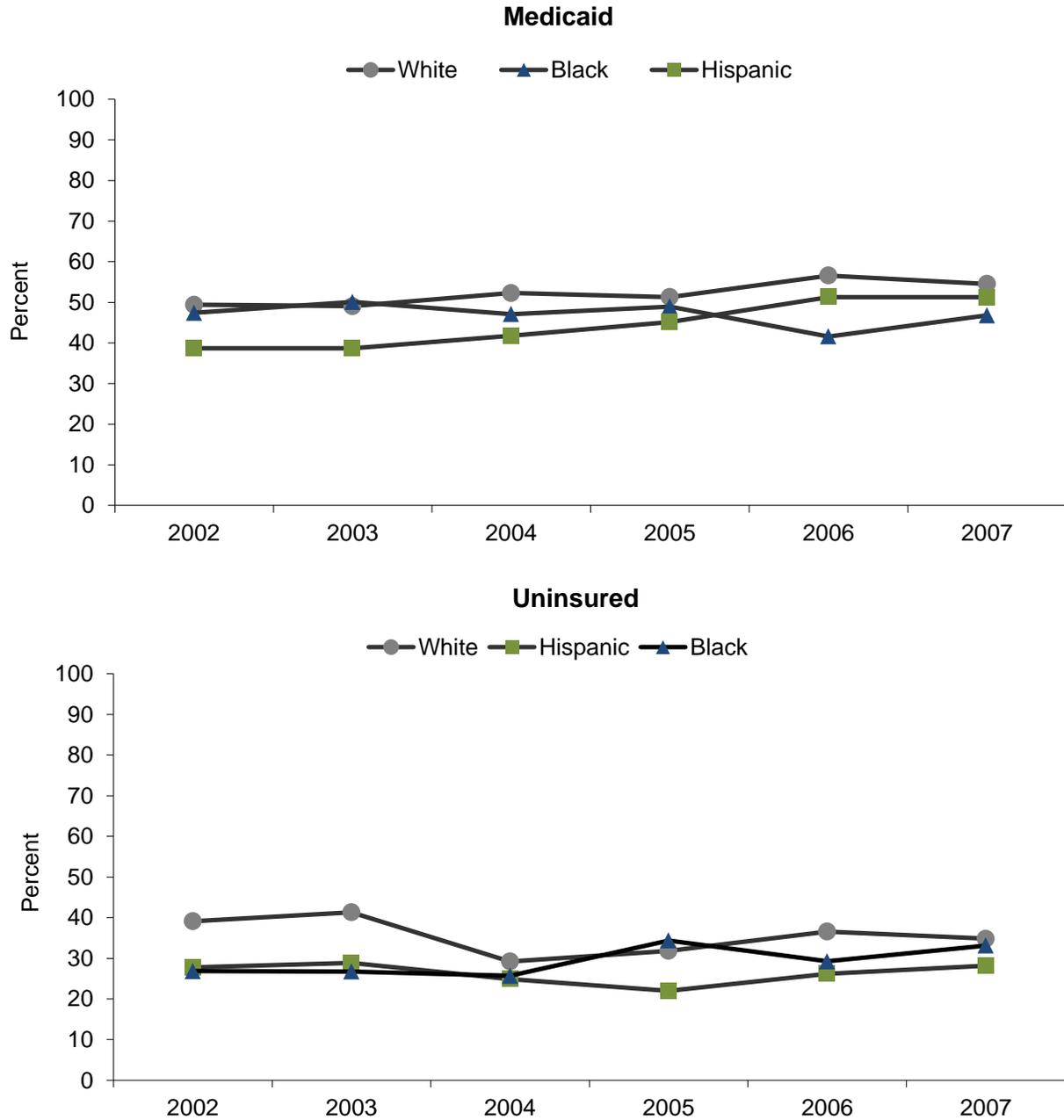


Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.

- From 2002 to 2007, White and Black adults with obesity were more likely than Hispanic adults to receive advice from a health provider to exercise more. From 2002 to 2007, the percentage of adults who received advice from a health provider to exercise more stayed the same for Whites but improved for Blacks and Hispanics.
- In 2002, among privately insured adults, Whites and Blacks with obesity were more likely than Hispanics to receive advice to exercise more. In 2007, there were no statistically significant differences between racial and ethnic groups.
- The percentage of adults with obesity who received advice to exercise more increased over time for all three racial and ethnic groups with Medicaid. In 2002, Whites with Medicaid were more likely than Hispanics to receive advice to exercise more, while in 2007 both Whites and Blacks with Medicaid were more likely to receive advice than Hispanics.
- The percentage of uninsured adults who received advice decreased over time for Whites but there no statistically significant changes for Blacks or Hispanics. In 2002, White uninsured adults were more likely than Hispanic adults to receive advice to exercise more. In 2007, White and Black uninsured adults were more likely to receive advice than Hispanic adults.

Figure 4.10. Adults ages 18-64 with obesity who ever received advice from a health provider about eating fewer high-fat or high-cholesterol foods, by race/ethnicity, stratified by insurance status, 2002-2007





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

- In 2002, White adults with obesity were more likely than Black and Hispanic adults to receive advice from a health provider about eating fewer high-fat or high cholesterol foods. In 2007, however, there were no statistically significant differences between Blacks and Whites. The disparity between White adults and Hispanic adults persisted in 2007, but the size of the disparity decreased over time. The percentage of adults with obesity who received advice improved over time for Blacks and Hispanics but was steady for Whites.
- In 2002, privately insured Hispanic adults were less likely than White and Black adults to receive advice from a health provider about eating fewer high-fat or high cholesterol

foods, but there were no statistically significant differences in 2007. The percentage of adults who received advice improved over time for Blacks and Hispanics but was steady for Whites.

- In 2002, among adults with Medicaid, Hispanics were less likely than Whites to receive advice from a health provider about healthy eating. In 2007, there were no statistically significant differences between Hispanics and Whites. The percentage of adults with Medicaid who received advice decreased over time for Blacks but increased for Whites and Hispanics.
- In 2002, among uninsured adults, Whites were more likely than Blacks and Hispanics to receive advice from a health provider about healthy eating. In 2007, there were no statistically significant racial or ethnic differences. The percentage of uninsured adults who received advice decreased over time for Whites but increased for Blacks. The percentage was steady for Hispanics.

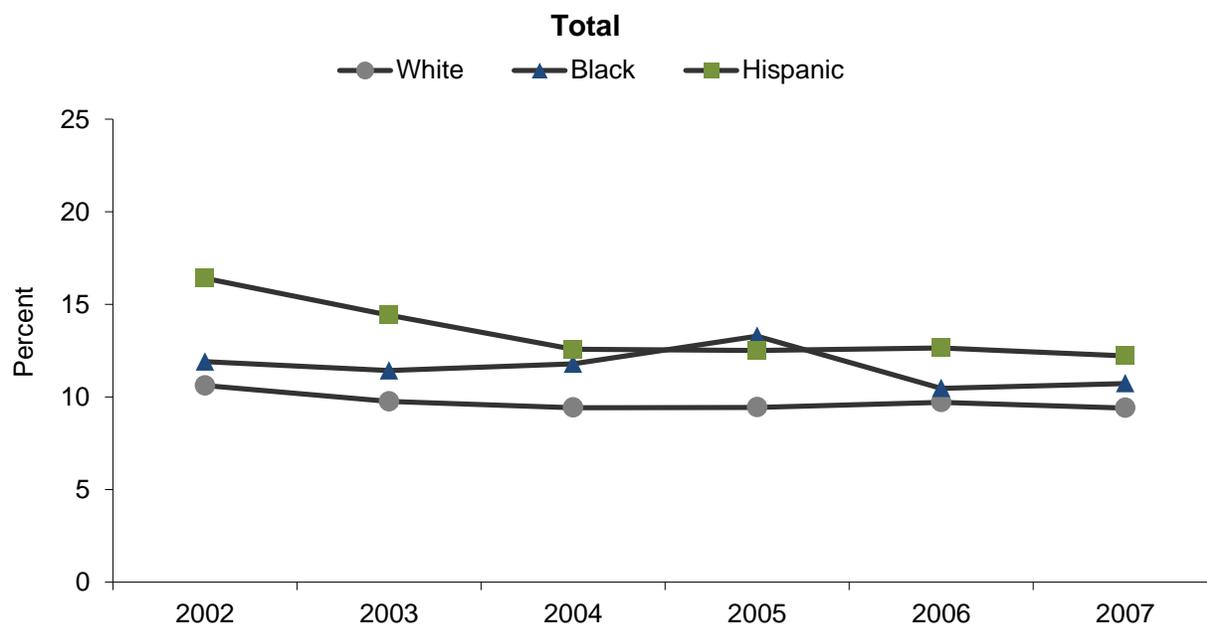
Patient Centeredness

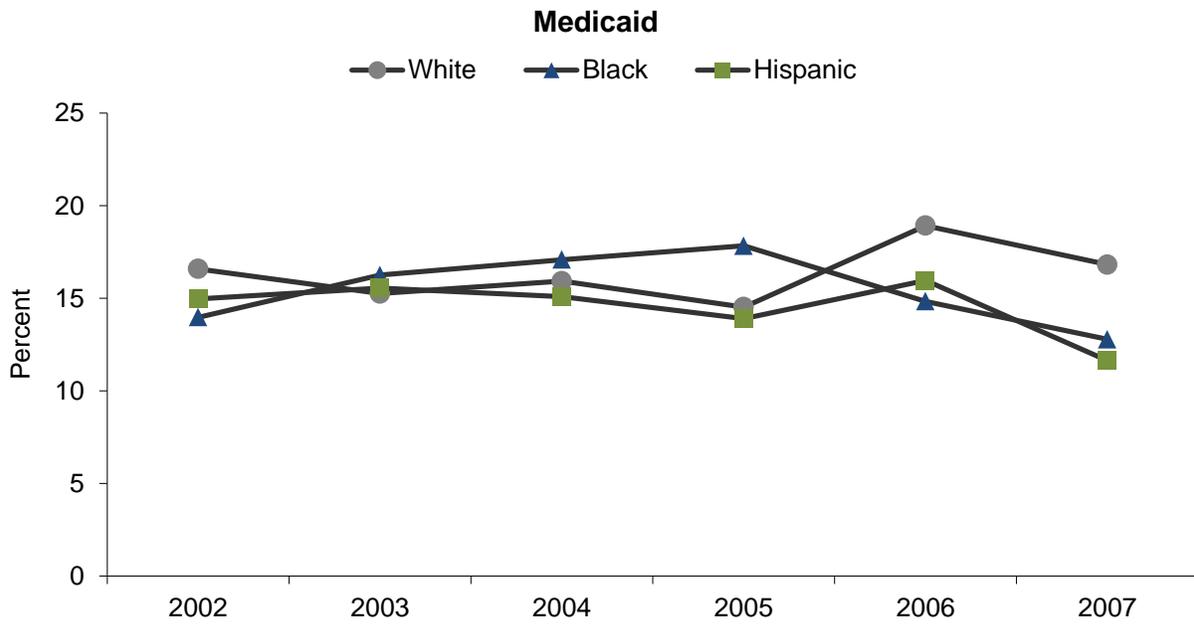
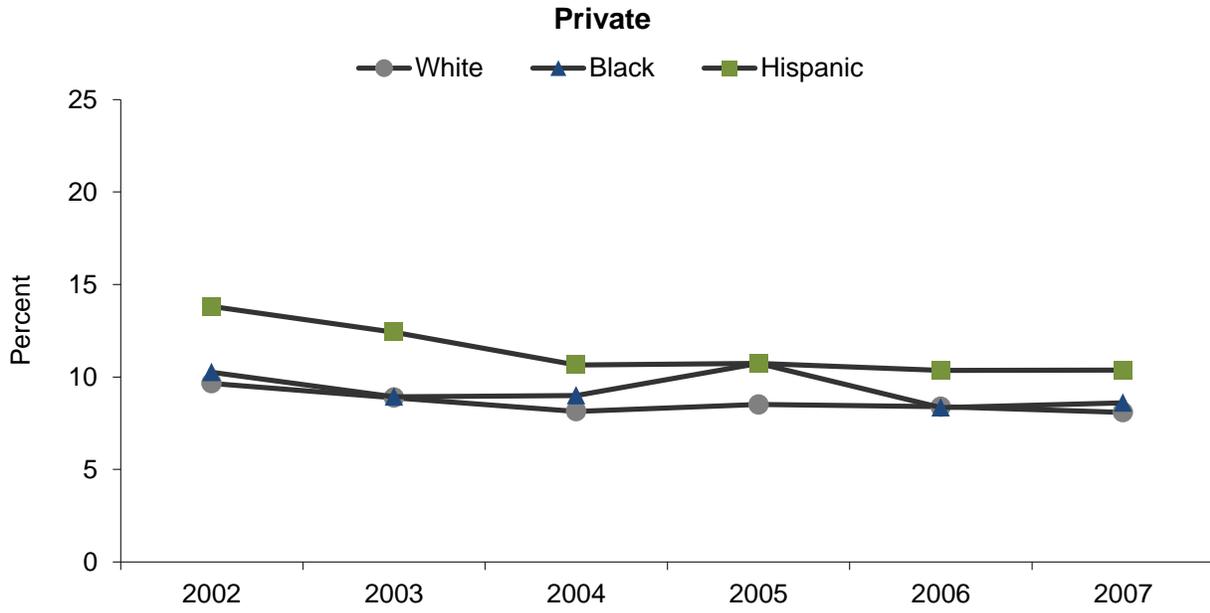
Patient-centered care is supported by good provider-patient communication so that patients’ needs and wants are understood and addressed and patients understand and participate in their own care. This style of care has been shown to improve patients’ health and health care. Unfortunately, many barriers exist to good communication.

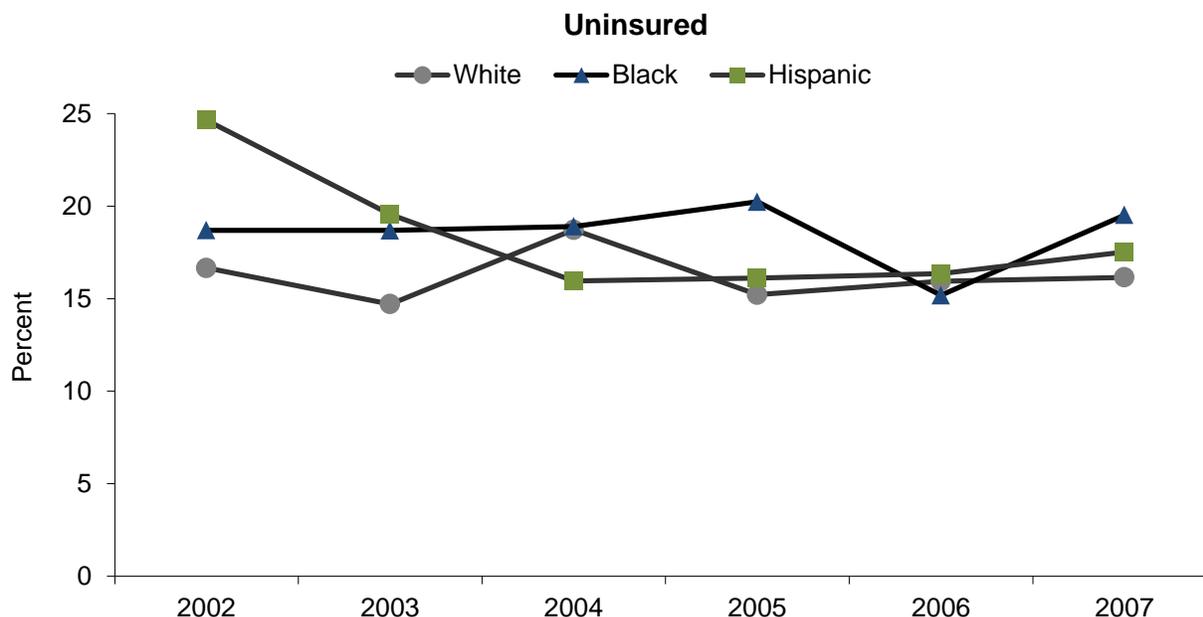
Patient Experiences of Care

Optimal health care requires good communication between patients and providers, yet barriers to provider-patient communication are common. To provide all patients with the best possible care, providers need to understand patients’ diverse health care needs and preferences and communicate clearly with patients about their care.

Figure 4.11. Adults ages 18-64 who reported poor communication with health providers, by race/ethnicity, stratified by insurance status, 2002-2007







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

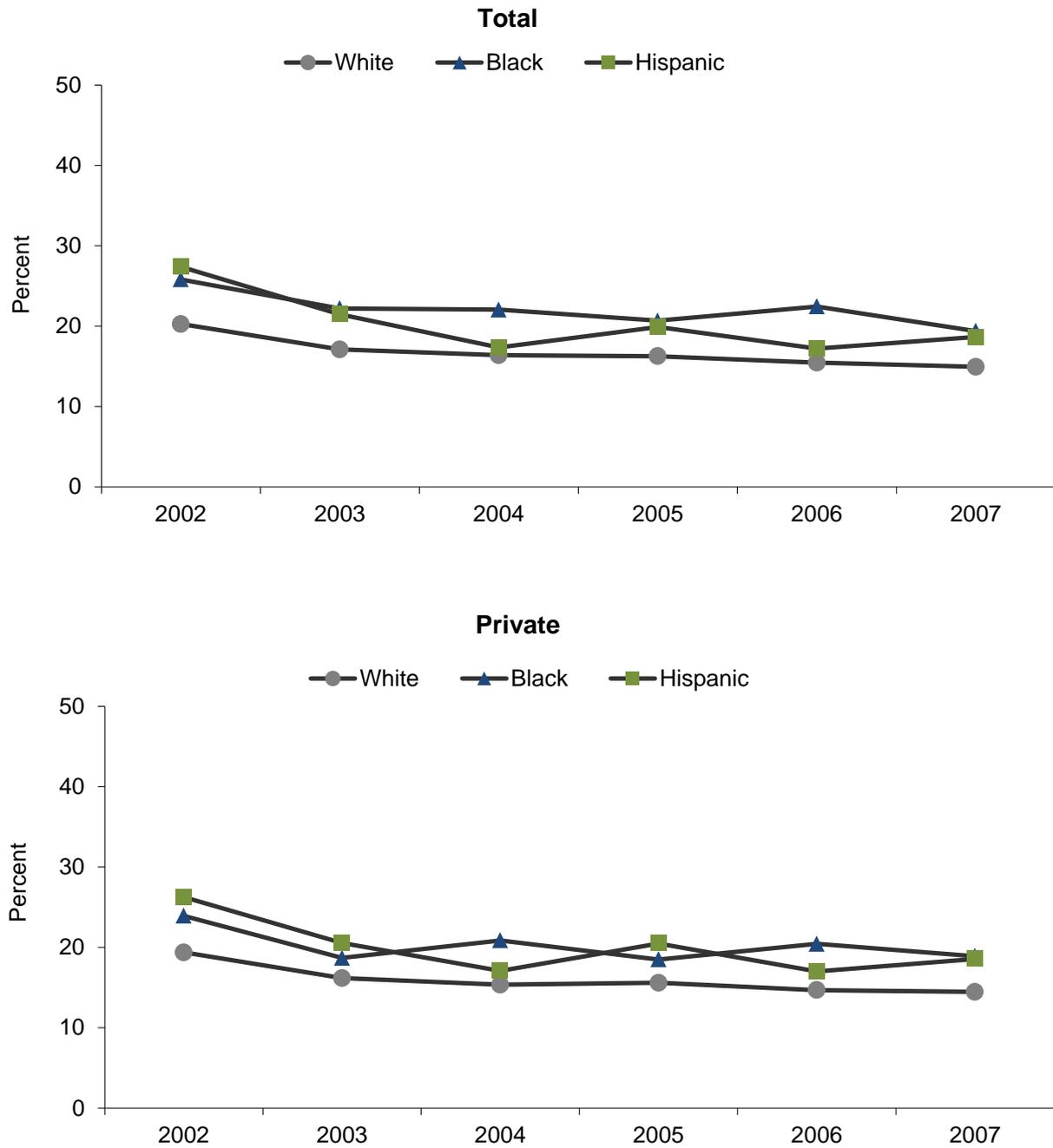
Note: For this measure, lower rates are better. Patients who report that their health providers sometimes or never listened carefully, explained things clearly, showed respect for what they had to say, or spent enough time with them are considered to have poor communication.

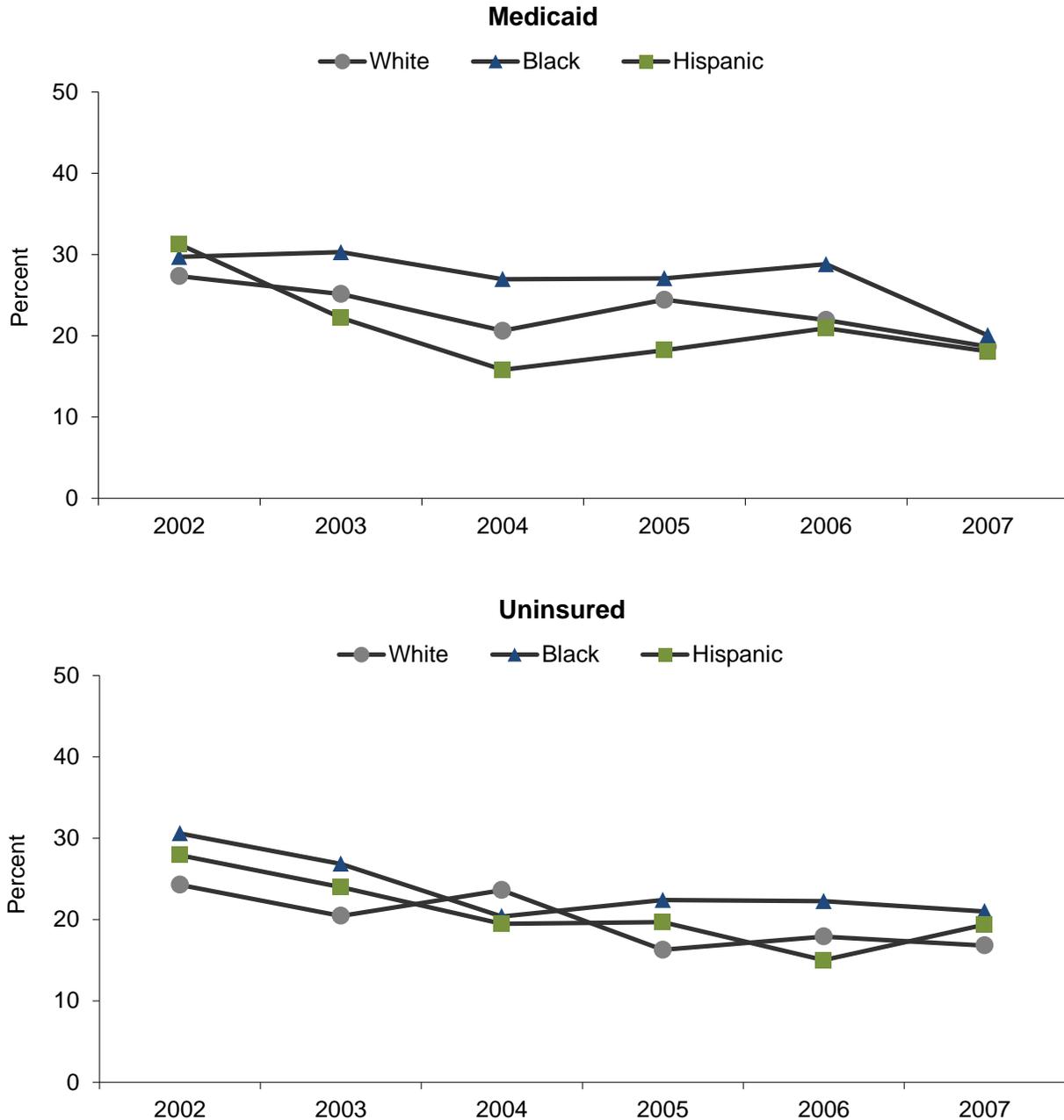
- Overall, from 2002 to 2007, Hispanic adults were more likely to report poor communication than White adults. Hispanic adults were more likely to report poor communication than Black adults in 2002 but not in 2007. For all racial and ethnic groups, the percentage reporting poor communication decreased over time.
- From 2002 to 2007, privately insured Hispanic adults were more likely to report poor communication than privately insured White adults. The percentage with private insurance who reported poor communication decreased over time for all racial and ethnic groups.
- The percentage of Hispanic adults with Medicaid reporting poor communication decreased from 2002 to 2007.
- In 2007, Whites were more likely to report poor communication than Hispanics.
- Uninsured Hispanic adults were more likely to report poor communication than uninsured White adults in 2002, but in 2007, the difference was not statistically significant.

Providers Asking Patients To Assist in Making Treatment Decisions

The high prevalence of chronic disease has placed more responsibility on patients. Conditions such as diabetes and hypertension require self-management by patients. It is vital that patients are provided with information that allows them to make informed decisions and feel engaged in their treatment and that it incorporates their values and preferences.

Figure 4.12. Adults ages 18-64 with a usual source of care whose health provider sometimes or never asked for the person's help to make treatment decisions, by race/ethnicity, stratified by insurance status, 2002-2007





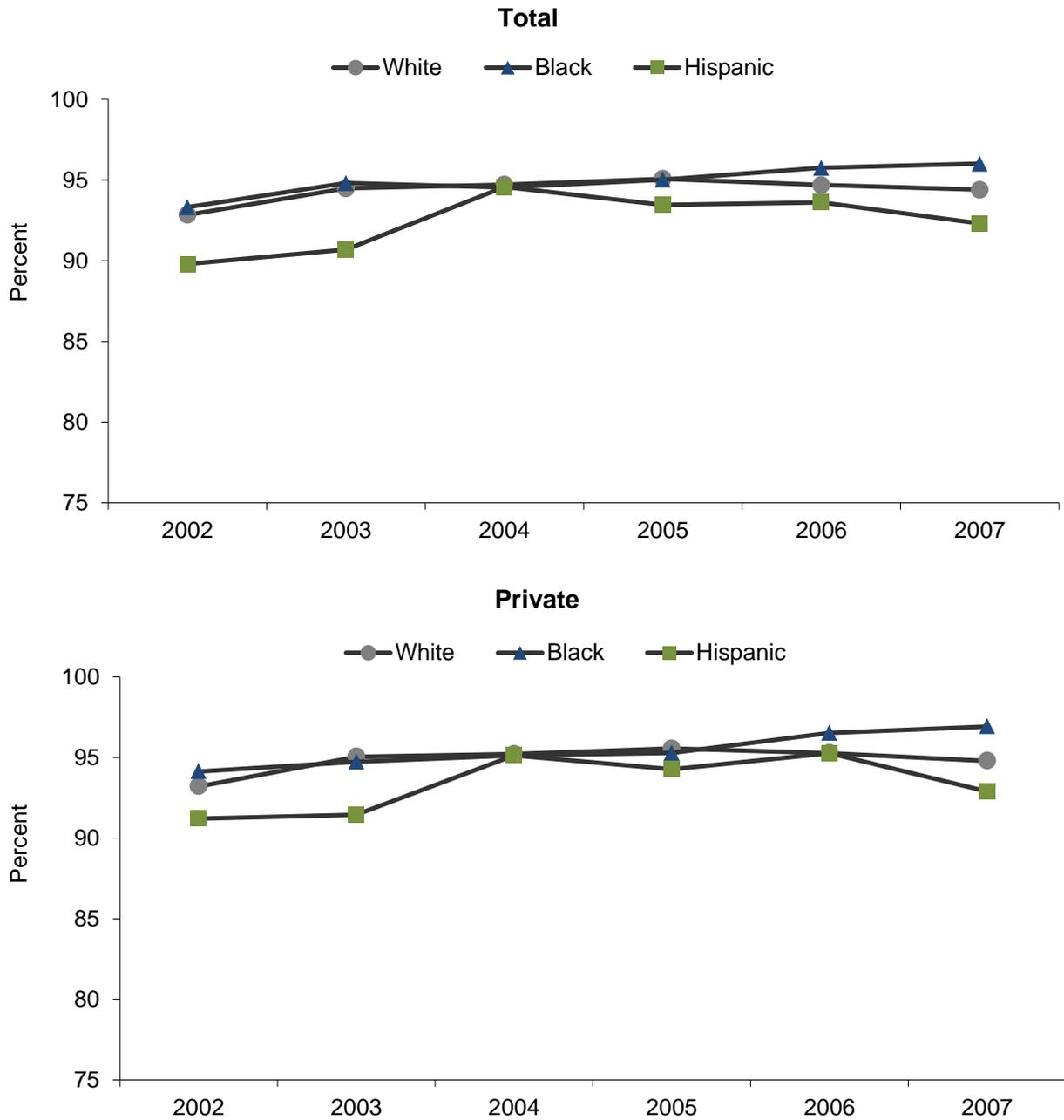
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.

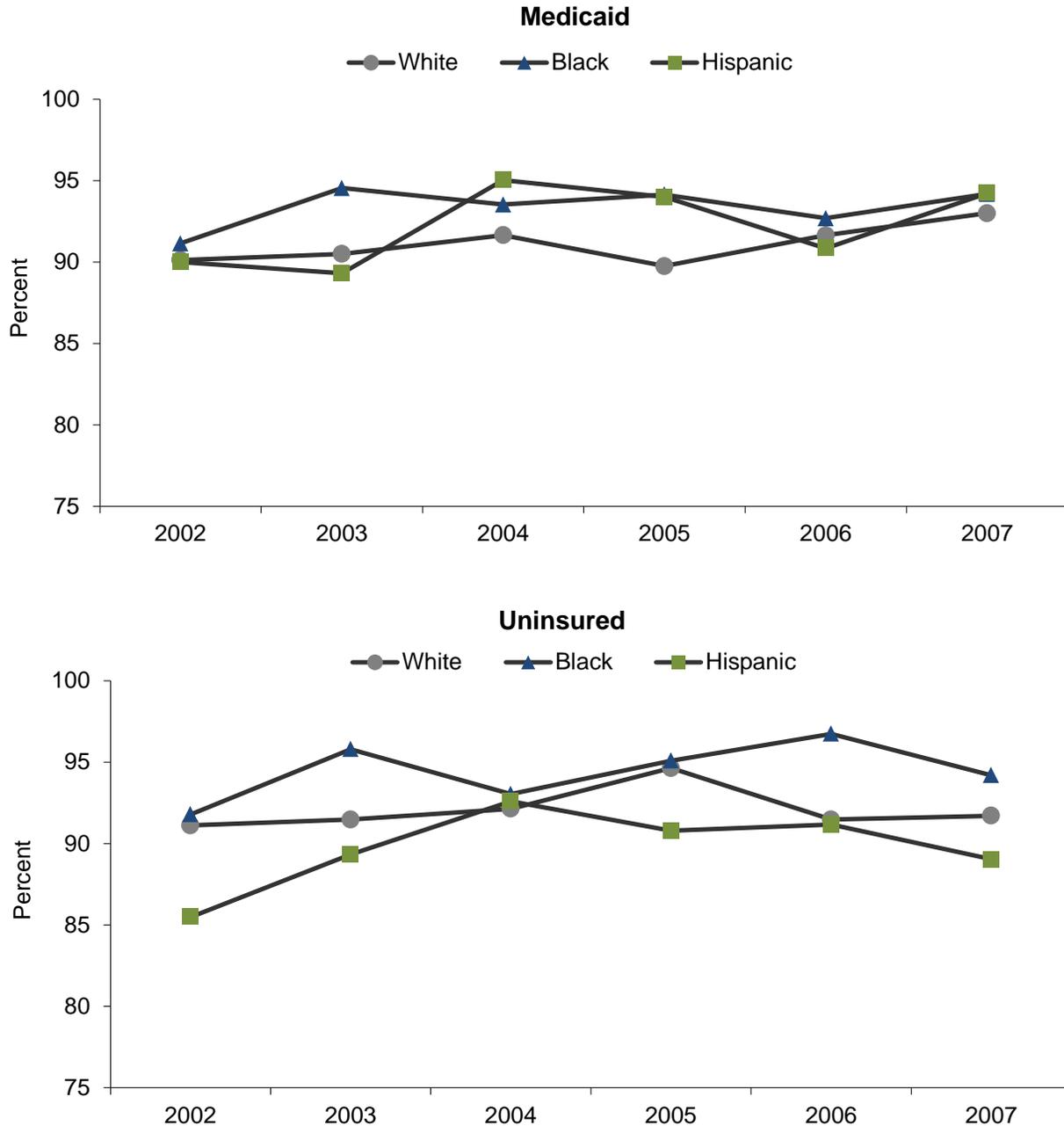
Note: For this measure, lower rates are better.

- From 2002 to 2007, overall, among adults with a usual source of care whose health provider sometimes or never asked for the person’s help to make treatment decisions, the percentage was higher for Blacks and Hispanics than for Whites. The same pattern held for adults with private insurance.
- Among adults with Medicaid and no insurance, there were no statistically significant racial or ethnic differences in the percentage whose health provider sometimes or never asked them to help make treatment decisions. For both groups, the percentage whose

health provider sometimes or never asked them to help make treatment decisions decreased over time.

Figure 4.13. Adults ages 18-64 with a usual source of care for whom health providers explained and provided all treatment options, by race/ethnicity, stratified by insurance status, 2002-2007





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

- From 2002 to 2007, overall, the percentage of adults with a usual source of care whose health providers explained and provided all treatment options improved for all racial and ethnic groups.
- In 2002, among adults with private insurance, Blacks were more likely than Hispanics to have their health providers explain and provide all treatment options, but there were no statistically significant differences between either group and Whites. In 2007, Blacks were more likely than both Hispanics and Whites to have their health provider explain and provide all treatment options. From 2002 to 2007, the percentage of adults with

private insurance whose health providers explained and provided all treatment options increased for all racial and ethnic groups.

- From 2002 to 2007, there were no statistically significant racial or ethnic differences among adults with Medicaid. In addition, the percentage of adults with Medicaid whose health providers explained and provided all treatment options increased for all racial and ethnic groups.
- In 2002, Hispanic uninsured adults were less likely than both Black and White uninsured adults to have their health provider explain and provide all treatment options, but there were no statistically significant differences in 2007. The percentage of uninsured adults whose health providers explained and provided all treatment options increased for all racial and ethnic groups over time.

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Racial and Ethnic Disparities

Chapter 5: 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) are disproportionately represented among those with access problems.

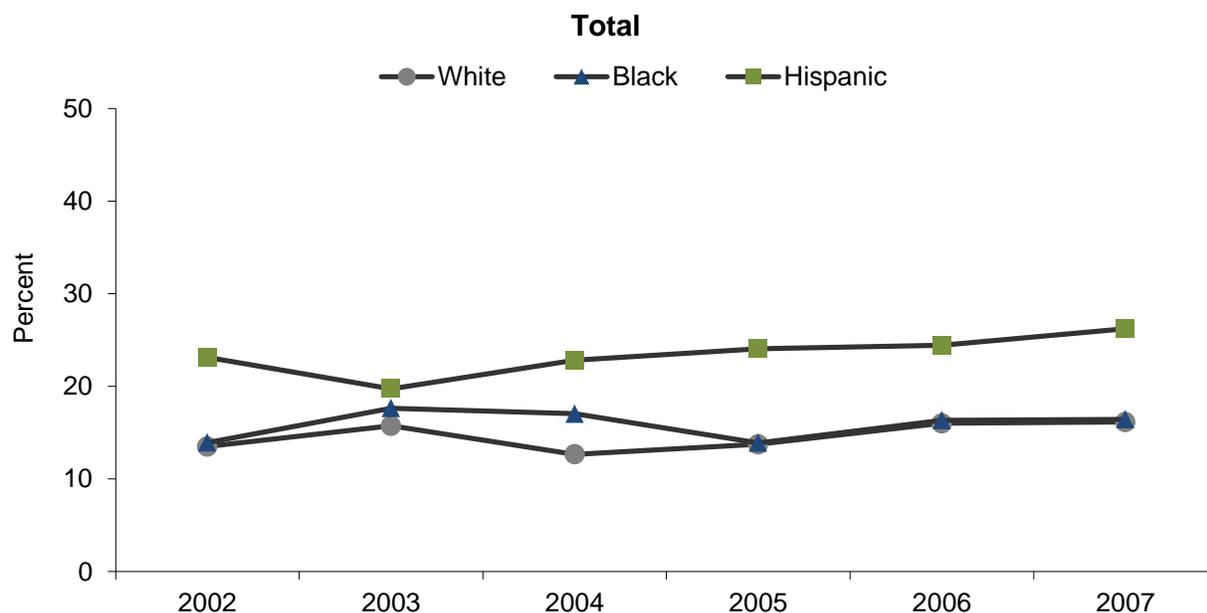
Facilitators and Barriers to Health Care

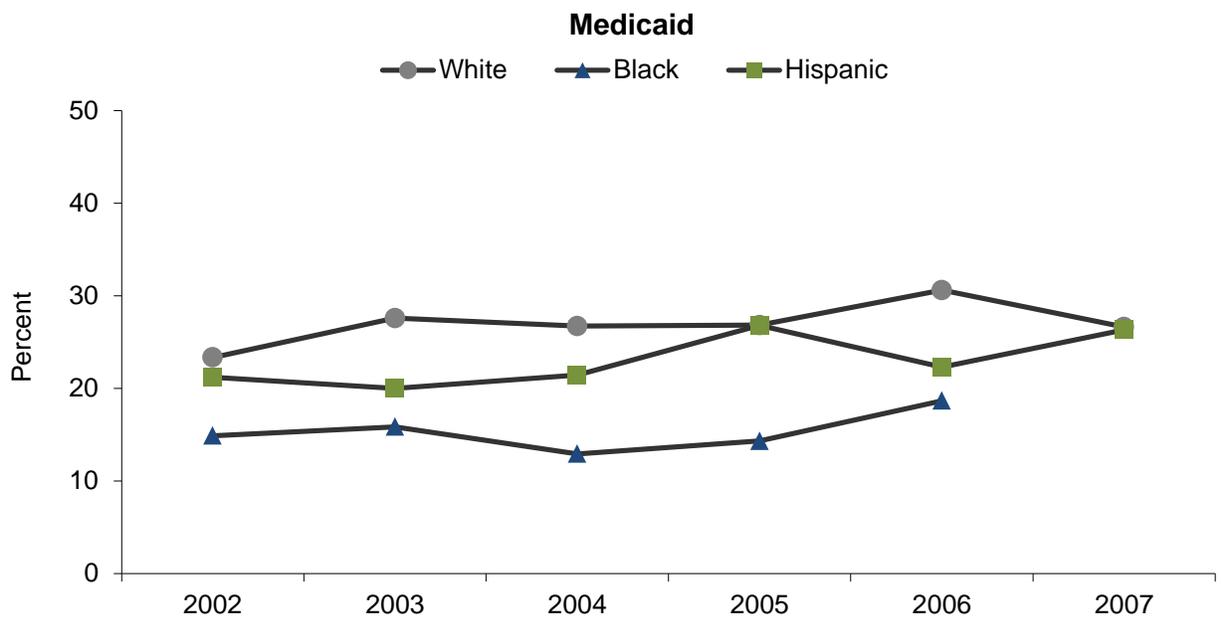
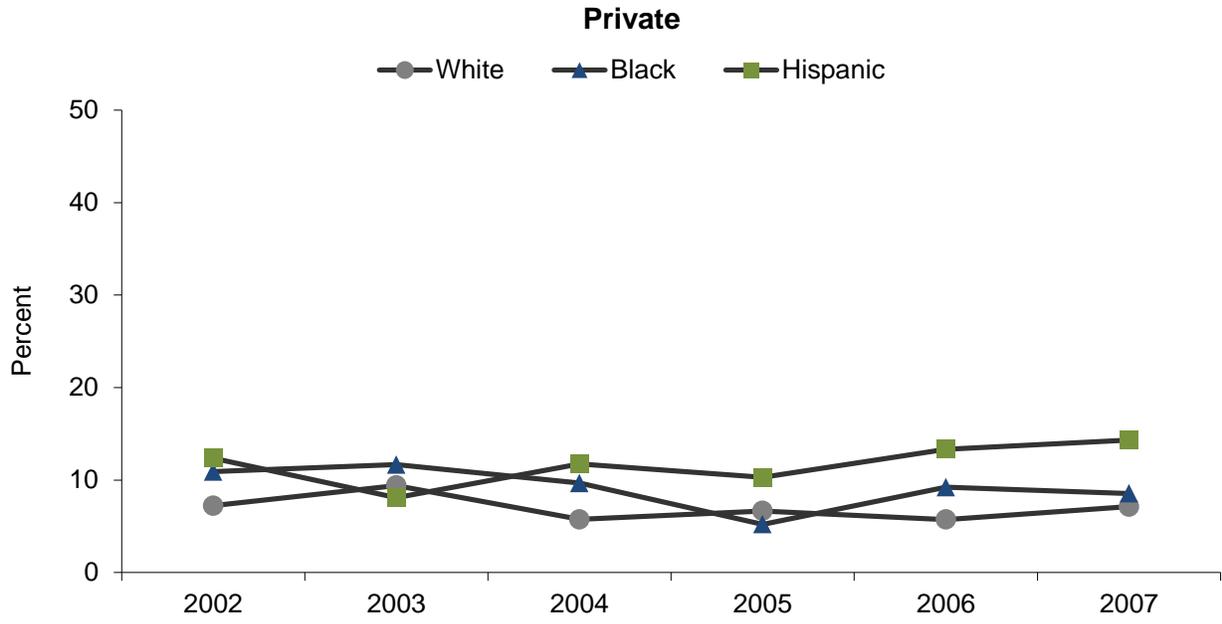
Facilitators and barriers to health care discussed in this section include usual source of care (including having a usual source of ongoing care and a usual primary care provider), patient perceptions of need, and financial/insurance burdens.

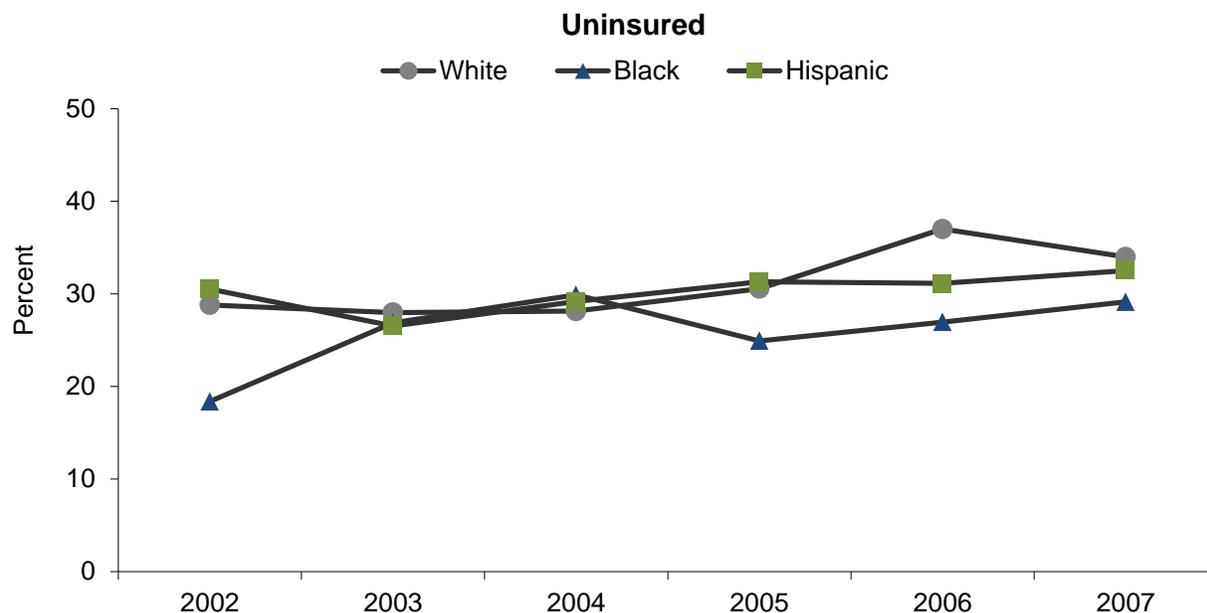
Usual Source of Care

People with a usual source of care (a provider or facility where one regularly receives care) experience improved health outcomes and reduced disparities¹ and costs.² Evidence suggests that the effect on quality of the combination of health insurance and a usual source of care is additive.³ In addition, people with a usual source of care are more likely to receive preventive health services.⁴

Figure 5.1. Adults ages 18-64 without a usual source of care, by race/ethnicity, stratified by insurance status, 2002-2007







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

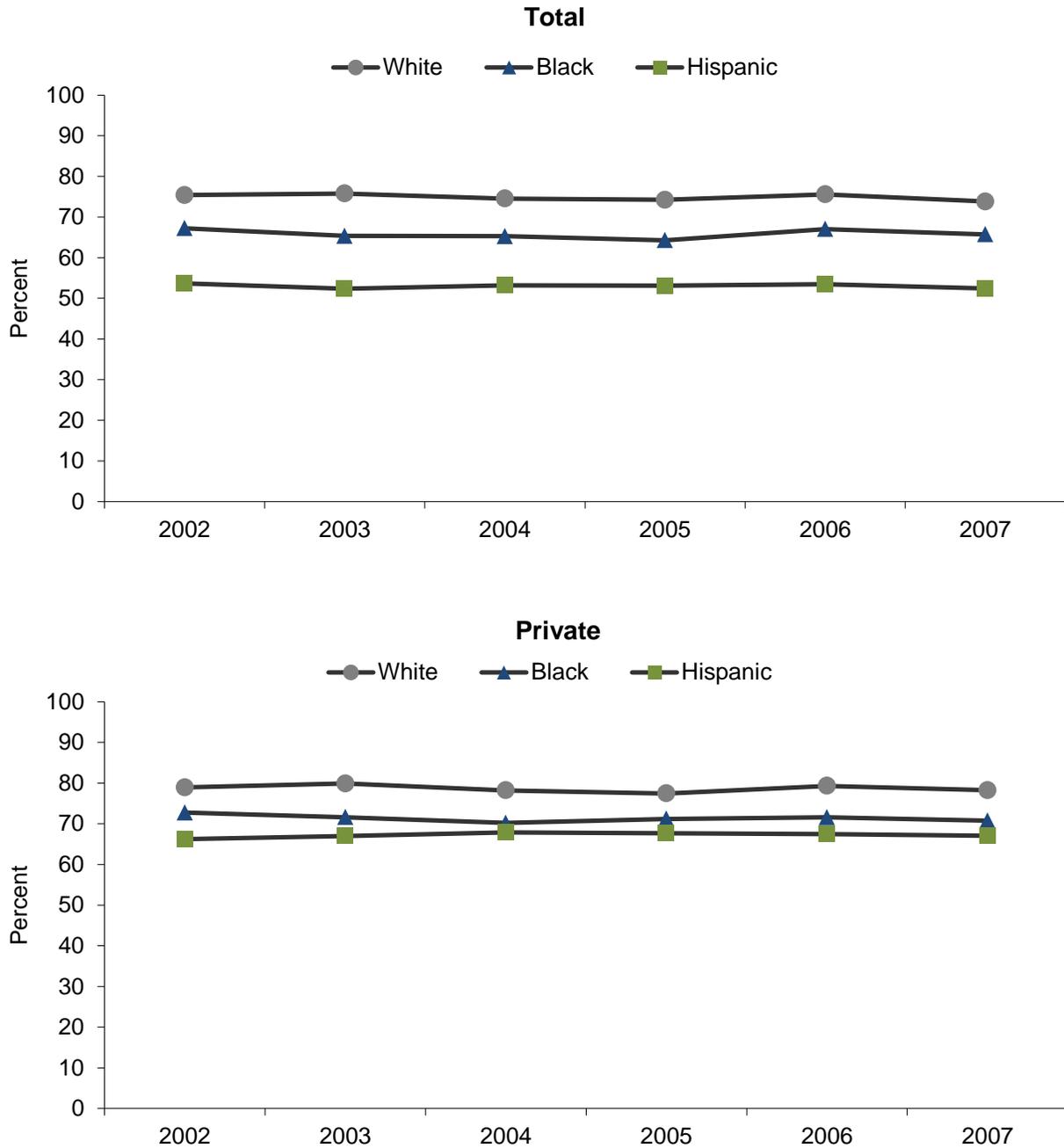
Note: For this measure, lower rates are better. Data for Black adults with Medicaid in 2007 do not meet the criteria for statistical reliability, data quality, or confidentiality.

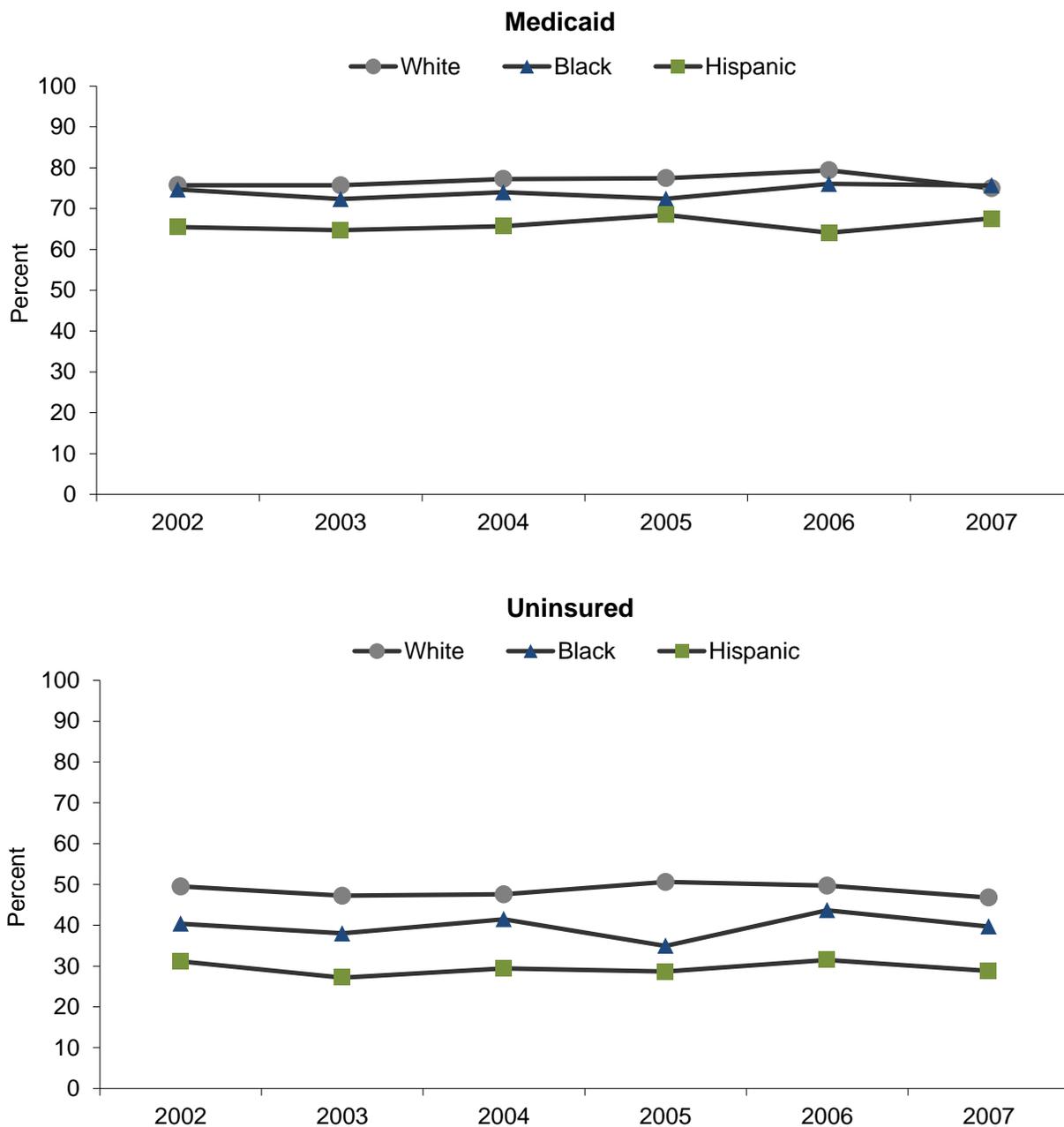
- From 2002 to 2007, Hispanic adults ages 18-64 were more likely to be without a usual source of care than White and Black adults.
- Among adults with private insurance, from 2002 to 2007, Hispanics were more likely to be without a usual source of care than Whites. In 2007, Hispanics also were more likely to be without a usual source of care than Blacks.
- Among adults with Medicaid, there were no statistically significant racial or ethnic differences from 2002 to 2007. However, during this time, the percentage of adults without a usual source of care increased for all racial and ethnic groups with Medicaid.
- In 2002, among uninsured adults, Whites and Hispanics were more likely to be without a usual source of care than Blacks, but there were no statistically significant differences in 2007. From 2002 to 2007, the percentage of uninsured adults without a usual source of care increased for all racial and ethnic groups.

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 provider⁵ and with good provider-patient communication. These factors increase the likelihood that patients receive appropriate care.⁶ 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.⁷ Having a usual primary care provider correlates with receipt of higher quality care.^{8,9}

Figure 5.2. Adults ages 18-64 with a usual primary care provider, by race/ethnicity, stratified by insurance status, 2002-2007





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

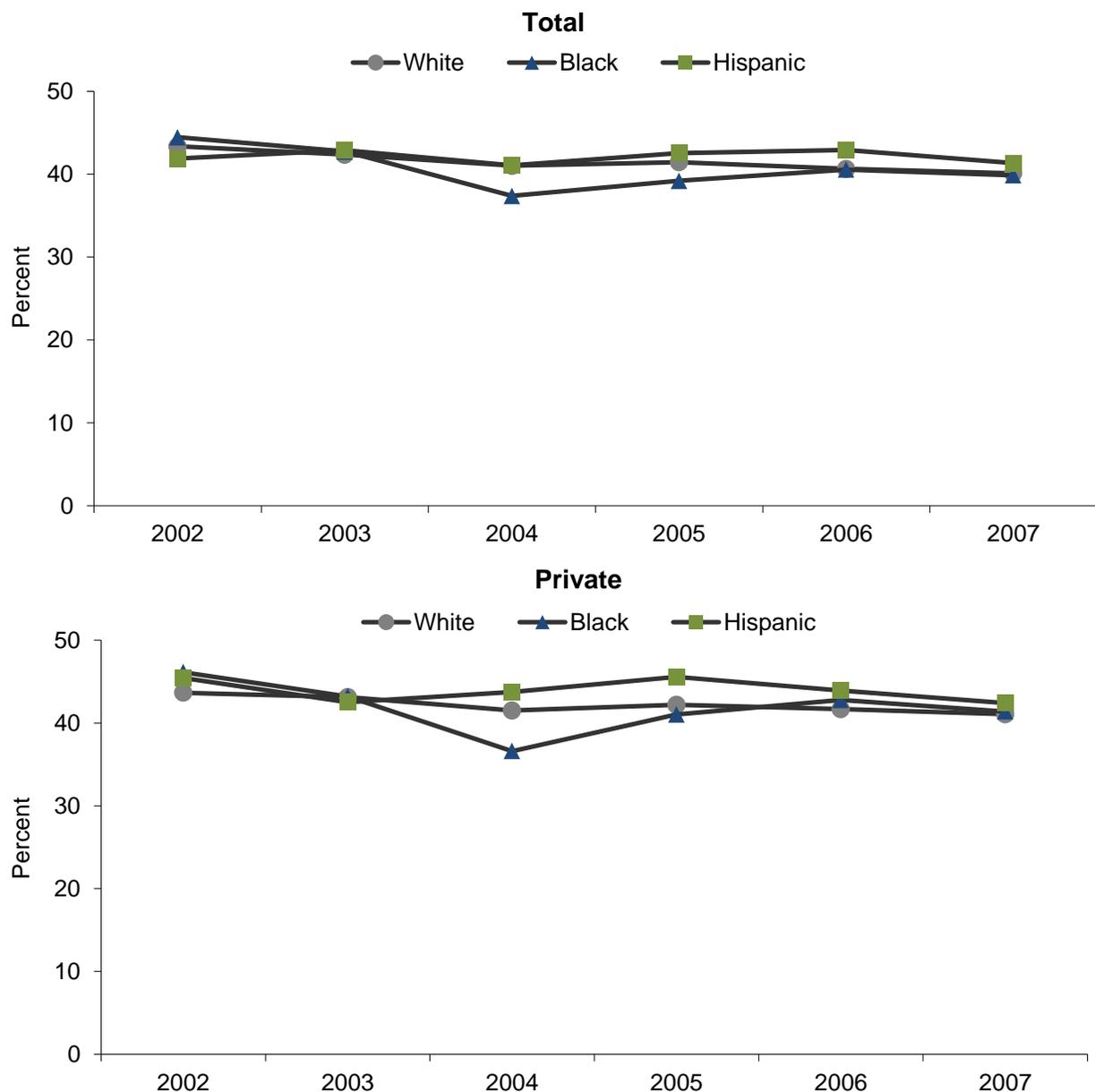
- From 2002 to 2007, Hispanic adults ages 18-64 were the least likely and White adults were the most likely to have a usual primary care provider.
- From 2002 to 2007, among adults with private insurance, Blacks and Hispanics were less likely than Whites to have a usual primary care provider.
- Among adults with Medicaid, the percentage with a usual primary care provider increased from 2002 to 2007 for Hispanics and Blacks. However, during this time, Hispanics were less likely to have a usual primary care provider than Whites and Blacks.

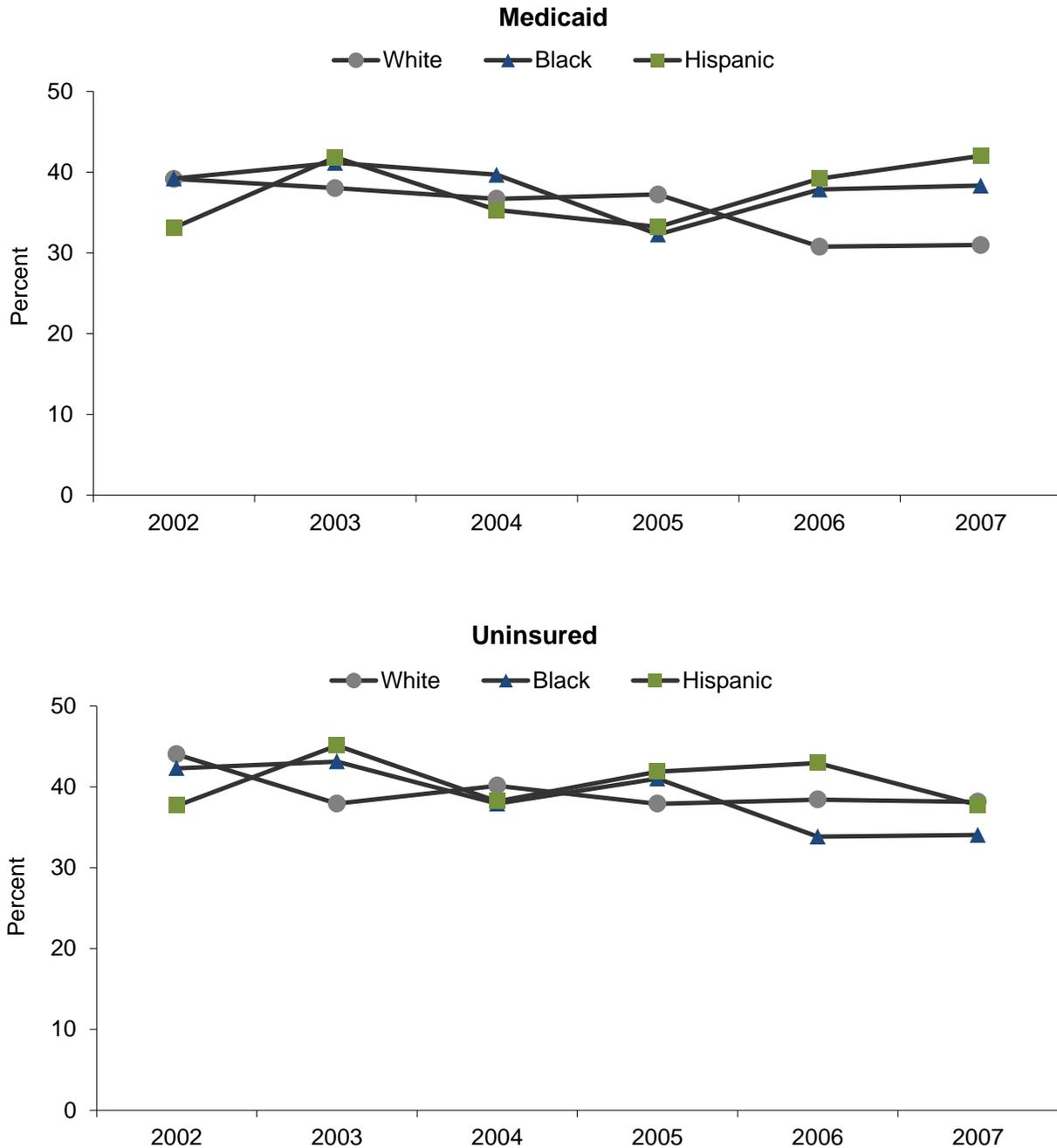
- Uninsured Black and Hispanic adults were less likely to have a usual primary care provider than White uninsured adults from 2002 to 2007.

Provider With Night or Weekend Hours

The health care delivery system’s structure and organization are critical factors for 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 and helping people who cannot afford time off to see their doctor after hours.

Figure 5.3. Adults ages 18-64 with a usual source of care, excluding hospital emergency rooms, who has office hours nights or weekends, by race/ethnicity, stratified by insurance status, 2002-2007





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

- From 2002 to 2007, the percentage of adults with a usual source of care with office hours nights or weekends decreased for Blacks and Whites but was unchanged for Hispanics. Overall, there were no statistically significant differences between racial and ethnic groups.
- From 2002 to 2007, among adults with private insurance, the percentage with a usual source of care who had office hours nights or weekends decreased for Blacks. There

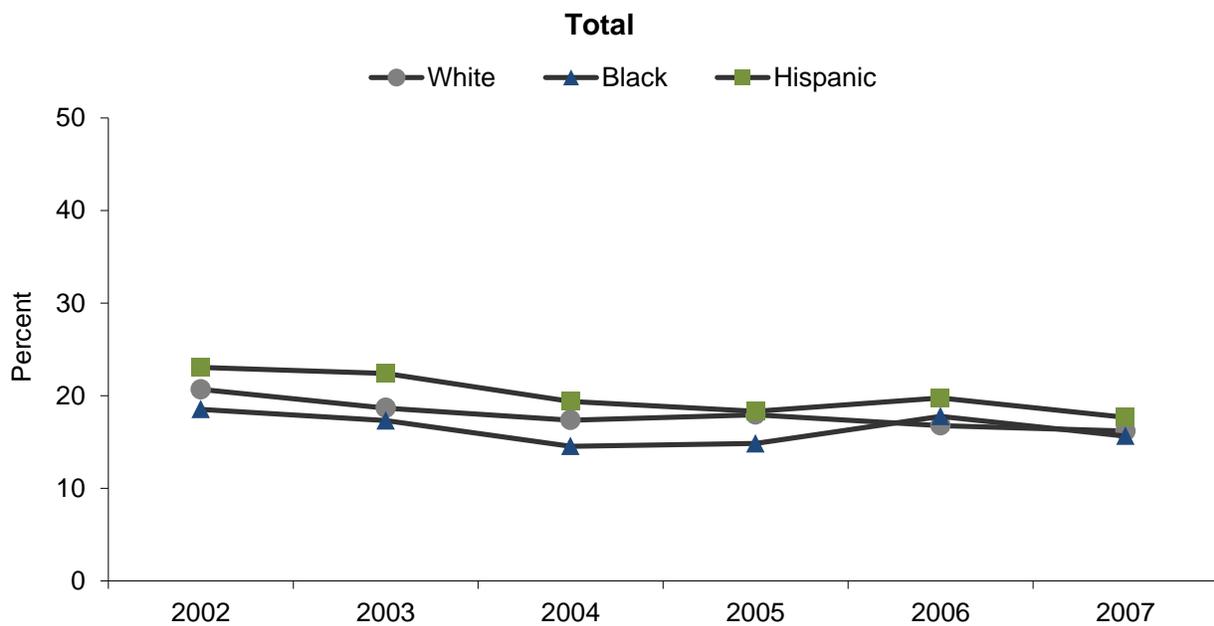
were no statistically significant changes for Hispanics and Whites. In addition, there were no statistically significant differences between racial and ethnic groups.

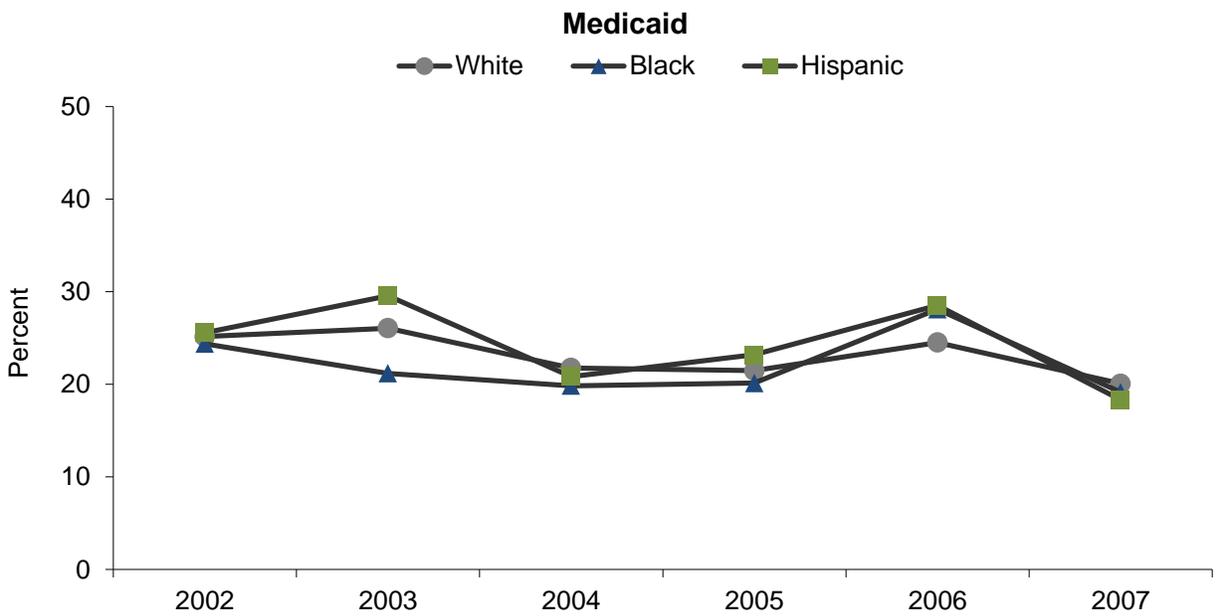
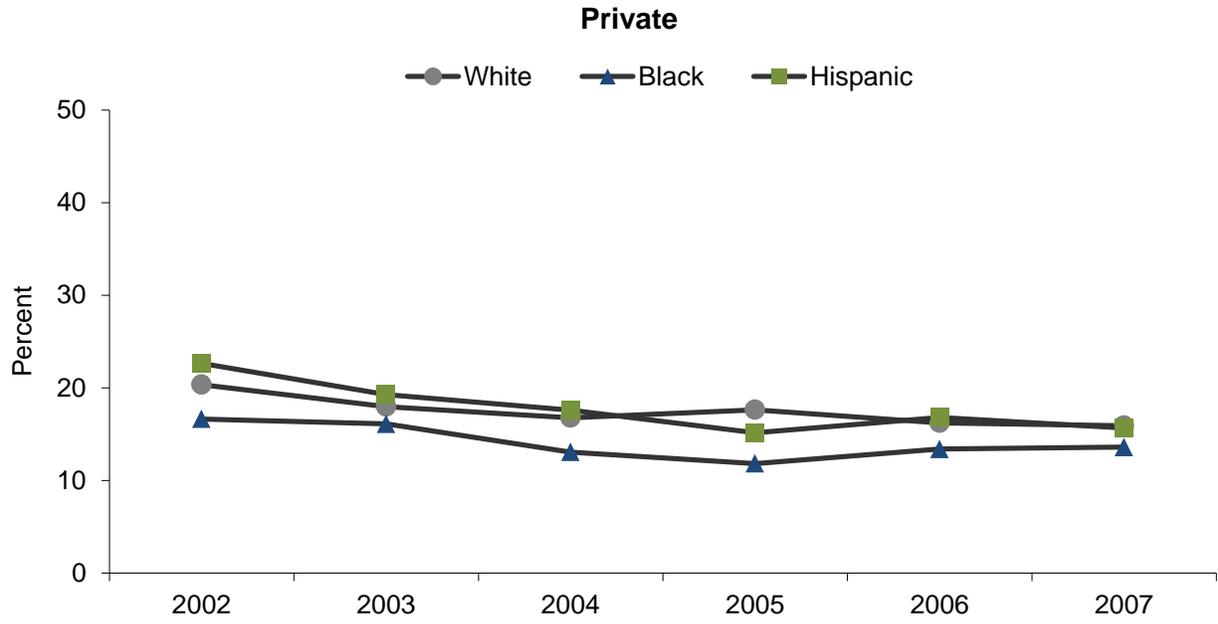
- From 2002 to 2007, among adults with Medicaid, the percentage whose usual source of care had office hours nights or weekends decreased for Blacks and Whites and increased for Hispanics. In 2002, there were no statistically significant racial or ethnic differences, but in 2007, Hispanics were more likely than Whites to have a usual source of care with office hours nights or weekends.
- From 2002 to 2007, the percentage of uninsured adults with a usual source of care who had office hours nights or weekends decreased for Blacks and Whites but was unchanged for Hispanics. There were no statistically significant differences between uninsured racial and ethnic groups.

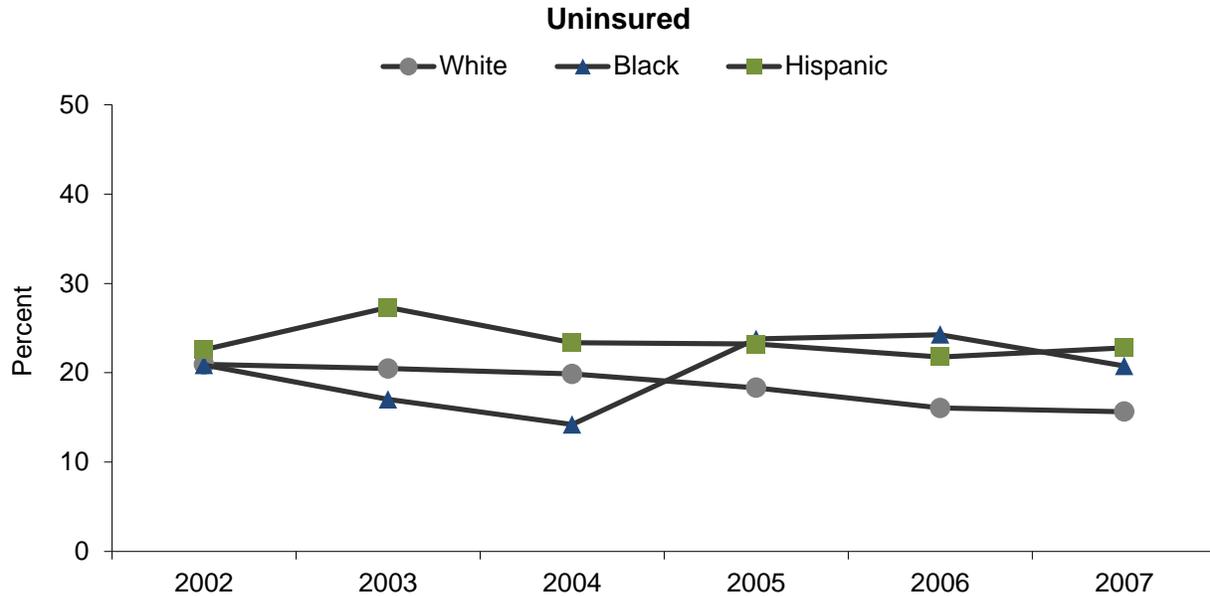
Difficulty Contacting Provider by Telephone

Patients cannot always meet a health care provider in person. Ensuring health care provider availability via telephone facilitates access to health care by increasing convenience and making providers available to patients who cannot travel to providers’ offices.

Figure 5.4. Adults ages 18-64 with difficulty contacting their usual source of care over the telephone, by race/ethnicity, stratified by insurance status, 2002-2007







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

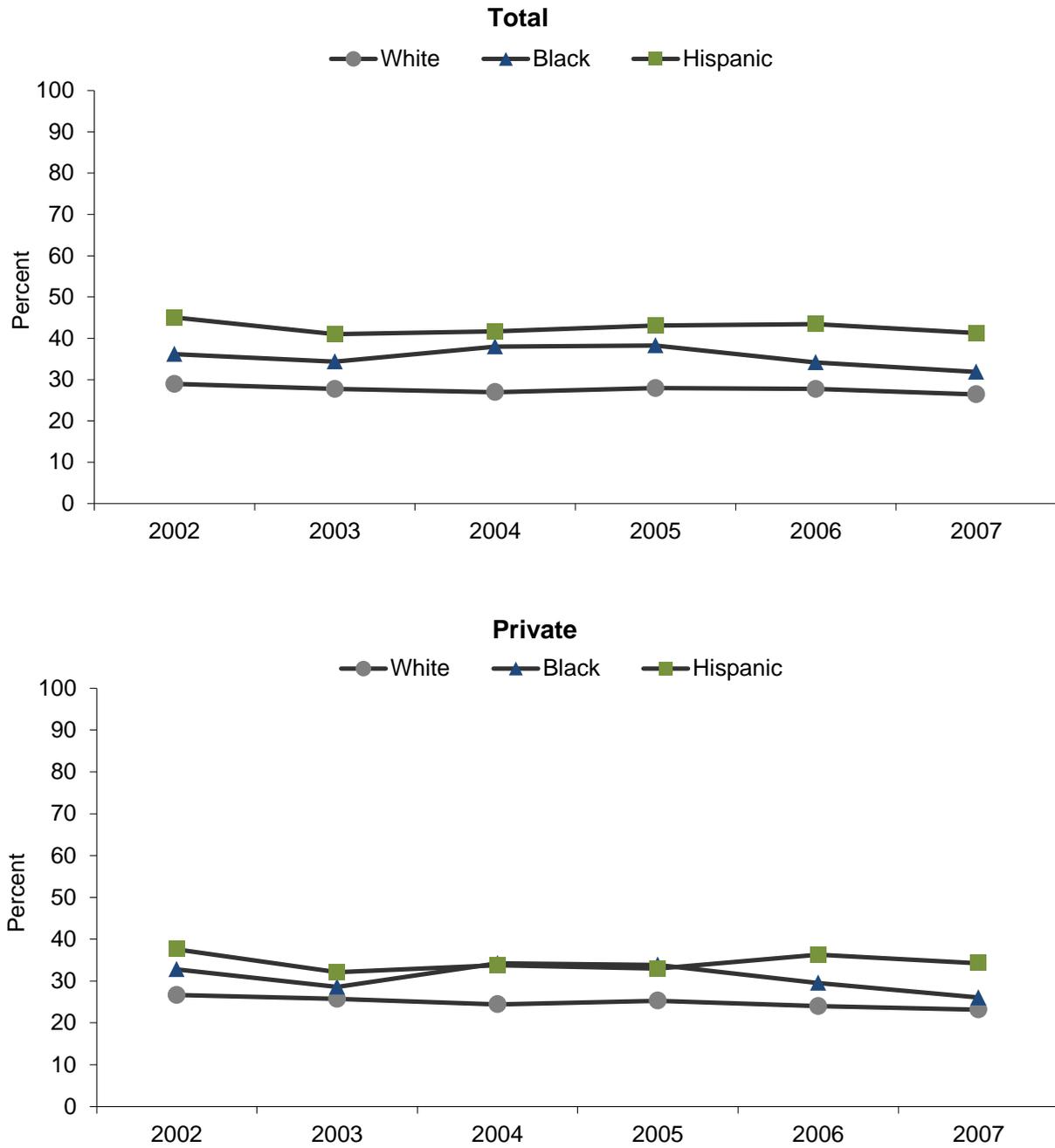
Note: For this measure, lower rates are better.

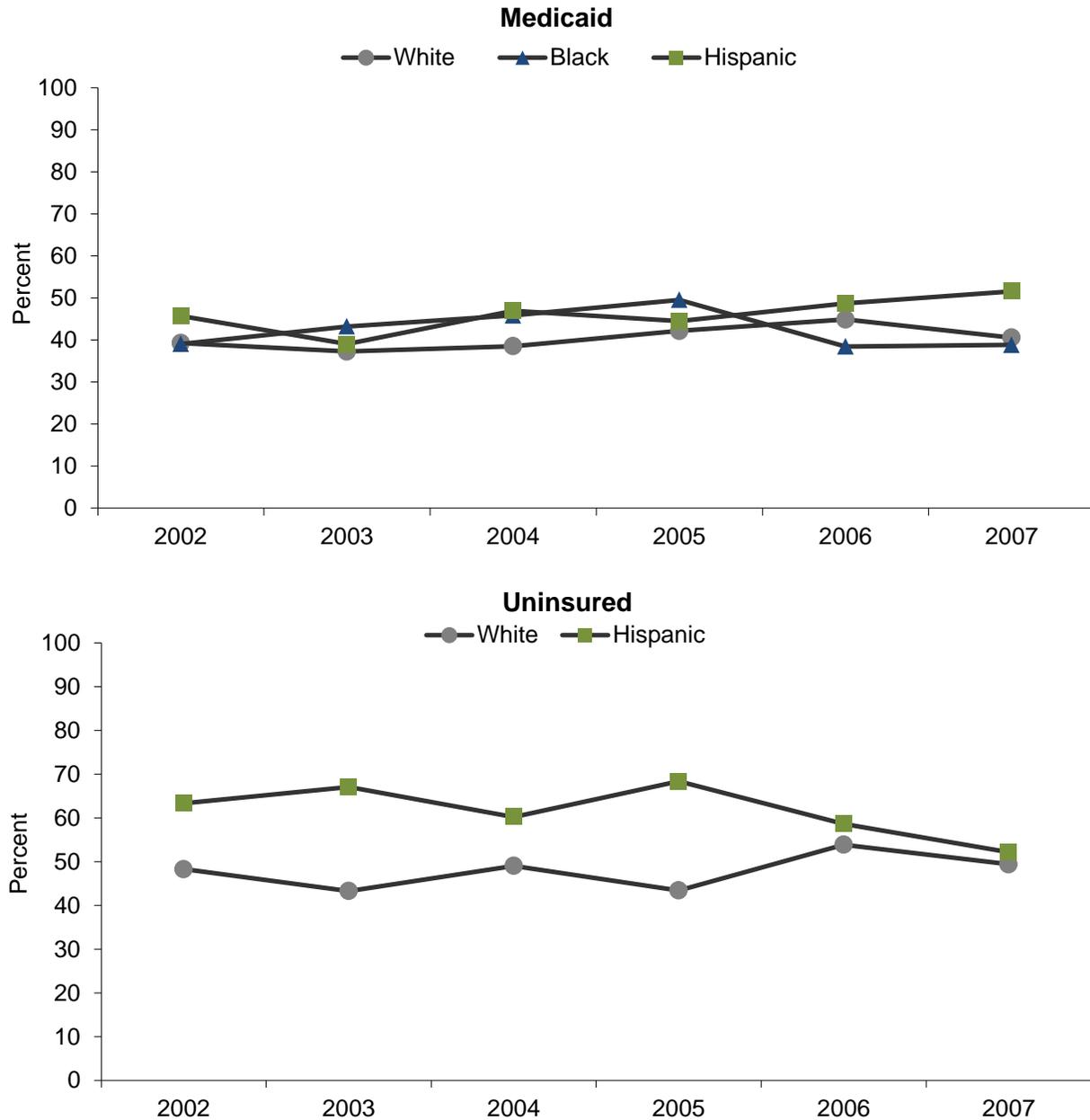
- Hispanic adults ages 18-64 were more likely than Black adults to have difficulty contacting their usual source of care over the telephone in 2002, but there were no statistically significant differences between racial and ethnic groups in 2007.
- Among privately insured adults, Whites and Hispanics were more likely than Blacks to have difficulty contacting their usual source of care in 2002, but there were no statistically significant differences between racial and ethnic groups in 2007.
- From 2002 to 2007, among adults with Medicaid, there were no statistically significant racial or ethnic differences.
- In 2002, there were no statistically significant racial or ethnic differences among uninsured adults. However, in 2007, uninsured Hispanic adults were more likely to have difficulty contacting their usual source of care than uninsured White adults.

Problems Seeing a Specialist

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 5.5. Adults ages 18-64 who had problems seeing a specialist they needed to see in the last 12 months, by race/ethnicity, stratified by insurance status, 2002-2007





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

Note: For this measure, lower rates are better. Data for uninsured Blacks from 2002 to 2007 do not meet the criteria for statistical reliability, data quality, or confidentiality.

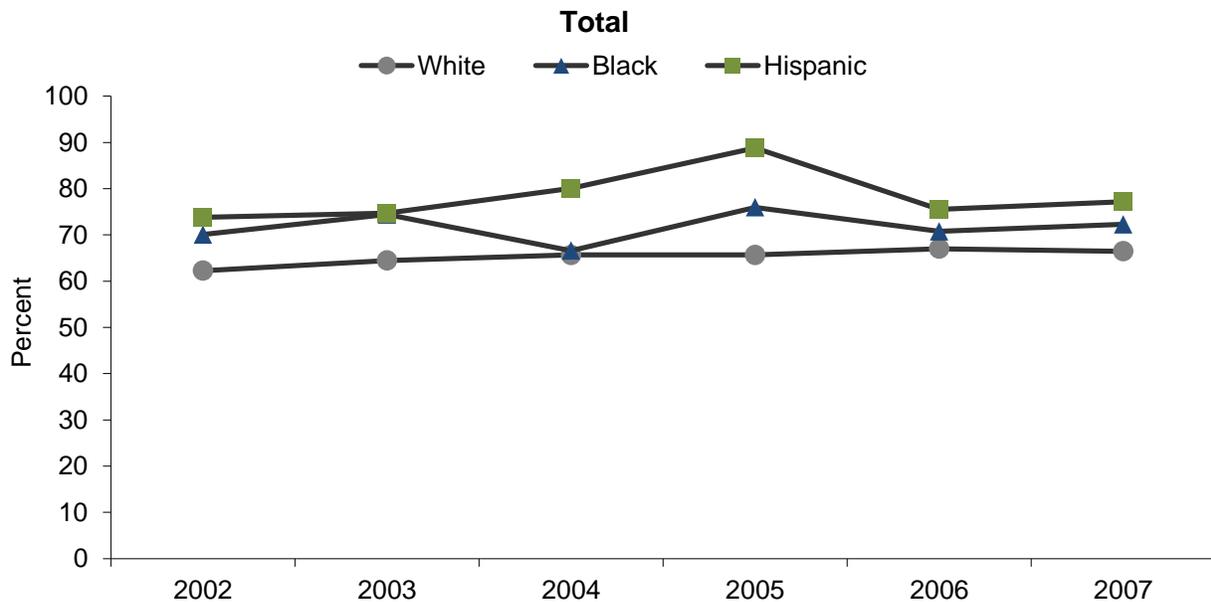
- From 2002 to 2007, Hispanic adults were more likely to have problems seeing a specialist they needed to see in the last 12 months compared with White and Black adults.
- From 2002 to 2007, among adults with private insurance, Hispanics were more likely than Whites to report problems seeing a specialist.
- During this time, among adults with Medicaid, there were no statistically significant racial or ethnic differences. However, the percentage reporting problems increased for Whites and Hispanics, while there were no statistically significant changes for Blacks.

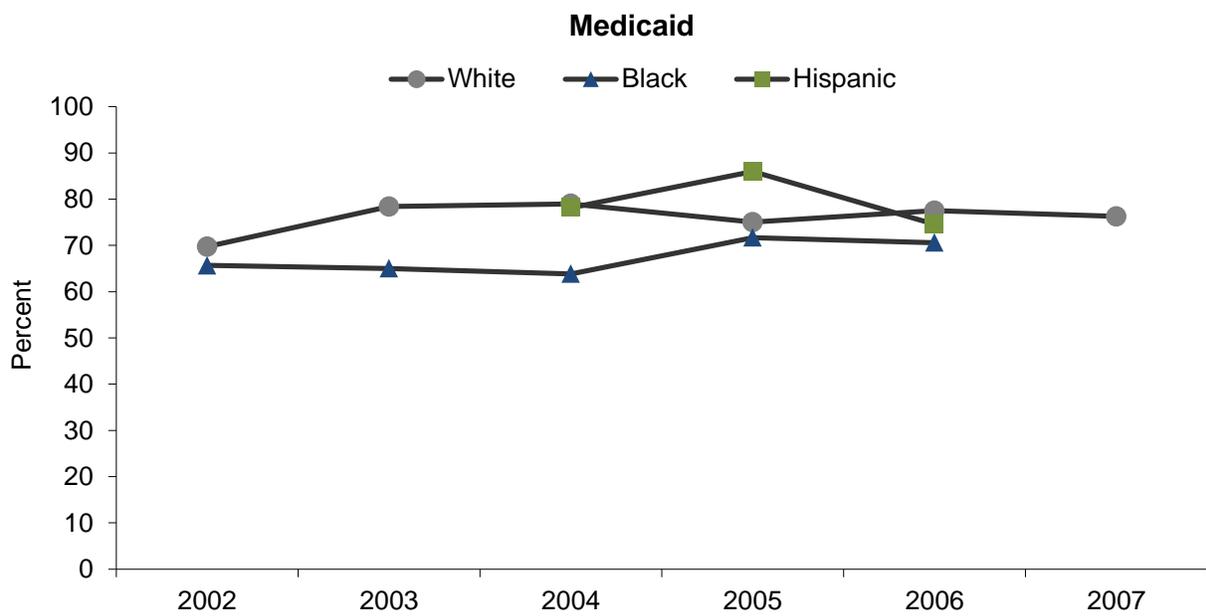
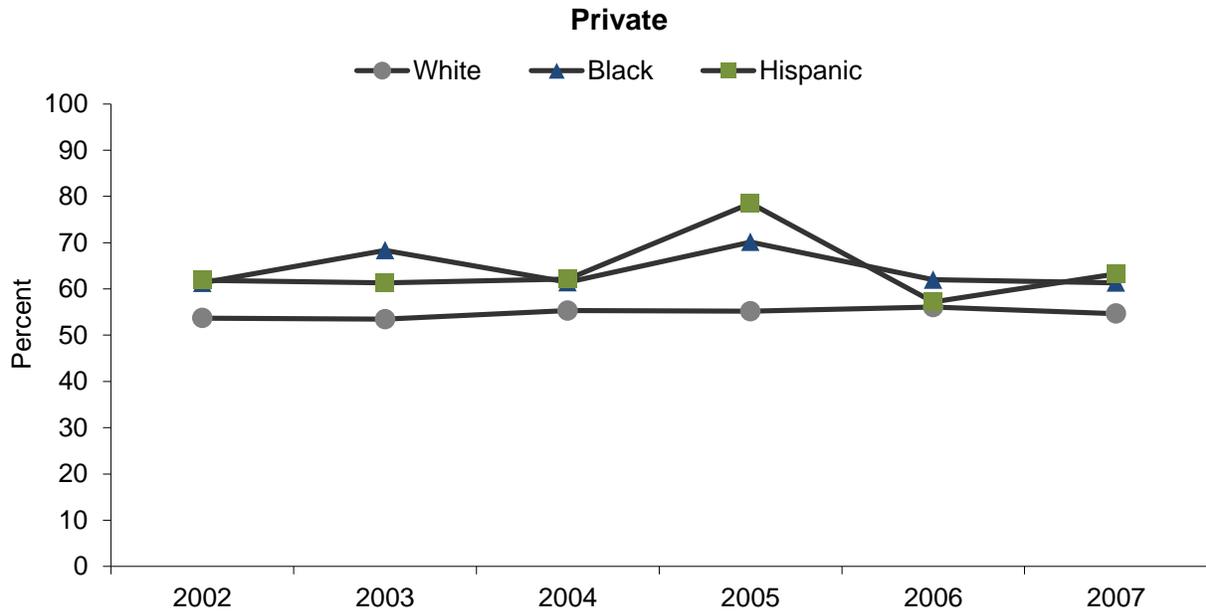
- In 2002, uninsured White adults were less likely than uninsured Hispanic adults to have problems seeing a specialist, but there were no statistically significant differences between the two groups in 2007. From 2002 to 2007, the percentage who had problems seeing a specialist decreased for Hispanic uninsured adults but increased for White uninsured adults.

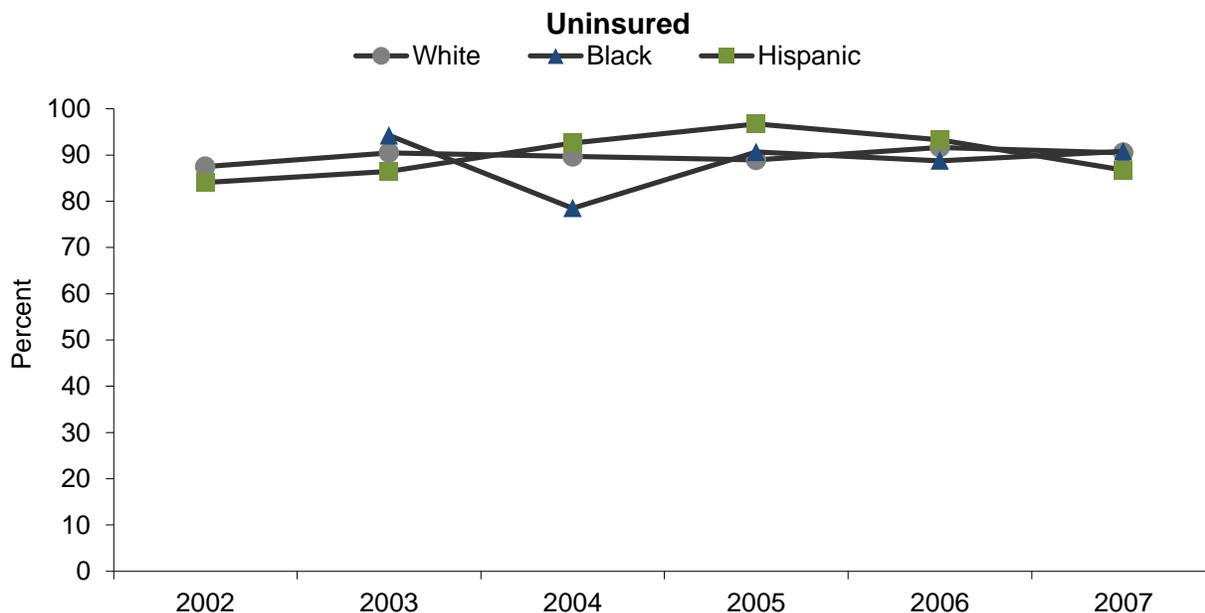
Financial Burden of Health Care

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.¹⁰ High premiums and out-of-pocket payments can be a significant barrier to accessing needed medical treatment and preventive care.¹¹ Some patients have 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 5.6. Adults ages 18-64 unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons, by race/ethnicity, stratified by insurance status, 2002-2007







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

Note: For this measure, lower rates are better. Data for Black adults with Medicaid in 2007, Hispanic adults with Medicaid in 2002-2003 and 2007, and Black uninsured adults in 2002 do not meet the criteria for statistical reliability, data quality, or confidentiality.

- From 2002 to 2007, Hispanic adults ages 18-64 were more likely than White adults to be unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons.
- From 2002 to 2007, there were no statistically significant differences between racial and ethnic groups for adults with private insurance or no insurance.
- There were no statistically significant differences between racial and ethnic groups for adults with Medicaid. However, the percentage of adults unable to get or delayed in getting care for financial or insurance reasons increased over time for Whites and Blacks.

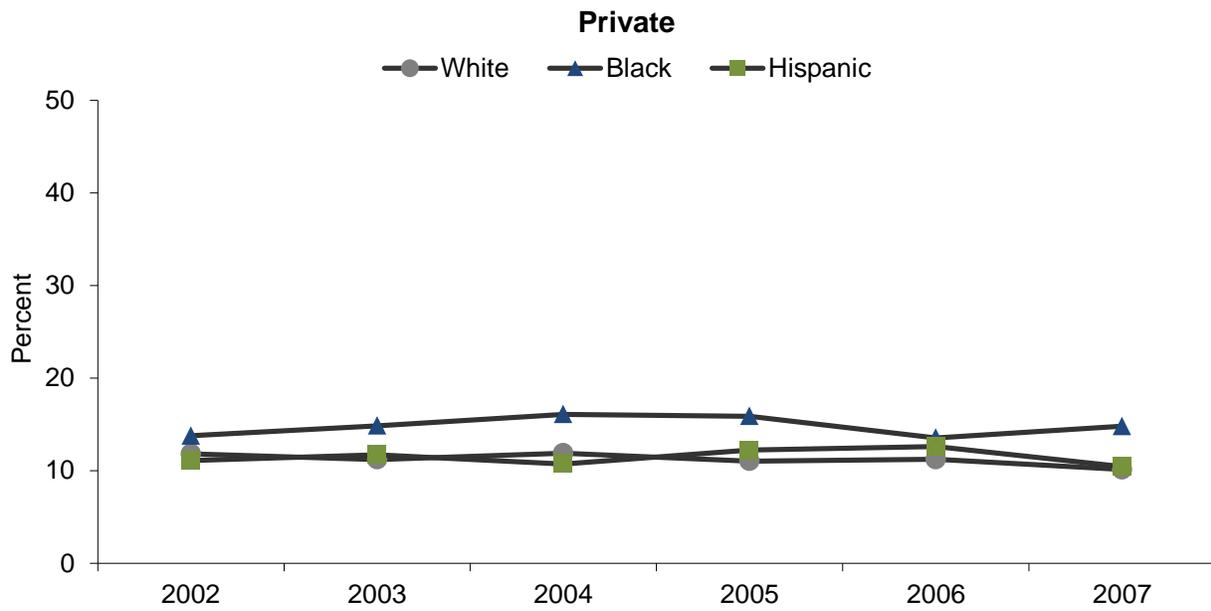
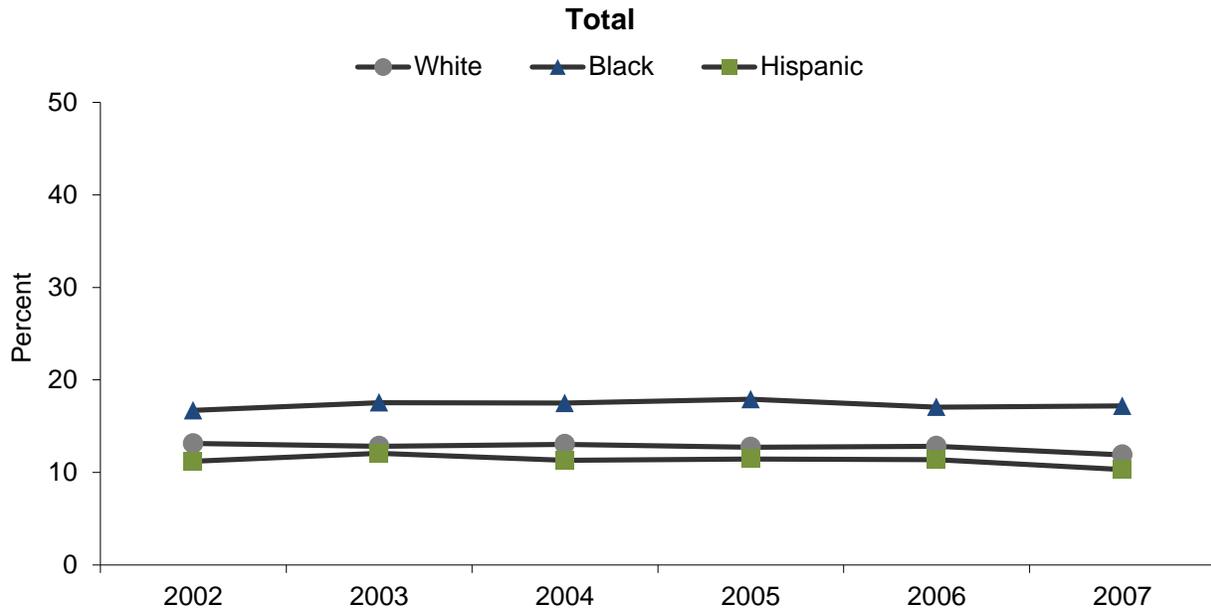
Utilization

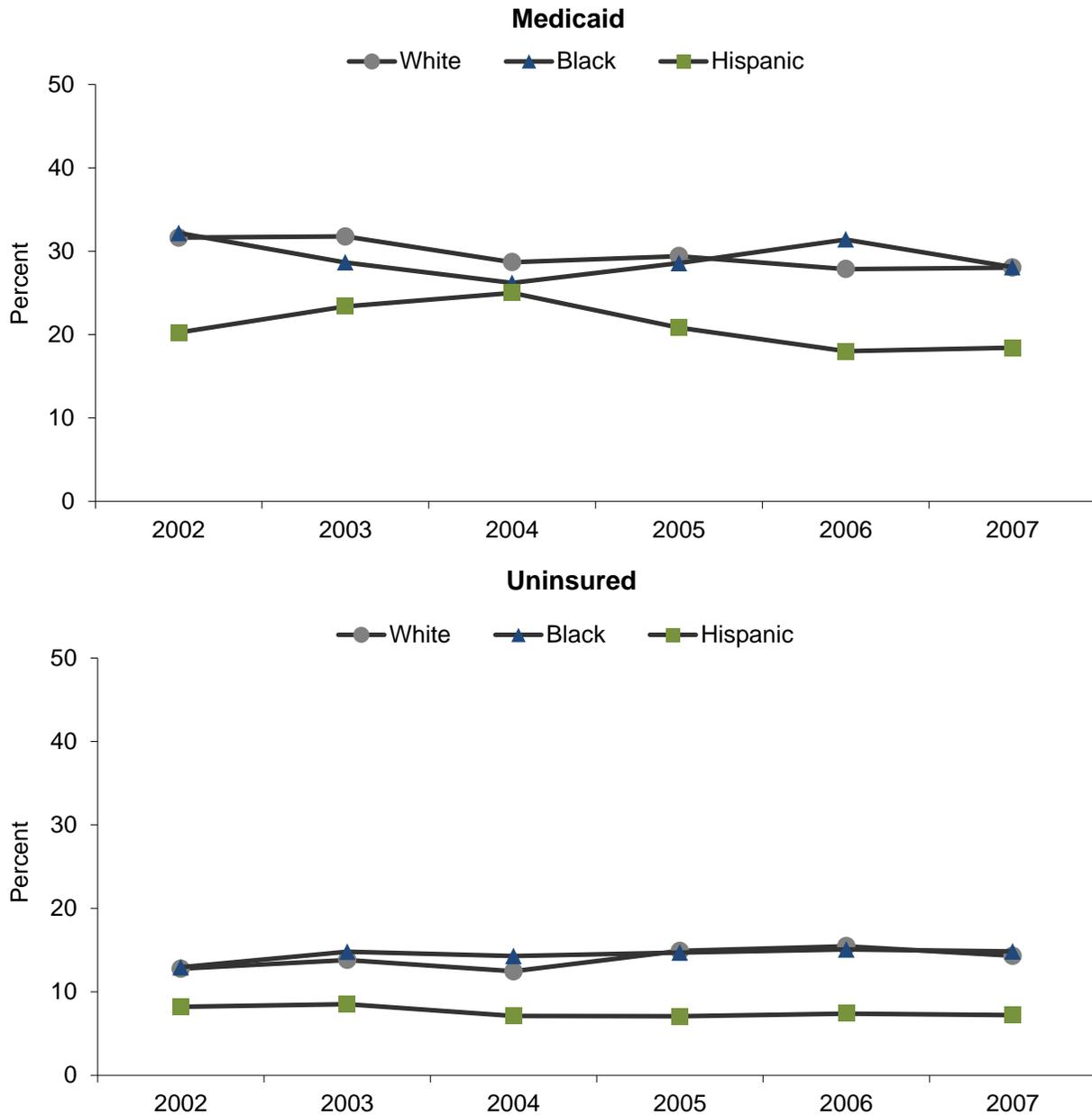
This section examines measures of health care use. Some differences in receipt of care reflect individual needs, health status, preferences, type of care available, economic factors, and behaviors. However, regular use of medical care is important for preserving health and functioning, while high rates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

Emergency Room Visits

Without good access to health care, people sometimes resort to using the emergency department for needed care. Delaying care until the need is urgent often results in poorer health outcomes and increased health care costs.

Figure 5.7. Adults ages 18-64 who had a hospital emergency room visit in the calendar year, by race/ethnicity, stratified by insurance status, 2002-2007





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

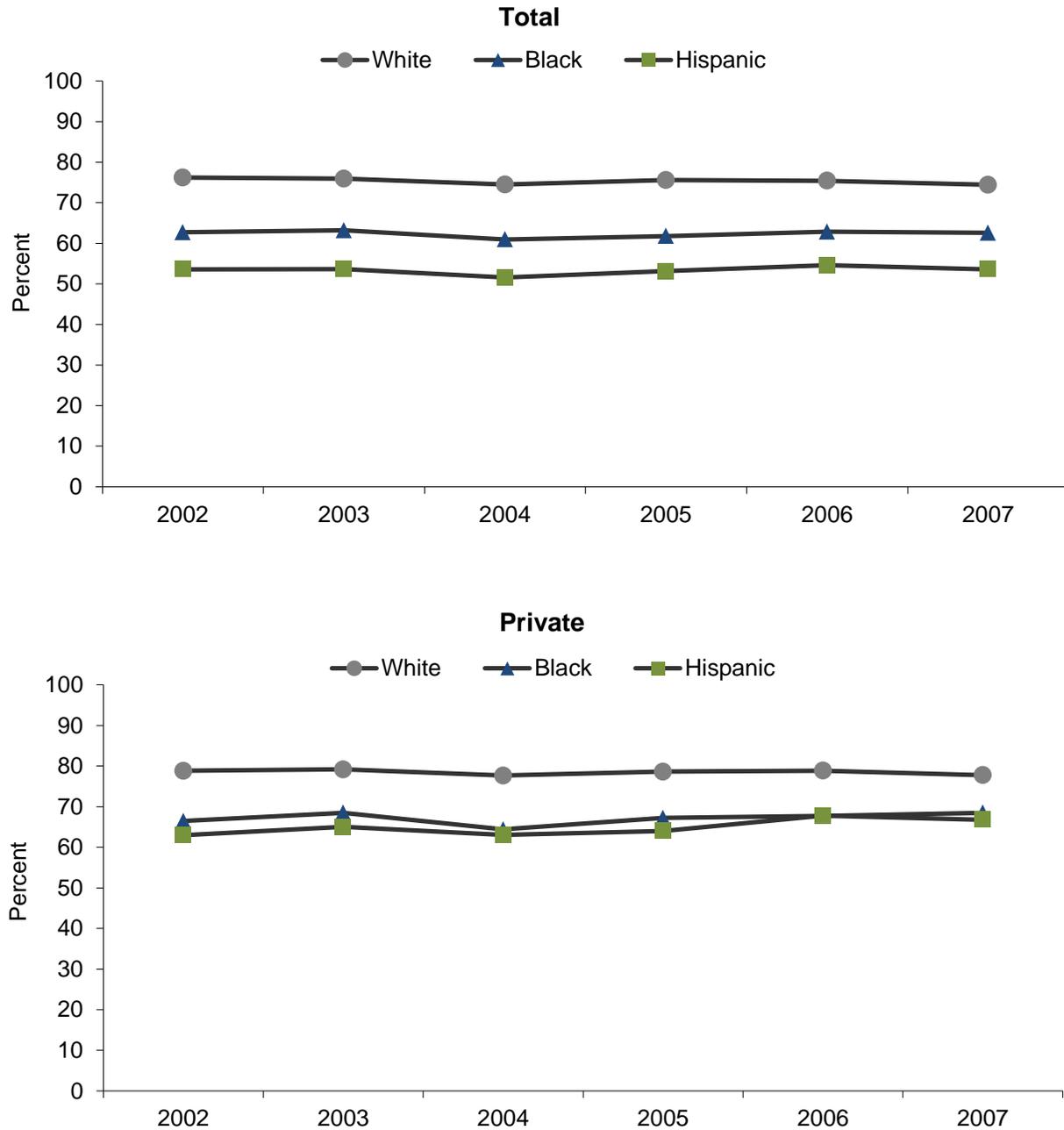
Note: For this measure, lower rates are better.

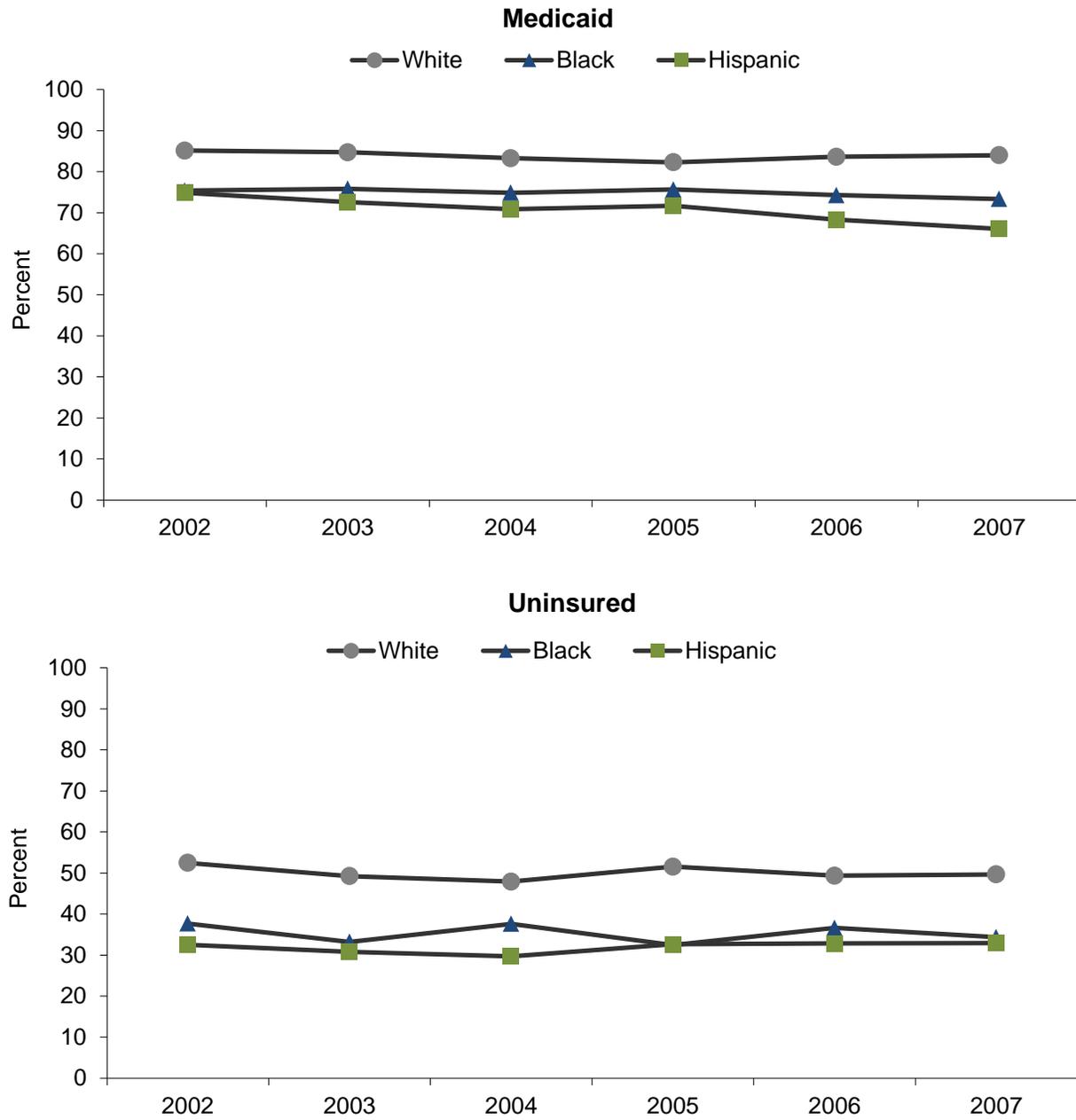
- From 2002 to 2007, Black adults ages 18-64 were more likely to have a hospital emergency room visit in the calendar year than Hispanic or White adults.
- Among those with private insurance, there were no statistically significant racial or ethnic differences in 2002, but in 2007 Black adults were more likely to have an emergency room visit in the calendar year than Hispanic or White adults.
- From 2002 to 2007, Black and White adults with Medicaid or no insurance were more likely to have an emergency room visit than their Hispanic counterparts.

Outpatient Visits

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

Figure 5.8. Adults ages 18-64 who had a physician office or hospital outpatient department visit, by race/ethnicity, stratified by insurance status, 2002-2007





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

- From 2002 to 2007, there were no statistically significant changes among Blacks or Hispanics in the percentage of adults who had a physician office or hospital outpatient department visit. The percentage decreased for Whites. From 2002 to 2007, White adults were the most likely and Hispanic adults were the least likely to have a physician office or hospital outpatient department visit.
- Among adults with private insurance, from 2002 to 2007, there were no statistically significant changes among Blacks or Whites in the percentage who had a physician office or hospital outpatient department visit. During this time, the percentage increased for

Hispanic adults. White adults with private insurance were more likely to have a physician office or hospital outpatient department visit than Black and Hispanic adults with private insurance.

- In 2002, among adults with Medicaid, Whites were more likely to have a physician office or hospital outpatient department visit than Blacks and Hispanics. In 2007, White adults with Medicaid were the most likely and Hispanic adults were the least likely to have a visit. From 2002 to 2007, the disparity between Blacks and Whites was steady, while the disparities between Hispanics and Blacks and between Hispanics and Whites increased.
- From 2002 to 2007, among uninsured adults, Whites were more likely to have a physician office or hospital outpatient department visit than Hispanics and Blacks. There were no statistically significant changes for any racial or ethnic group in the percentage who had a physician office or hospital outpatient department visit.

References

1. Starfield B, Shi L. The medical home, access to care, and insurance: a review of evidence. *Pediatrics* 2004;113(5 Suppl):1493-8.
2. De Maeseeneer JM, De Prins L, Gosset C, et al., Provider continuity in family medicine: does it make a difference for total health care costs? *Ann Fam Med* 2003;1(3):144-8.
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Part II: Child Health

Insurance Disparities

Chapter 6: Quality of Ambulatory Health Care

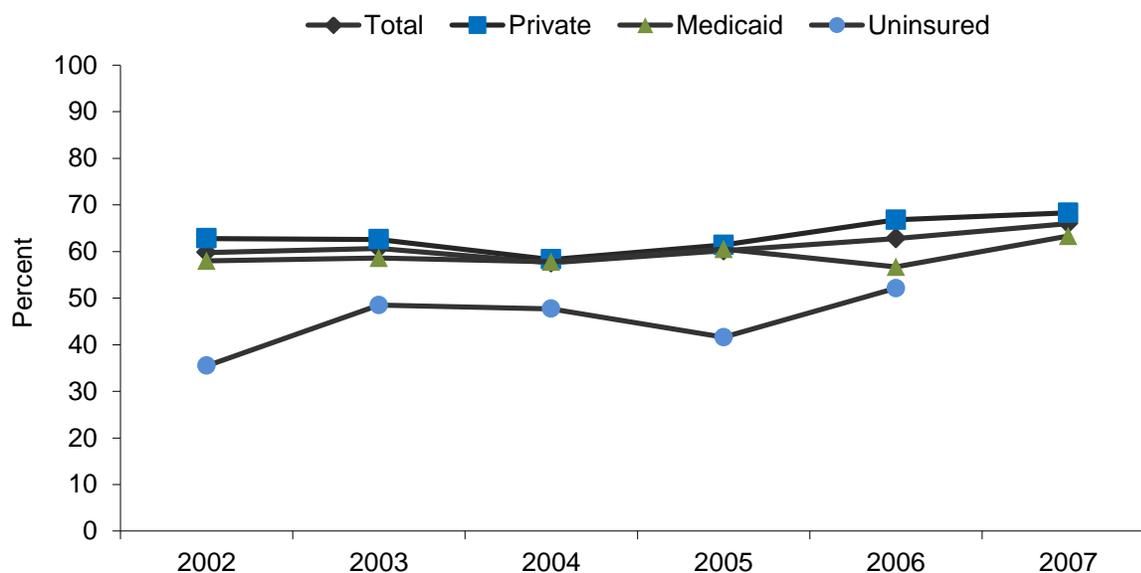
The Coverage Analyses Trends Report examined insurance disparities for each measure. These measures evaluated children under age 18.

Effectiveness

Prevention: Vision Care

Vision checks for children may detect problems of which children and their parents were previously unaware. Early detection also improves the chances that corrective treatments will be successful.

Figure 6.1. Children ages 3-6 who ever had their vision checked by a health provider, by insurance status, 2002-2007



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

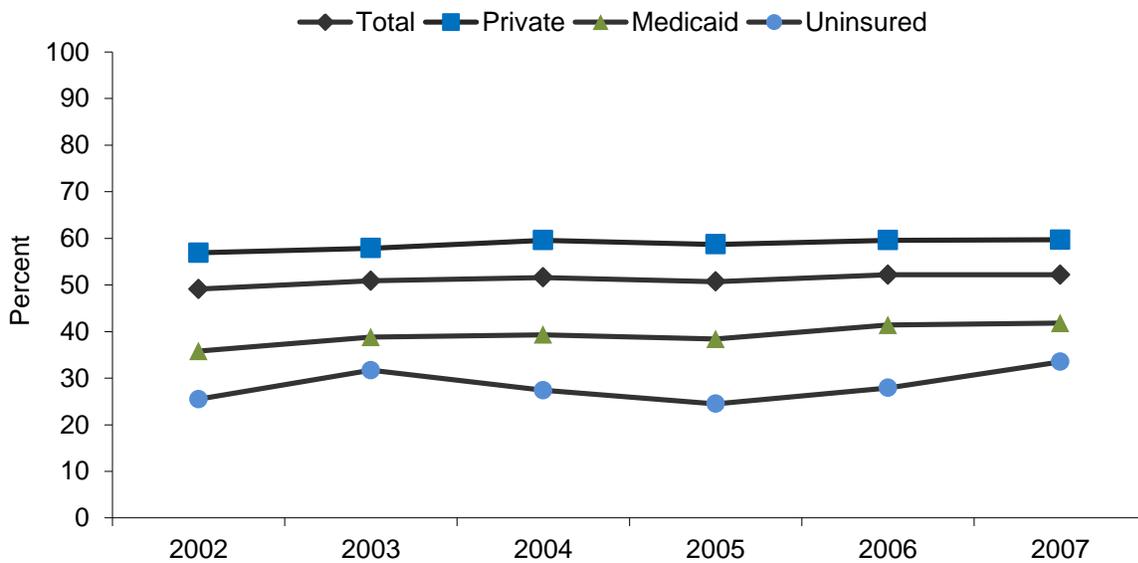
Note: Data for uninsured children in 2007 do not meet the criteria for statistical reliability, data quality, or confidentiality.

- The percentage of children who had their vision checked by a health provider increased from 2002 to 2007 for all insurance groups.
- In 2002, uninsured children were less likely to have their vision checked than children with Medicaid or private insurance. However, in 2006, uninsured children were less likely to have their vision checked than children with private insurance but there was no statistically significant difference between uninsured children and children with Medicaid.

Prevention: Dental Care

According to the National Institute of Dental and Craniofacial Research, presence of dental caries is the single most common chronic disease of childhood, occurring five times as frequently as asthma, the second most common chronic disease in children.¹ Regular dental visits help to improve overall oral health and prevent dental caries.

Figure 6.2. Children ages 2-17 who had a dental visit in the calendar year, by insurance status, 2002-2007



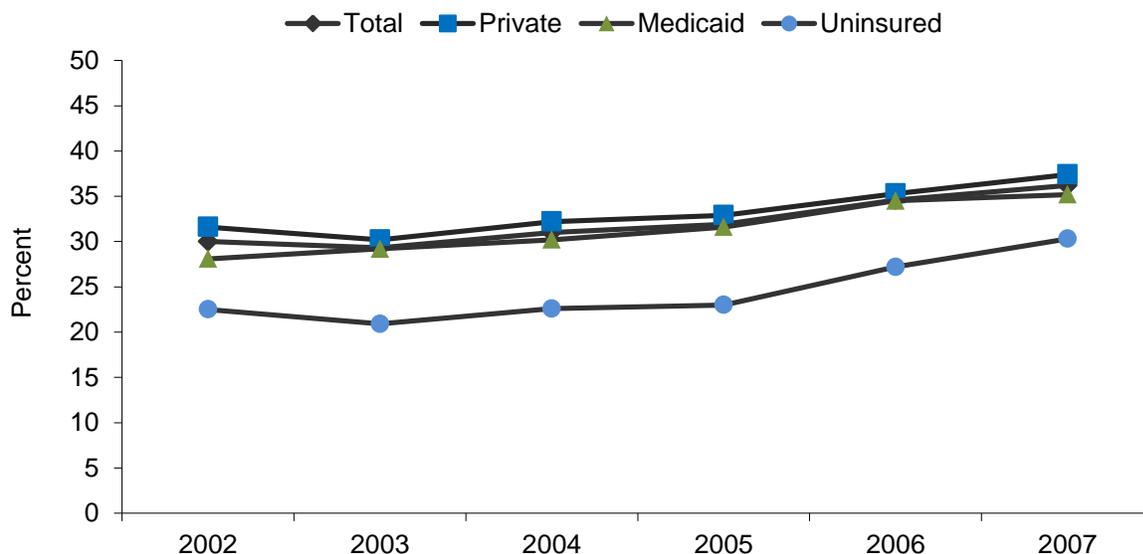
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.

- From 2002 to 2007, the percentage of children ages 2-17 who had a dental visit in the calendar year increased for all insurance groups.
- From 2002 to 2007, children with private insurance were the most likely and uninsured children were the least likely to have a dental visit in the calendar year.

Prevention: Advice on Physical Activity and Healthy Eating

Childhood represents a period when healthy, lifelong habits are often formed. Health care providers can play an important role in encouraging healthy behaviors in children, such as regular exercise and healthy eating.

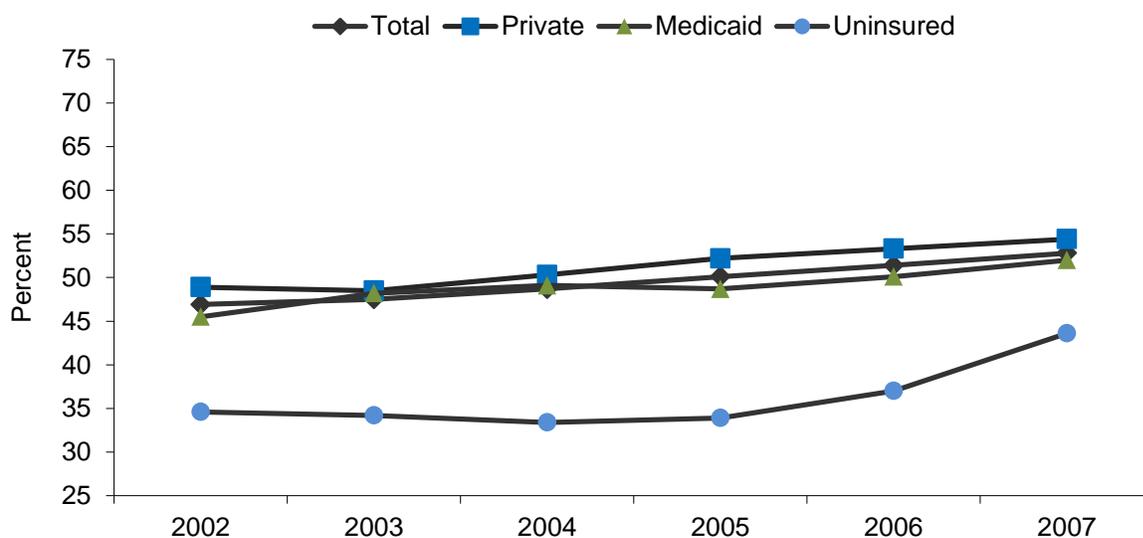
Figure 6.3. Children ages 2-17 for whom a health provider ever gave advice about the amount and kind of exercise, sports, or physically active hobbies they should have, by insurance status, 2002-2007



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

- From 2002 to 2007, the percentage of children ages 2-17 for whom a health provider ever gave advice about the amount and kind of exercise, sports, or physically active hobbies they should have increased for all insurance groups.
- From 2002 to 2007, uninsured children were less likely than privately insured children to receive advice from a health provider about exercise.

Figure 6.4. Children ages 2-17 for whom a health provider ever gave advice about healthy eating, by insurance status, 2002-2007



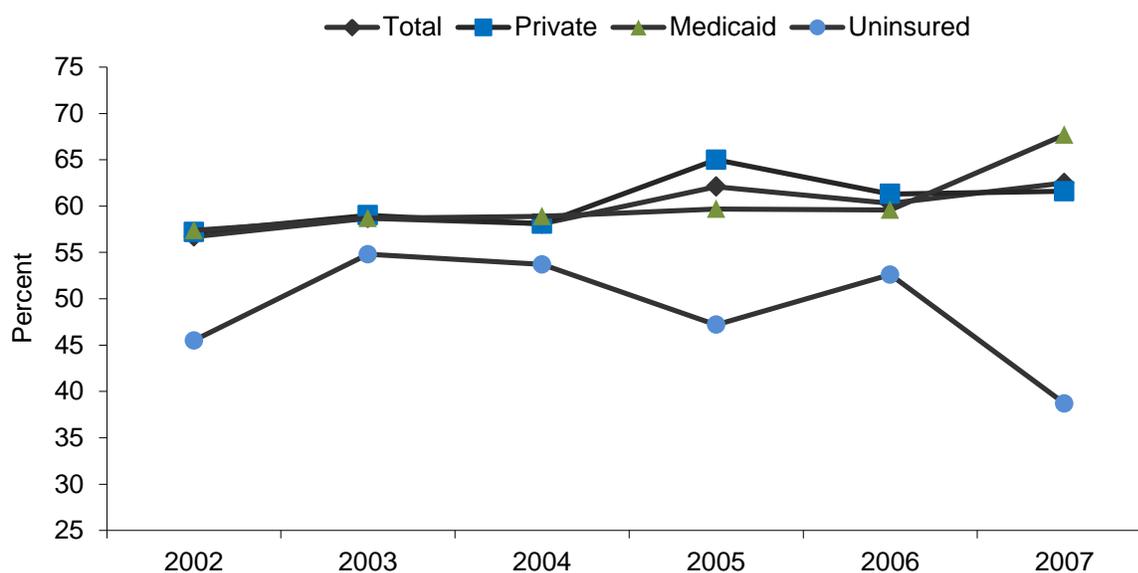
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.

- From 2002 to 2007, the percentage of children ages 2-17 for whom a health provider ever gave advice about healthy eating increased for all insurance groups.
- From 2002 to 2007, uninsured children were less likely to receive advice about healthy eating than privately insured children and children with Medicaid.

Prevention: Advice on Vehicle Safety

Unintentional injury is the leading cause of death of children. Wearing a helmet drastically reduces the risk of head and facial injuries by bicyclists, even if a crash involves a motor vehicle.² The American Academy of Pediatrics (AAP) recommends that pediatricians encourage parents and other child care providers to require children to wear a bicycle helmet when they begin riding tricycles or other wheeled vehicles or toys. AAP also provides detailed guidance for pediatricians to share with parents and other caregivers on the proper use of child safety seats.

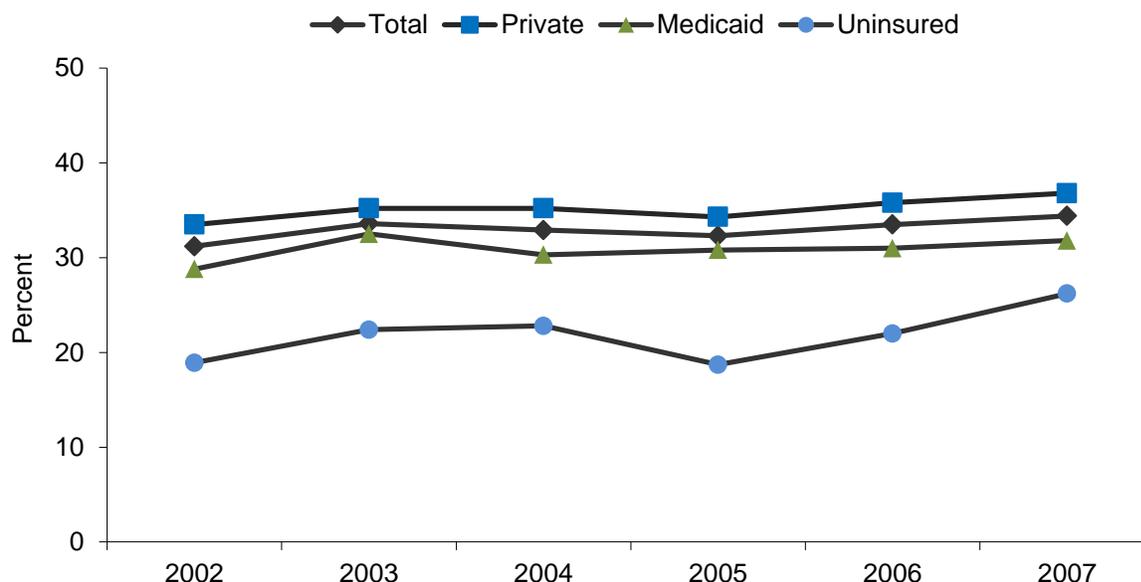
Figure 6.5. Children 0 to 40 lb for whom a health provider ever gave advice about using child safety seats when riding in a car, by insurance status, 2002-2007



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

- From 2002 to 2007, the percentage of children 0 to 40 lb for whom a health provider gave advice about using child safety seats increased for children with private insurance or Medicaid but decreased for uninsured children.
- There were no statistically significant differences in 2002 between insurance groups; however, in 2007, children with Medicaid were the most likely and uninsured children were the least likely to receive advice about using child safety seats.

Figure 6.6. Children ages 2-17 for whom a health provider ever gave advice about using a helmet when riding a bicycle or motorcycle, by insurance status, 2002-2007



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

- From 2002 to 2007, the percentage of children for whom a health provider gave advice about using a helmet when riding a bicycle or motorcycle increased for uninsured children. There were no statistically significant changes in the percentage of children with Medicaid or private insurance who received advice.
- In 2002, uninsured children were less likely than privately insured children and children with Medicaid to receive advice from a health provider about using a helmet. In 2007, uninsured children were still less likely than privately insured children to receive advice about using a helmet, but there was no statistically significant difference between uninsured children and children with Medicaid.

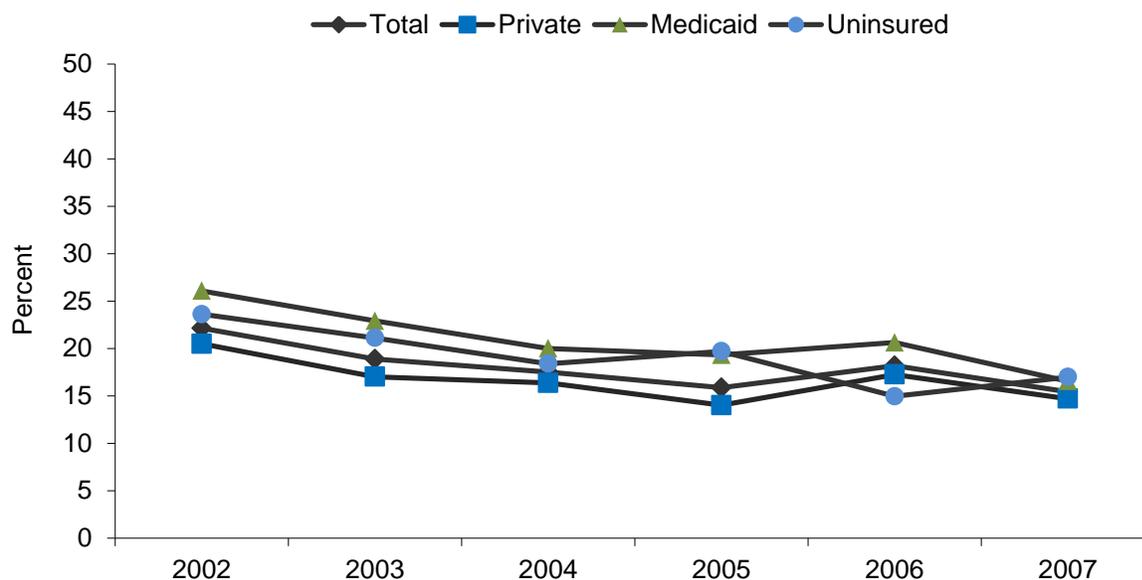
Patient Centeredness

Patient-centered care is supported by good provider-patient communication so that patients' needs and wants are understood and addressed and patients understand and participate in their own care. This style of care has been shown to improve patients' health and health care. Unfortunately, many barriers exist to good communication.

Patient Experiences of Care

Communication in children's health care can be challenging since the child's experiences are interpreted through the eyes of a parent or guardian. During a health care encounter, a responsible adult caregiver will be involved in communicating with the provider and interpreting decisions in an age-appropriate manner to the patient. Optimal communication in children's health care can therefore have a significant impact on receipt of high-quality care and subsequent health status. This is especially true for children with special health care needs.

Figure 6.7. Children ages 2-17 with a usual source of care whose health providers sometimes or never asked for the person's help to make treatment decisions, by insurance status, 2002-2007



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

- From 2002 to 2007, the percentage of children ages 2-17 whose providers sometimes or never asked for the person's help to make treatment decisions decreased for all insurance groups.
- In 2002, the percentage of children whose providers sometimes or never asked for the person's help to make treatment decisions was higher for children with Medicaid than for children with private insurance. In 2007, there were no statistically significant differences between insurance groups.

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Insurance Disparities

Chapter 7: 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) are disproportionately represented among those with access problems.

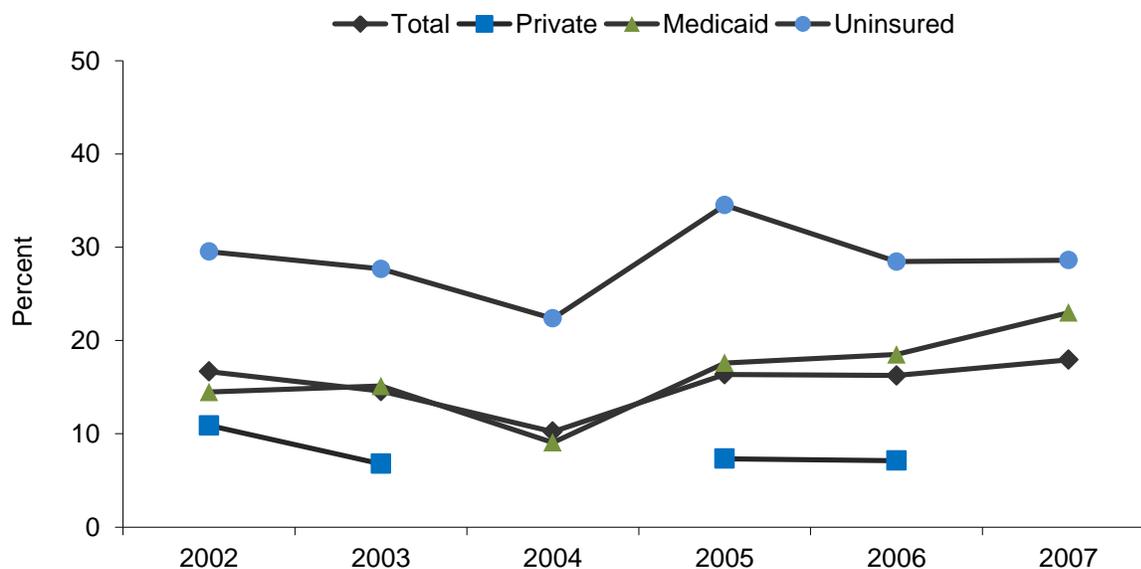
Facilitators and Barriers to Health Care

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

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)¹ and costs.² Evidence suggests that the effect on quality of the combination of health insurance and a usual source of care is additive.³ In addition, people with a usual source of care are more likely to receive preventive health services.⁴

Figure 7.1. Children without a usual source of care, by insurance status, 2002-2007



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

Note: For this measure, lower rates are better. Data for children with private insurance in 2004 and 2007 do not meet the criteria for statistical reliability, data quality, or confidentiality

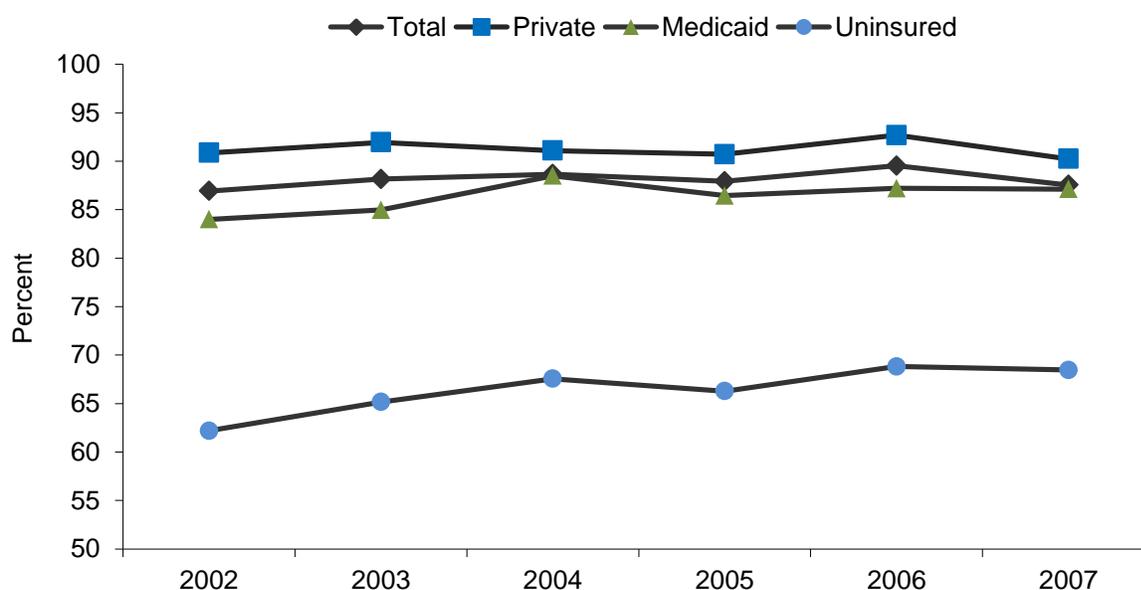
- From 2002 to 2007, the percentage of children without a usual source of care increased for children with Medicaid but decreased for uninsured children.

- In 2002, uninsured children were more likely to be without a usual source of care than children with Medicaid or private insurance. In 2007, however, there was no statistically significant difference between children with Medicaid and uninsured children.

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 provider⁵ and with good provider-patient communication. These factors increase the likelihood that patients receive appropriate care.⁶ 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.⁷ Having a usual primary care provider correlates with receipt of higher quality care.^{8,9}

Figure 7.2. Children with a usual primary care provider, by insurance status, 2002-2007



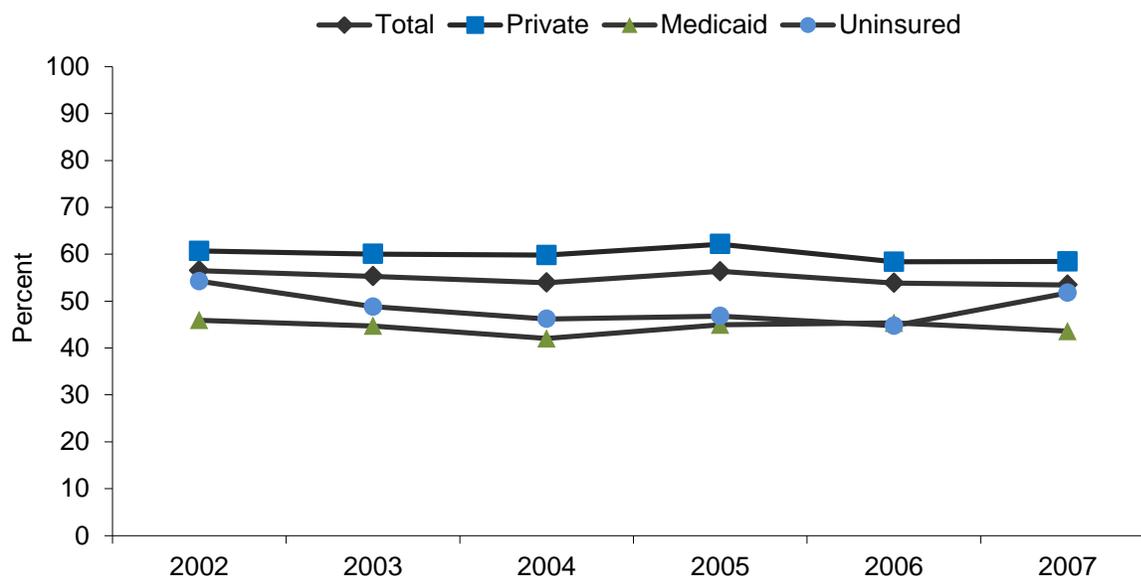
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.

- From 2002 to 2007, the percentage of children with a usual primary care provider increased for uninsured children and children with Medicaid but was unchanged for children with private insurance.
- From 2002 to 2007, uninsured children were the least likely and children with private insurance were the most likely to have a usual primary care provider.

Provider With Night or Weekend Hours

The health care delivery system's structure and organization are critical factors for 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 and helping people who cannot afford time off to see their doctor after hours.

Figure 7.3. Children with a usual source of care, excluding hospital emergency rooms, who has office hours nights or weekends, by insurance status, 2002-2007



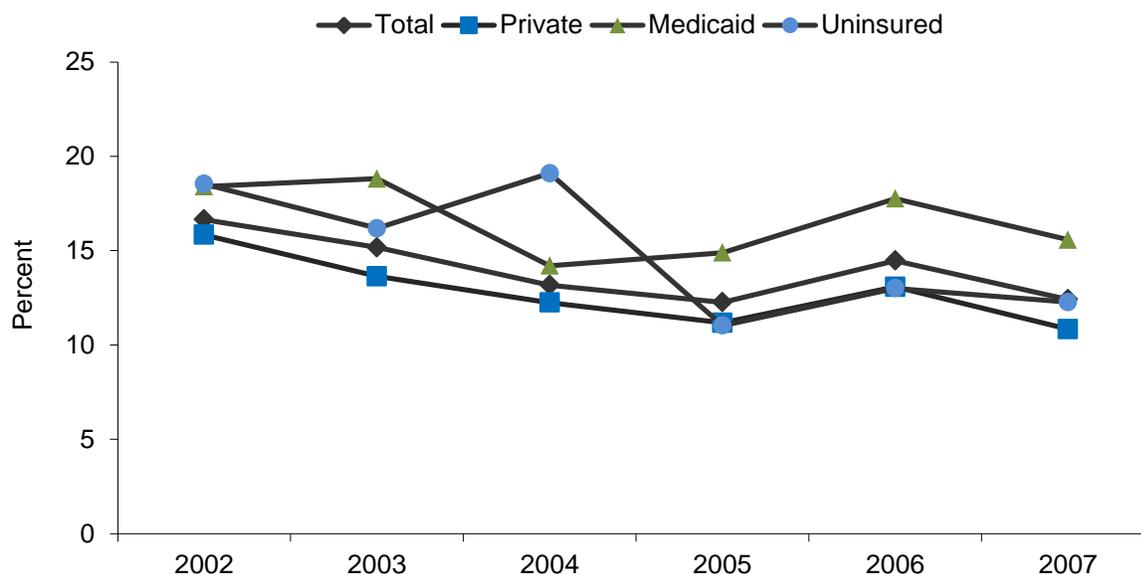
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.

- From 2002 to 2007, the percentage of children with a usual source of care who had office hours nights or weekends decreased for uninsured children but was unchanged for children with private insurance or Medicaid.
- From 2002 to 2007, children with private insurance were more likely to have a usual source of care with night or weekend hours than children with Medicaid.
- In 2002, uninsured children were more likely to have a usual source of care with night or weekend hours than children with Medicaid, but there were no statistically significant differences between the two groups in 2007.

Difficulty Contacting Provider by Telephone

Patients cannot always meet a health care provider in person. Ensuring health care provider availability via telephone facilitates access to health care by increasing convenience and making providers available to patients who cannot travel to providers' offices.

Figure 7.4. Children with difficulty contacting their usual source of care over the telephone, by insurance status, 2002-2007



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

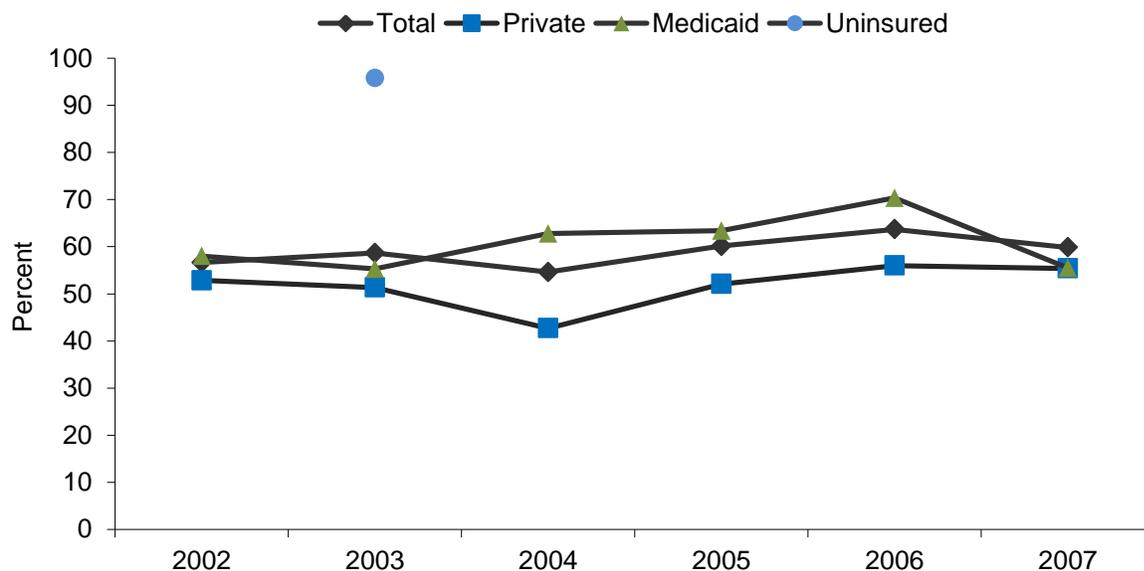
Note: For this measure, lower rates are better. A parent, guardian, or other caregiver may have attempted to contact the child's usual source of care.

- From 2002 to 2007, the percentage of children with difficulty contacting their usual source of care over the telephone decreased for all insurance groups.
- There were no statistically significant differences between insurance groups in 2002; however, in 2007, children with Medicaid were more likely to have difficulty contacting their usual source of care over the telephone than children with private insurance.

Financial Burden of Health Care

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.¹⁰ High premiums and out-of-pocket payments can be a significant barrier to accessing needed medical treatment and preventive care.¹¹ Some patients have 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 7.5. Children unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons, by insurance status, 2002-2007



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

Note: Data for uninsured children in 2002 and 2004-2007 do not meet the criteria for statistical reliability, data quality, or confidentiality

- From 2002 to 2007, there were no statistically significant differences between children with private insurance and children with Medicaid in the percentage unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons.

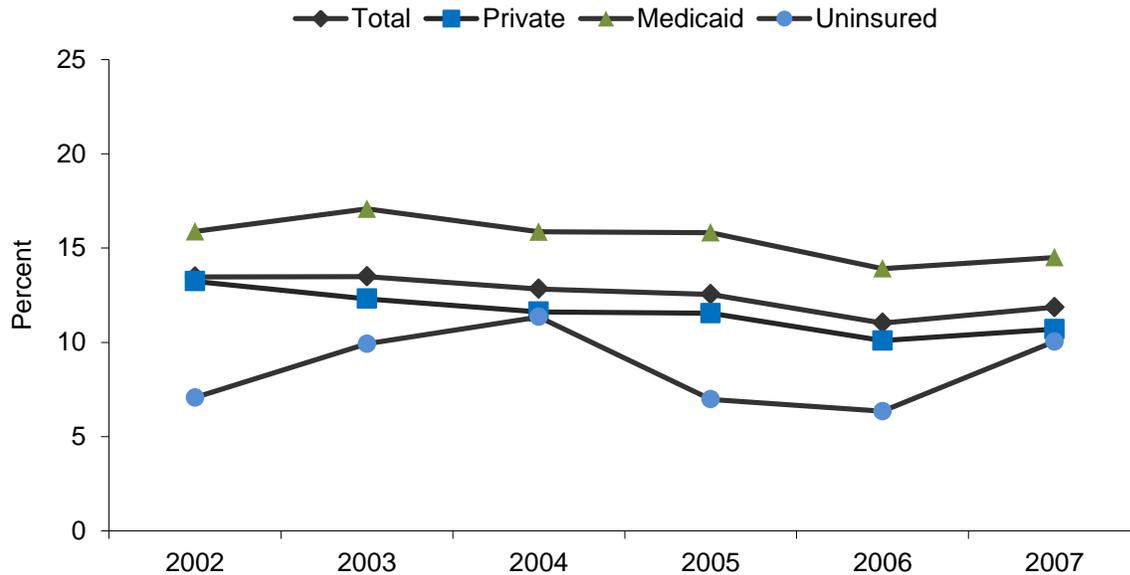
Utilization

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 medical care is important for preserving health and functioning, while high rates of emergency department use suggest lack of access to routine care and other avenues of treatment.

Emergency Room Visits

Without good access to health care, people sometimes resort to using the emergency department when care is needed. Delaying care until the need is urgent often results in poorer health outcomes and increased health care costs.

Figure 7.6. Children who had a hospital emergency room visit in the calendar year, by insurance status, 2002-2007



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

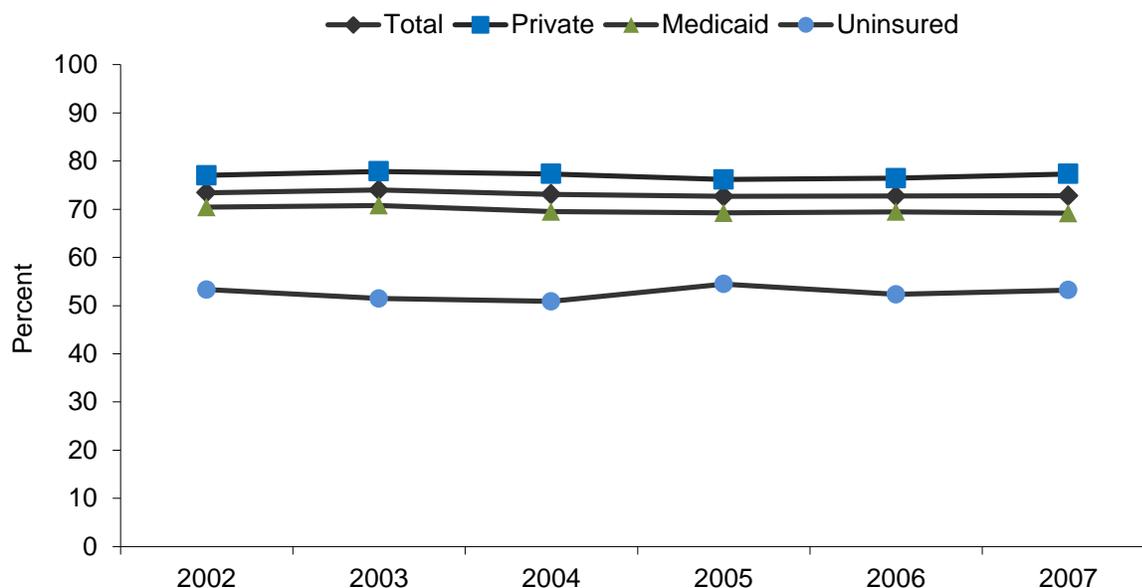
Note: For this measure, lower rates are better.

- From 2002 to 2007, the percentage of children with an emergency room visit in the calendar year decreased for children with private insurance and children with Medicaid. There were no statistically significant changes for uninsured children.
- In 2002, uninsured children were the least likely and children with Medicaid were the most likely to have a hospital emergency room visit in the calendar year. In 2007, children with Medicaid were still the most likely to have a hospital emergency room visit, but there was no statistically significant difference between uninsured children and children with private insurance.

Outpatient Visits

In addition to seeing providers when sick, children visit providers to receive recommended screenings, vaccines, and counseling. There are several schedules for well-child visits, most of which recommend at least one visit per year.

Figure 7.7. Children ages 2-17 who had a physician office or hospital outpatient department visit, by insurance status, 2002-2007



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

- From 2002 to 2007, the percentage of children with a physician office or hospital outpatient department visit was unchanged for children in all insurance groups.
- From 2002 to 2007, children with private insurance were the most likely and uninsured children were the least likely to have a physician office or hospital outpatient department visit.

References

1. Starfield B, Shi L. The medical home, access to care, and insurance: a review of evidence. *Pediatrics* 2004;113(5 Suppl):1493-8.
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5. Mainous AG 3rd, Baker R, Love MM, et al. Continuity of care and trust in one's physician: evidence from primary care in the United States and the United Kingdom. *Fam Med* 2001;33(1):22-7.
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Racial and Ethnic Disparities

Chapter 8: Quality of Ambulatory Health Care

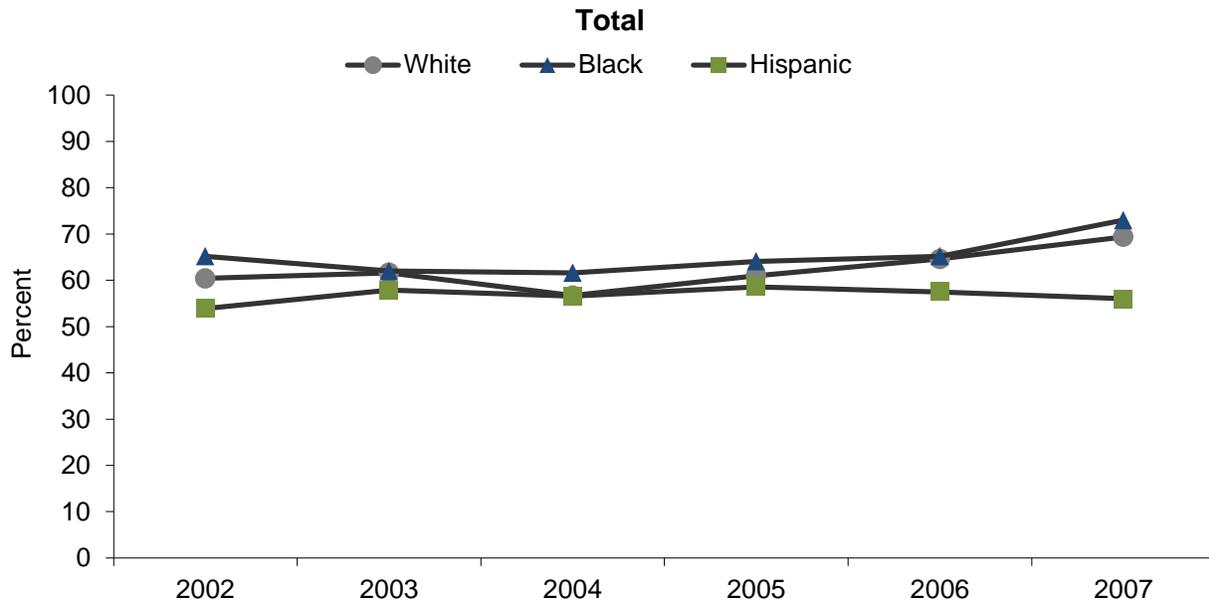
The Coverage Analyses Trends Report examined racial and ethnic disparities for each measure, including disparities among those with the same insurance status. These measures evaluated children under age 18.

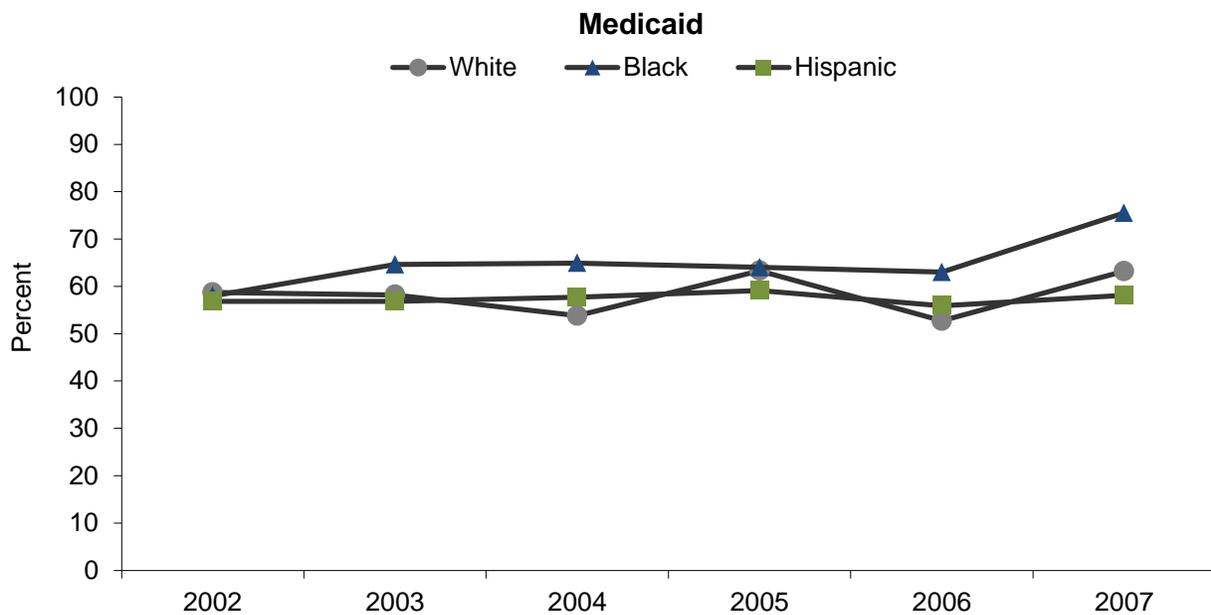
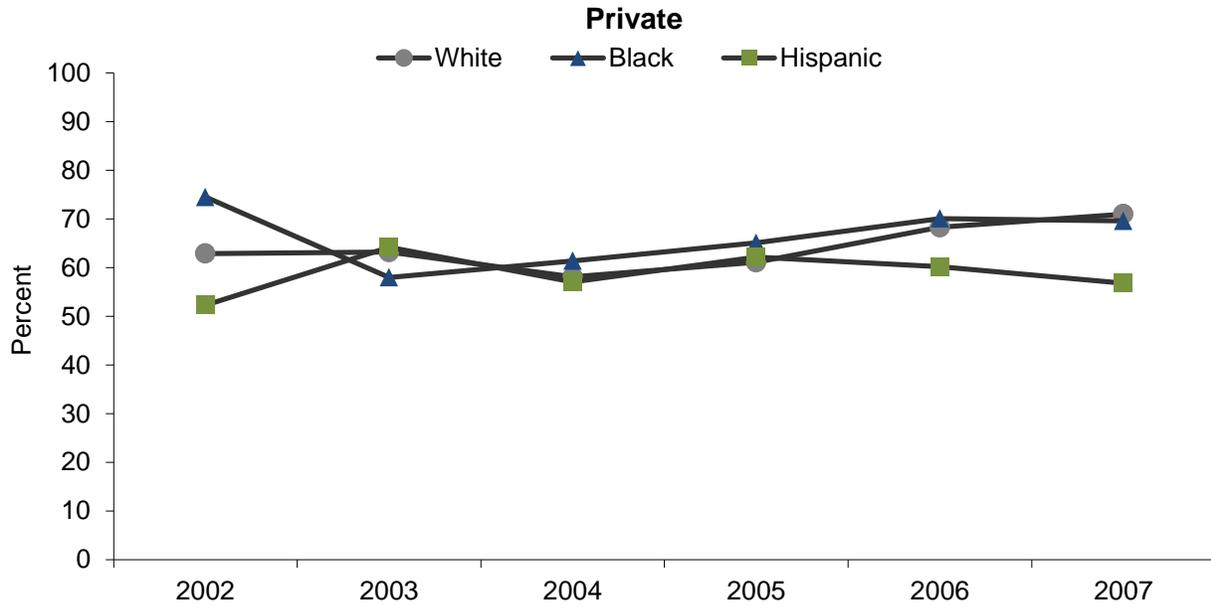
Effectiveness

Prevention: Vision Care

Vision checks for children may detect problems of which children and their parents were previously unaware. Early detection also improves the chances that corrective treatments will be successful.

Figure 8.1. Children ages 3-6 who ever had their vision checked by a health provider, by race/ethnicity, stratified by insurance status, 2002-2007





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

Note: Data for uninsured children from 2002 to 2007 do not meet the criteria for statistical reliability, data quality, or confidentiality.

- From 2002 to 2007, White and Black children ages 3-6 were more likely than Hispanic children ages 3-6 to have their vision checked by a health provider. Disparities between Hispanic and White children and Hispanic and Black children increased over time, as the percentage of children ages 3-6 who had vision checks increased for Whites and Blacks but did not change for Hispanics.
- From 2002 to 2007, the percentage of children with private insurance who had their vision checked improved for Whites but did not change for Hispanics and Blacks. In 2002, among children with private insurance, Blacks were more likely than Hispanics and

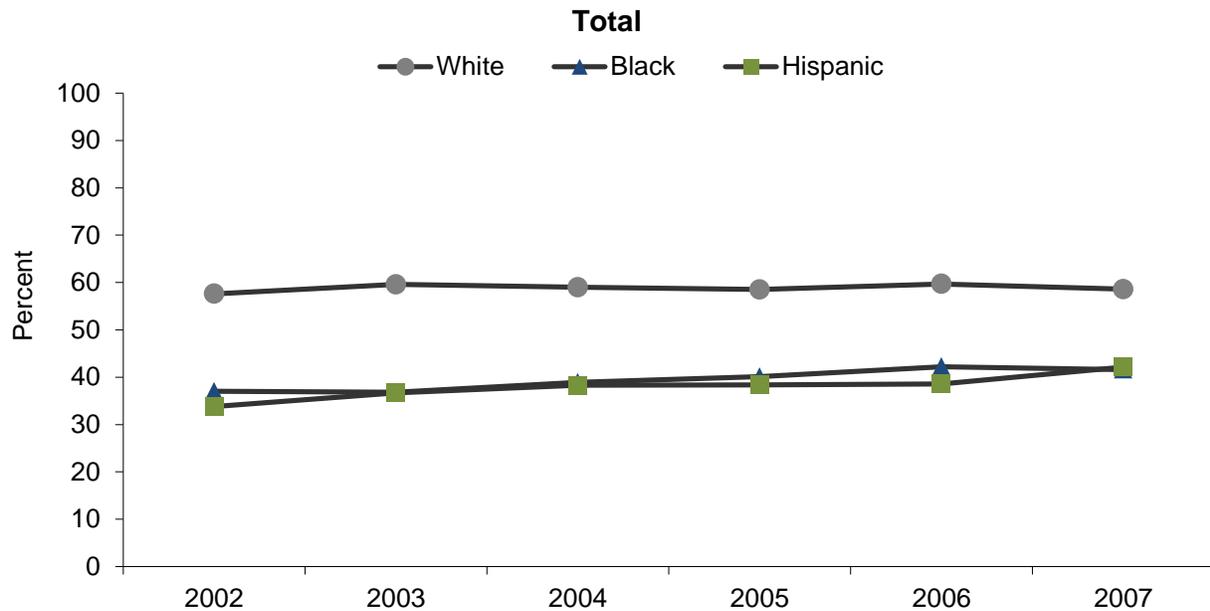
Whites to have their vision checked. In 2007, the percentage of children with private insurance who had their vision checked was higher for Blacks and Whites than for Hispanics.

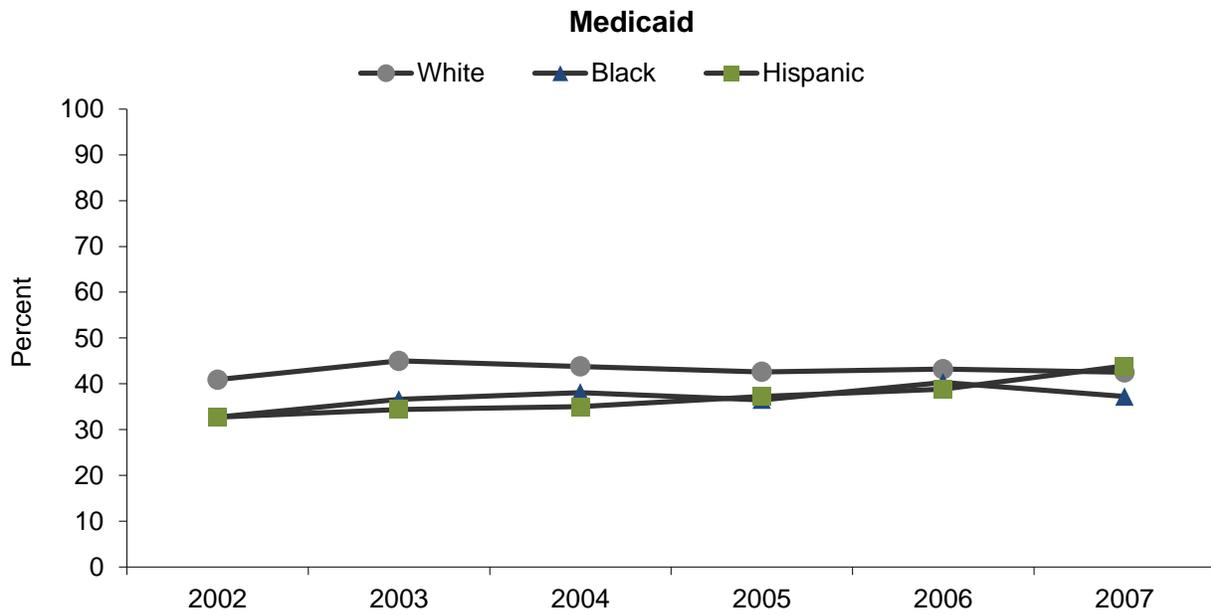
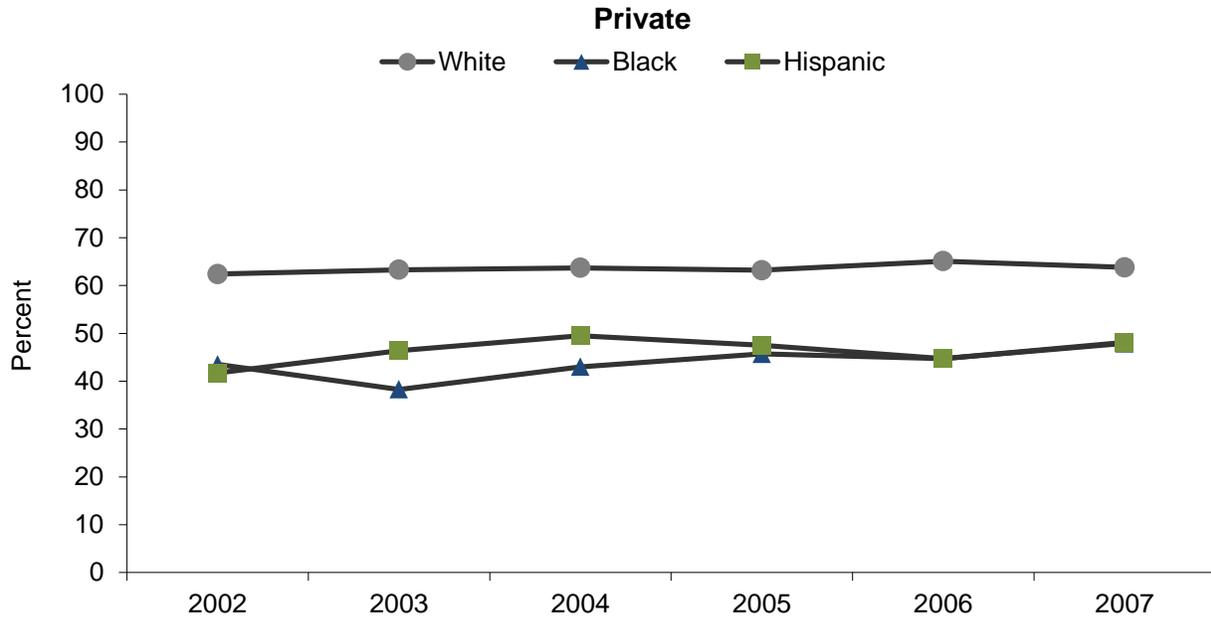
- From 2002 to 2007, among children with Medicaid, the percentage who had their vision checked increased for Blacks and Whites. In 2002, there were no statistically significant differences between racial and ethnic groups, but in 2007, Blacks were more likely to have their vision checked than Hispanics and Whites.

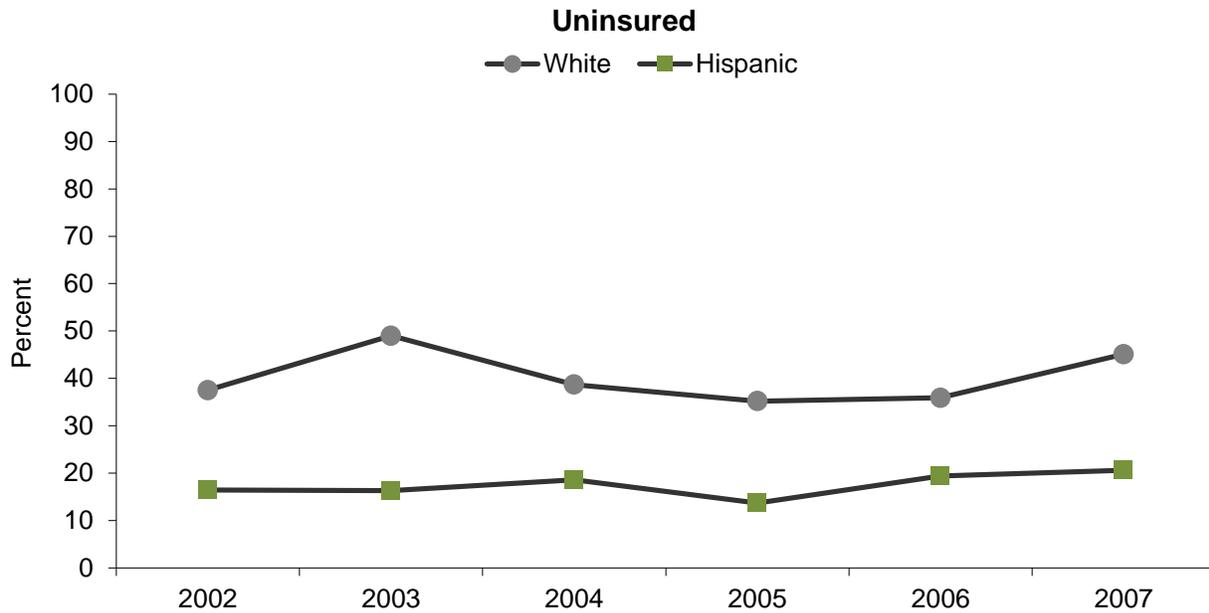
Prevention: Children’s Dental Care

According to the National Institute of Dental and Craniofacial Research, presence of dental caries is the single most common chronic disease of childhood, occurring five times as frequently as asthma, the second most common chronic disease in children.¹ Regular dental visits help to improve overall oral health and prevent dental caries.

Figure 8.2. Children ages 2-17 who had a dental visit in the calendar year, by race/ethnicity, stratified by insurance status, 2002-2007







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

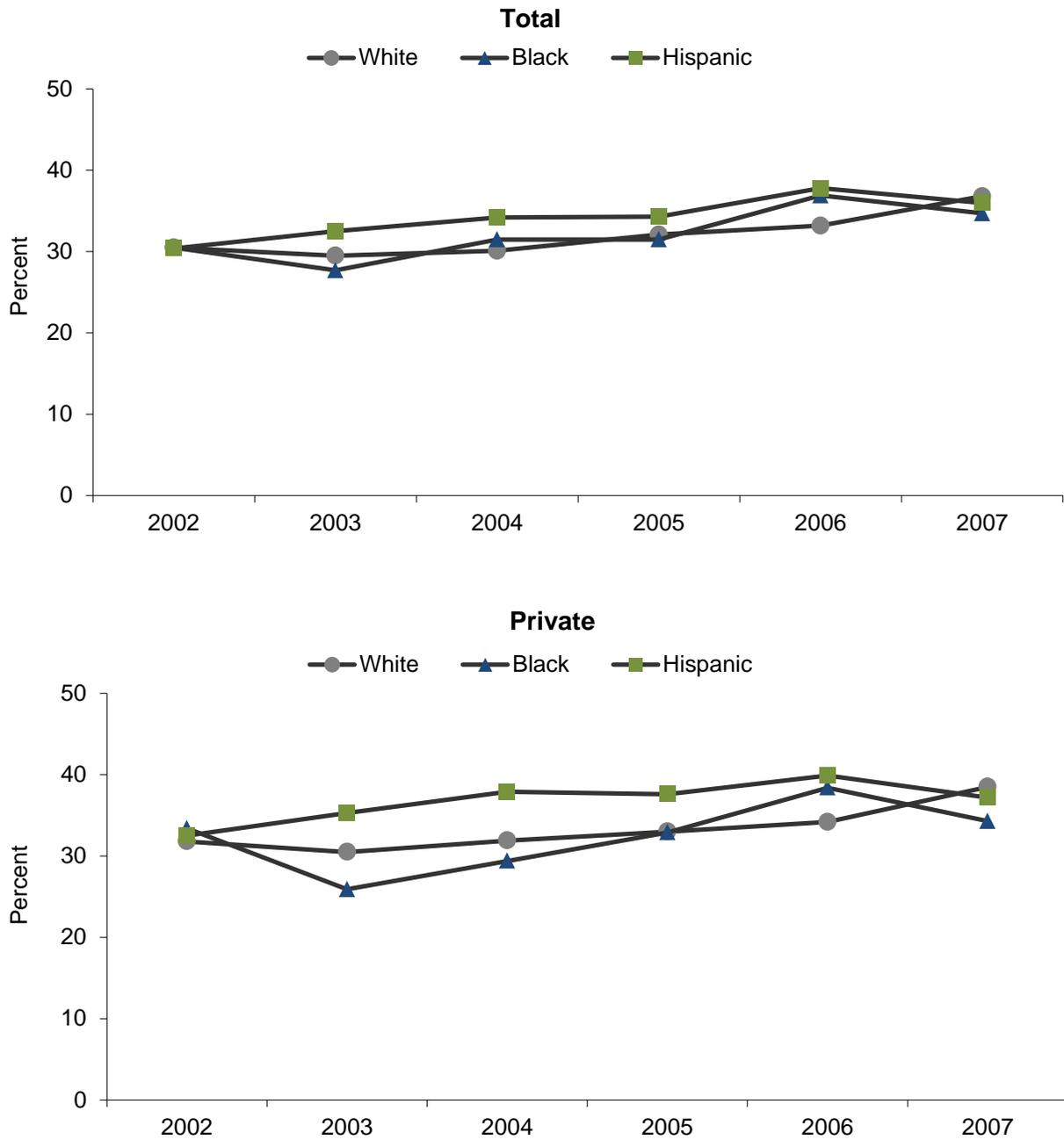
Note: Data for uninsured Black children from 2002 to 2007 do not meet the criteria for statistical reliability, data quality, or confidentiality

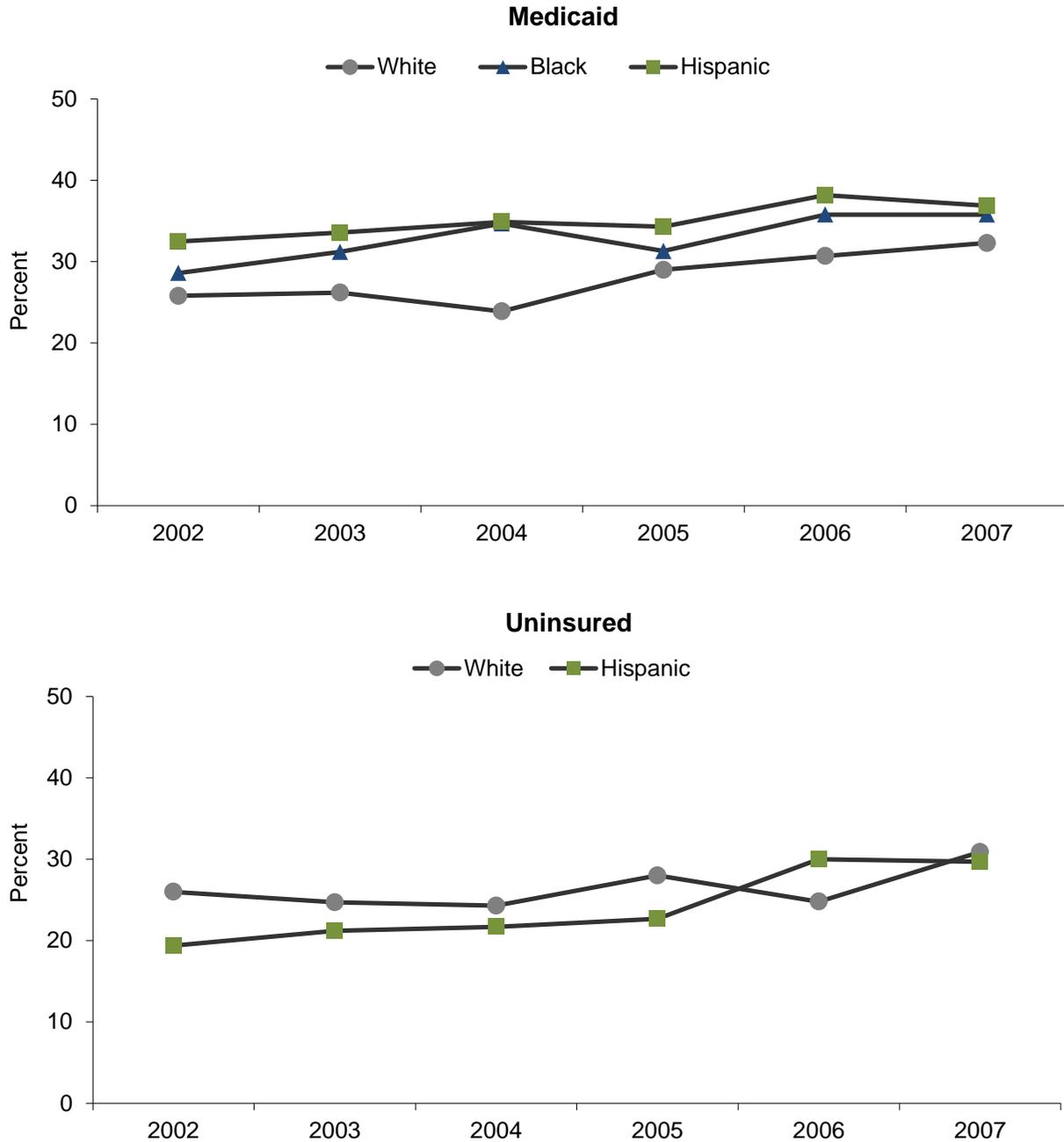
- From 2002 to 2007, the total percentage of children ages 2-17 who had a dental visit in the calendar year was higher for Whites than for Hispanics and Blacks. However, the percentage of children who had a dental visit in the calendar year increased for Hispanics and Blacks from 2002 to 2007, reducing the disparities between Whites and Hispanics and between Whites and Blacks.
- From 2002 to 2007, White children with private insurance were more likely to have a dental visit than Hispanic and Black children with private insurance.
- Among children with Medicaid, the percentage of children who had a dental visit in the calendar year increased over time for both Blacks and Hispanics but rate remained stable for Whites. In 2002, White children with Medicaid were more likely to have a dental visit in the calendar year than Black or Hispanic children with Medicaid, but there were no statistically significant differences between the groups in 2007.
- From 2002 to 2007, Hispanic uninsured children were less likely to have a dental visit in the calendar year than White uninsured children.

Prevention: Advice on Physical Activity and Healthy Eating

Childhood represents a period when healthy, lifelong habits are often formed. Health care providers can play an important role in encouraging healthy behaviors in children, such as regular exercise and healthy eating.

Figure 8.3. Children ages 2-17 for whom a health provider ever gave advice about the amount and kind of exercise, sports, or physically active hobbies they should have, by race/ethnicity, stratified by insurance status, 2002-2007



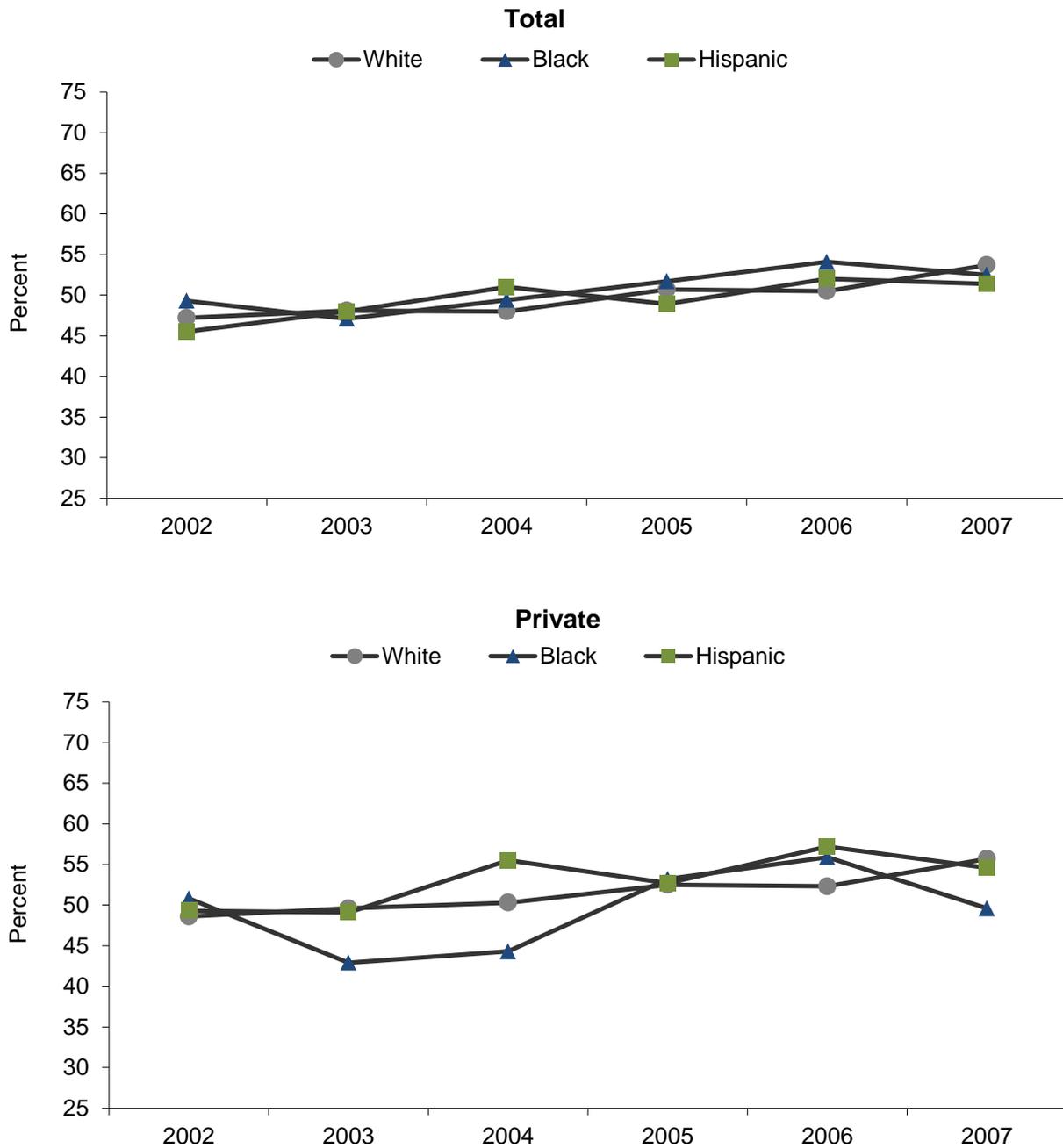


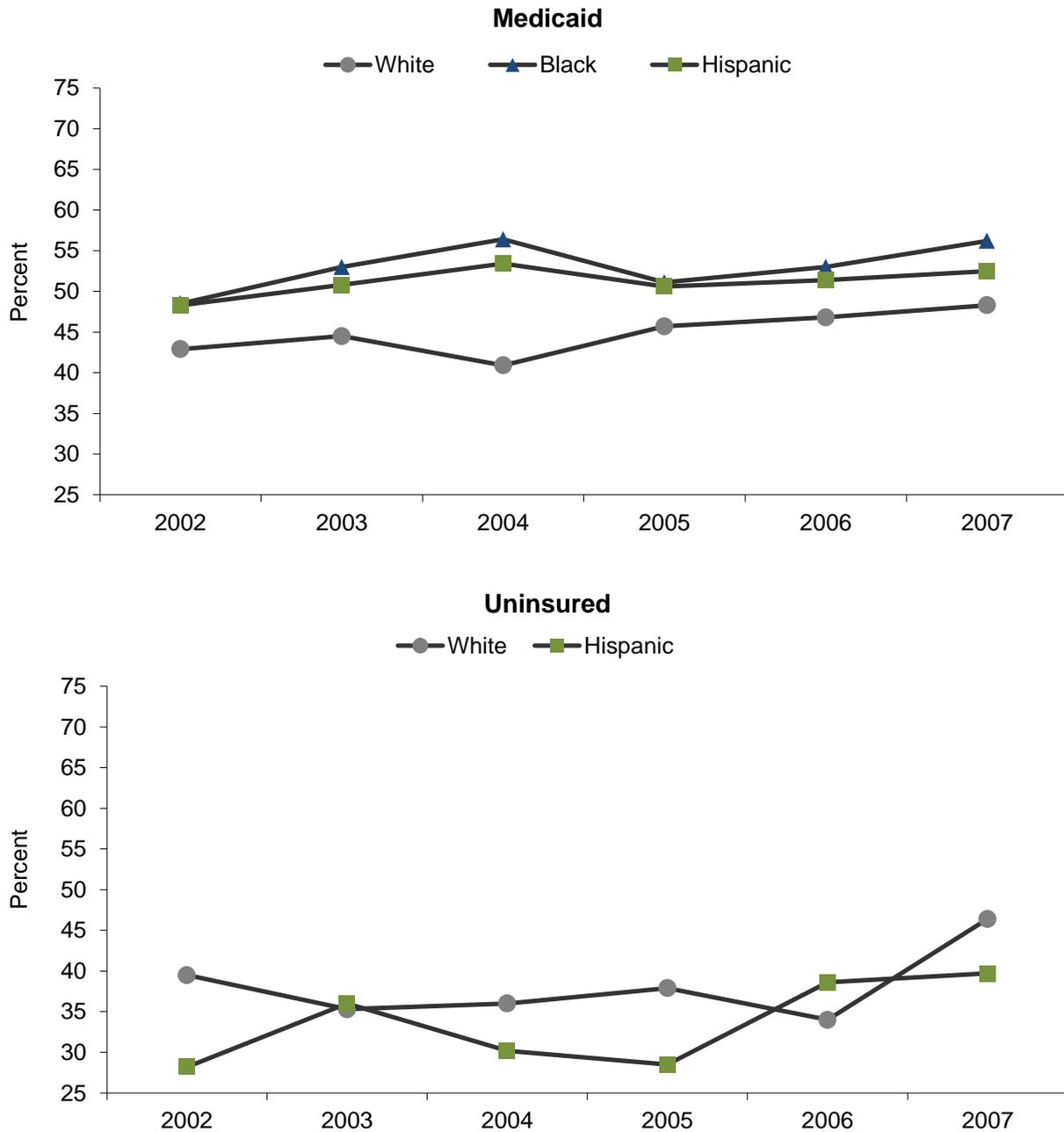
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.

Note: Data for uninsured Black children from 2002 to 2007 do not meet the criteria for statistical reliability, data quality, or confidentiality.

- From 2002 to 2007, the percentage of children for whom providers gave advice about the amount or kind of exercise, sports, or physically active hobbies they should have increased for all racial and ethnic groups and all insurance groups.
- From 2002 to 2007, there were no statistically significant racial or ethnic disparities within any insurance group in the percentage of children for whom a health provider gave advice about physical activity.

Figure 8.4. Children ages 2-17 for whom a health provider ever gave advice about healthy eating, by race/ethnicity, stratified by insurance status, 2002-2007





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

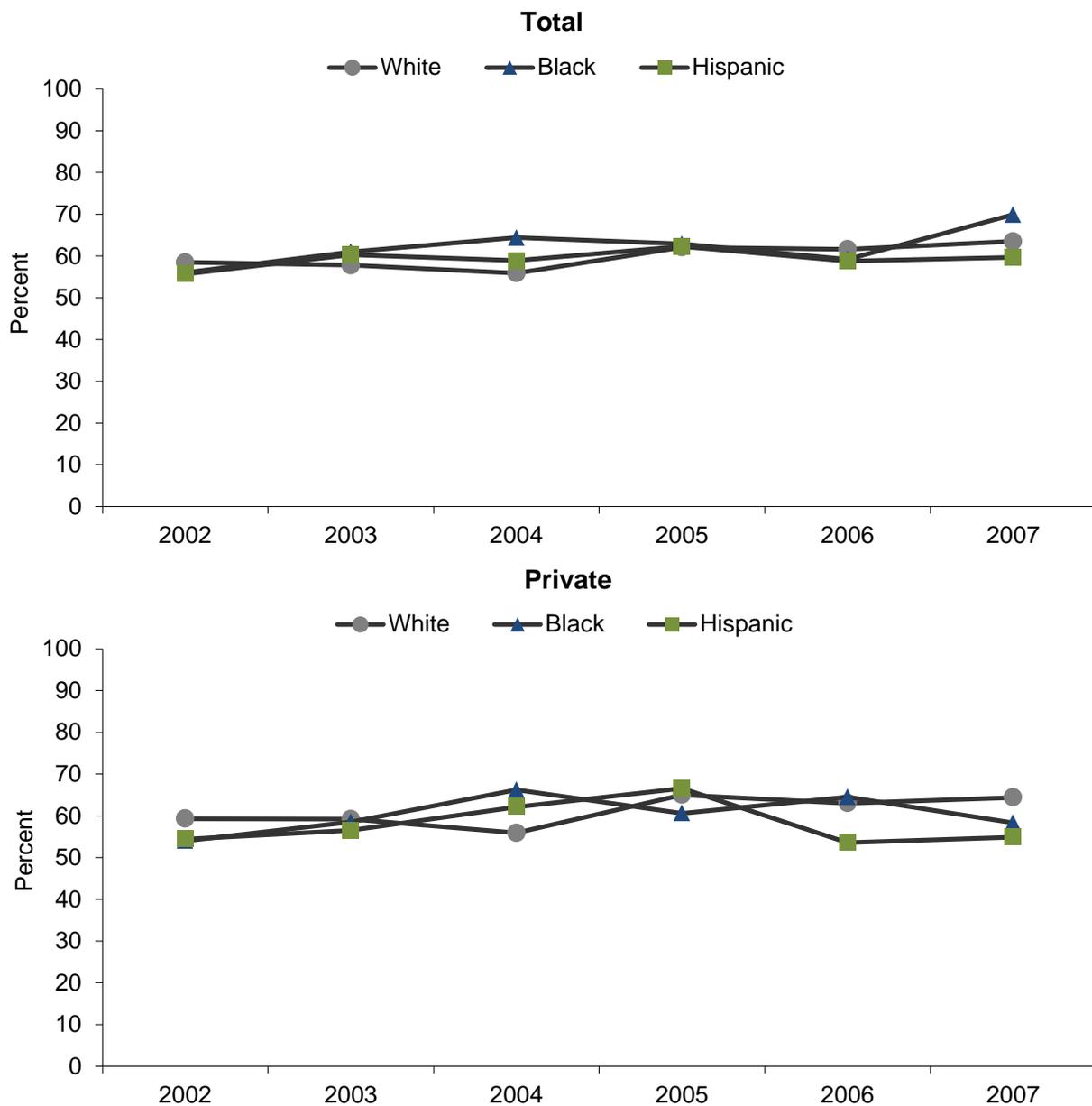
Note: Data for uninsured Blacks from 2002 to 2007 do not meet the criteria for statistical reliability, data quality, or confidentiality.

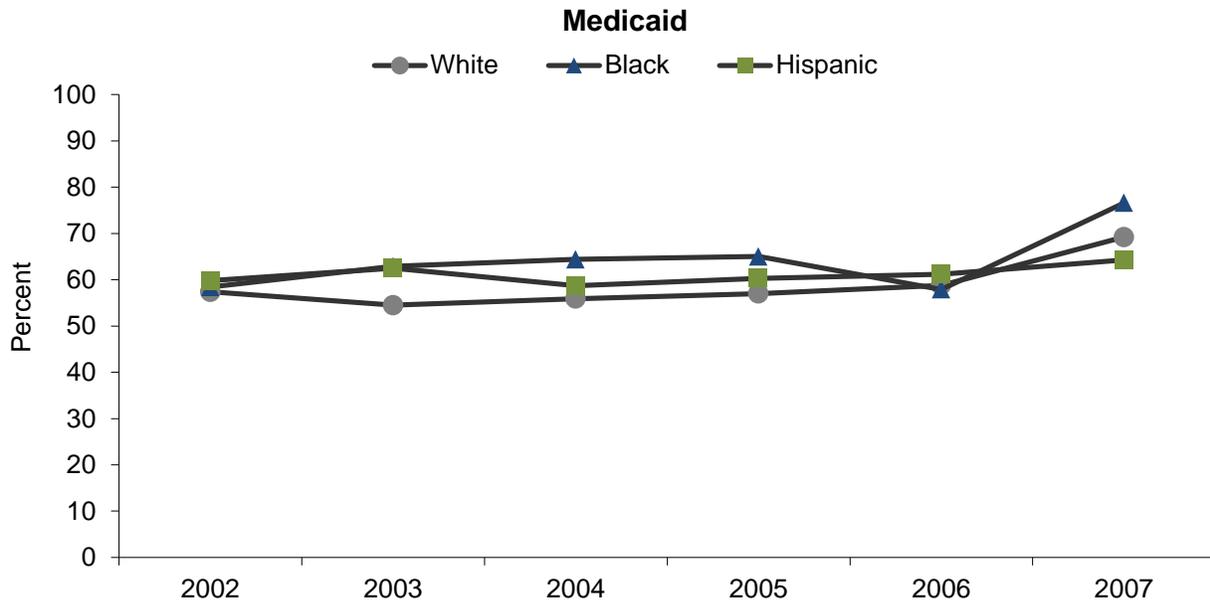
- From 2002 to 2007, the percentage of children for whom providers gave advice about healthy eating increased for all racial and ethnic groups and all insurance groups, except Blacks with private insurance.
- From 2002 to 2007, there were no statistically significant racial or ethnic disparities within any insurance group in the percentage of children for whom a health provider ever gave advice about healthy eating.

Prevention: Advice on Vehicle Safety

Unintentional injury is the leading cause of death of children. Wearing a helmet drastically reduces the risk of head and facial injuries by bicyclists, even if a crash involves a motor vehicle.² The American Academy of Pediatrics (AAP) recommends that pediatricians encourage parents and other child care providers to require children to wear a bicycle helmet when they begin riding tricycles or other wheeled vehicles or toys. AAP also provides detailed guidance for pediatricians to share with parents and other caregivers on the proper use of child safety seats in cars.

Figure 8.5. Children 0 to 40 lb for whom a health provider ever gave advice about using child safety seats when riding in a car, by race/ethnicity, stratified by insurance status, 2002-2007



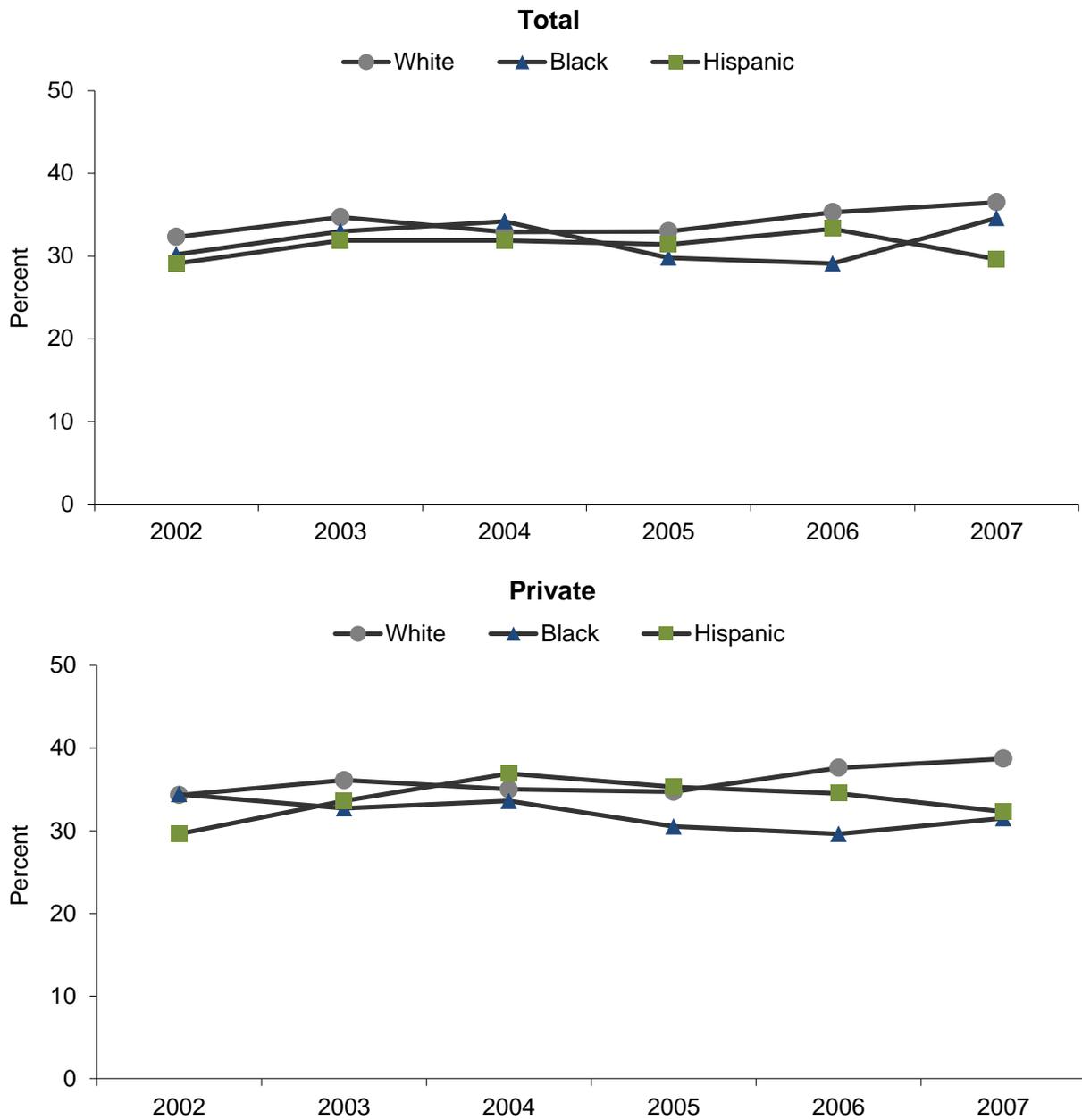


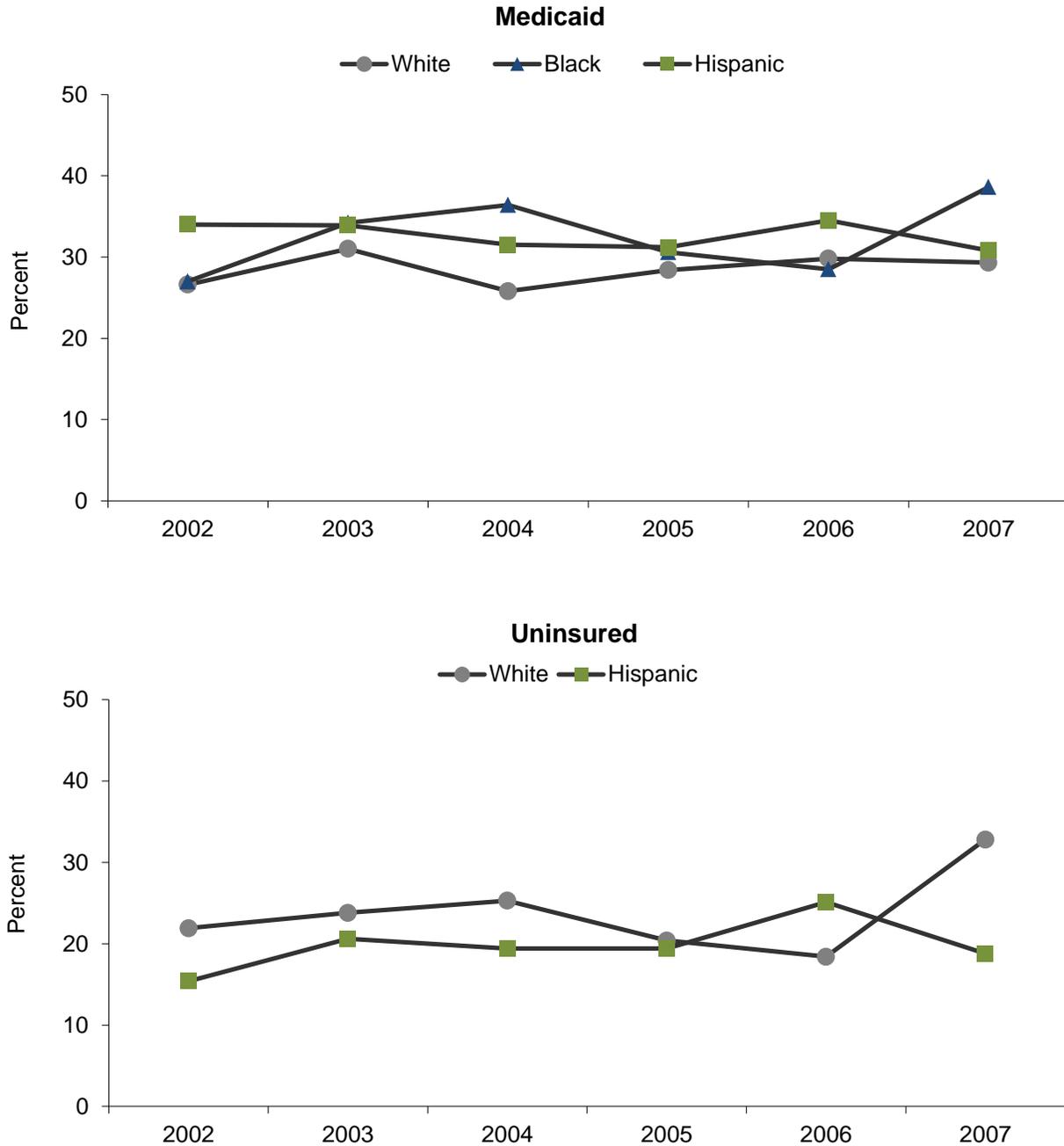
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2007.

Note: Data for uninsured children from 2002 to 2007 do not meet the criteria for statistical reliability, data quality, or confidentiality.

- From 2002 to 2007, the overall percentage of children for whom a health provider gave advice about using child safety seats increased for all racial and ethnic groups. In 2002, there were no statistically significant racial or ethnic differences, but in 2007, Hispanic children were less likely than Black children to have a health provider give advice about using child safety seats.
- Among children with private insurance, the percentage for whom a health provider gave advice about child safety seats increased from 2002 to 2007 for Blacks and Whites but did not change for Hispanics. Also from 2002 to 2007, there were no statistically significant racial or ethnic disparities.
- Among children with Medicaid, the percentage for whom a health provider gave advice about child safety seats increased from 2002 to 2007 for all racial and ethnic groups, most significantly for Blacks. Although there were no statistically significant racial or ethnic differences in 2002, Black children with Medicaid were more likely to have a health provider give them advice about using child safety seats than Hispanic children with Medicaid in 2007.

Figure 8.6. Children ages 2-17 for whom a health provider ever gave advice about using a helmet when riding a bicycle or motorcycle, by race/ethnicity, stratified by insurance status, 2002-2007





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

Note: Data for uninsured Black children from 2002 to 2007 do not meet the criteria for statistical reliability, data quality, or confidentiality.

- Although there were no statistically significant racial or ethnic disparities in 2002, Hispanic children ages 2-17 were less likely than White children in 2007 to have received advice from a health provider about using a helmet when riding a bicycle or motorcycle.
- Among children with private insurance, there were no statistically significant racial or ethnic differences in 2002. From 2002 to 2007, the percentage who received advice about using a helmet decreased for Blacks and increased for Whites. Thus, in 2007, Black

children with private insurance were less likely than White children with private insurance to have received advice about using a helmet.

- Among children with Medicaid, from 2002 to 2007, the percentage who received advice about using a helmet increased for Blacks., There were no statistically significant changes for Whites and Hispanics. In 2002, White children with Medicaid were less likely to receive advice about using a helmet than Hispanic children with Medicaid. In 2007, White and Hispanic children with Medicaid were less likely to receive advice about using a helmet than Black children with Medicaid.
- From 2002 to 2007, the percentage of uninsured children who received advice about using a helmet increased for Whites and Hispanics. There were no statistically significant differences between Whites and Hispanics in 2002, but in 2007, Hispanics were less likely than Whites to have received advice about using a helmet.

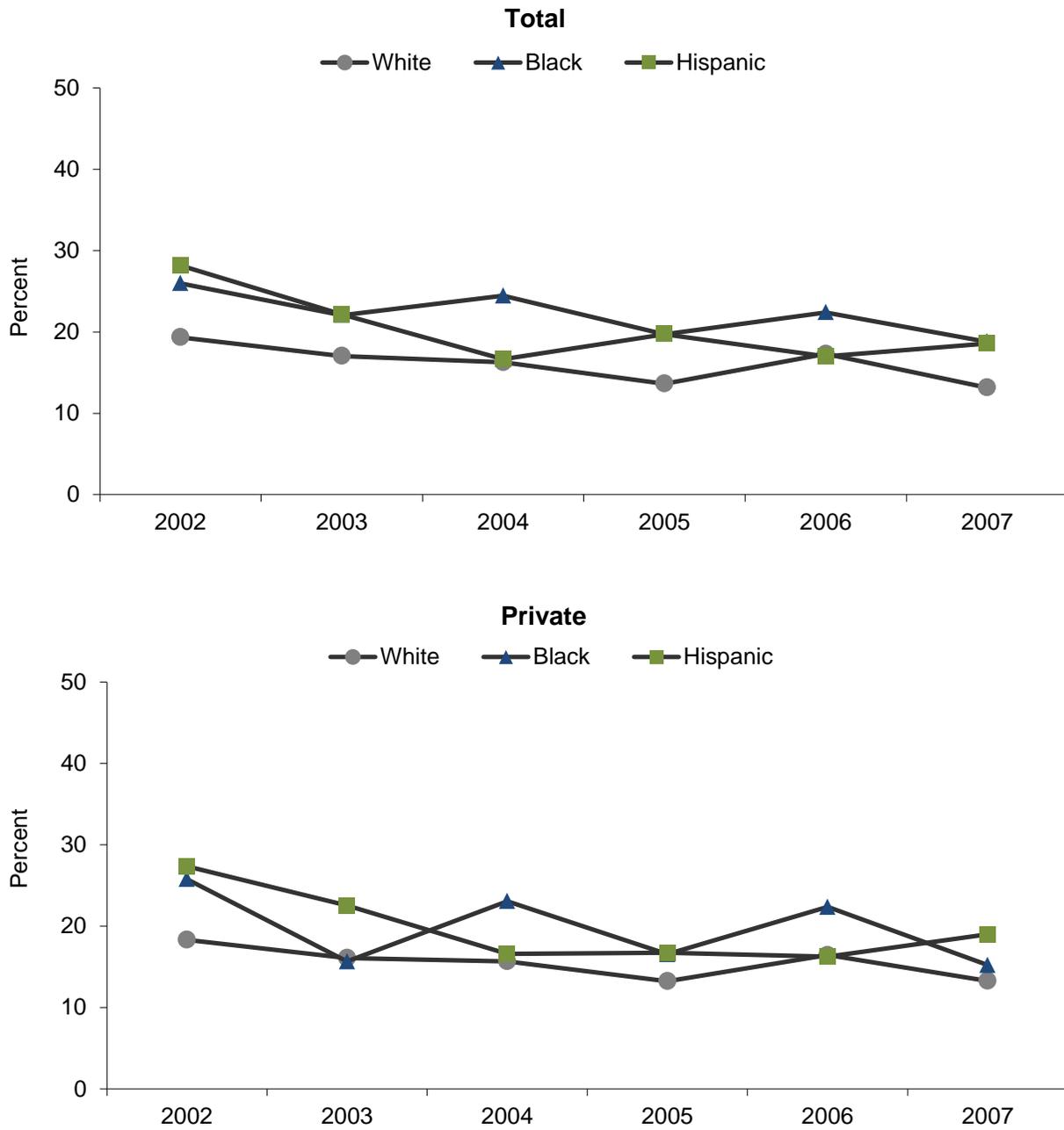
Patient Centeredness

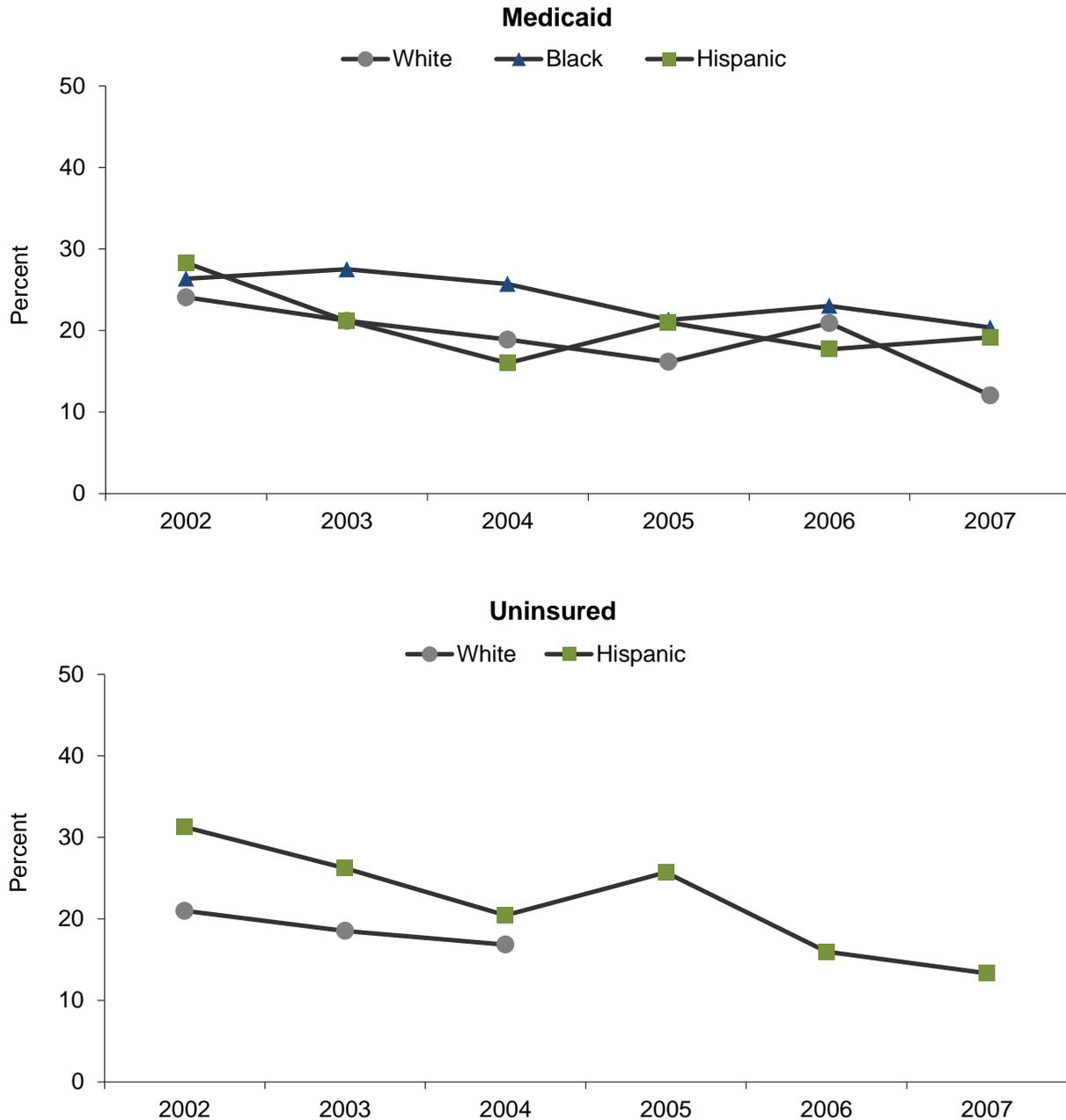
Patient-centered care is supported by good provider-patient communication so that patients' needs and wants are understood and addressed and patients understand and participate in their own care. This style of care has been shown to improve patients' health and health care. Unfortunately, many barriers exist to good communication.

Patient Experiences of Care

Communication in children's health care can be challenging since the child's experiences are interpreted through the eyes of a parent or guardian. During a health care encounter, a responsible adult caregiver will be involved in communicating with the provider and interpreting decisions in an age-appropriate manner to the patient. Optimal communication in children's health care can therefore have a significant impact on receipt of high-quality care and subsequent health status. This is especially true for children with special health care needs.

Figure 8.7. Children ages 2-17 with a usual source of care whose health providers sometimes or never asked for the person’s help to make treatment decisions, by race/ethnicity, stratified by insurance status, 2002-2007





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

Note: Data for uninsured Black children from 2002 to 2007 and uninsured White children from 2005 to 2007 do not meet the criteria for statistical reliability, data quality, or confidentiality.

- In nearly all years from 2002 to 2007, the percentage of children with a usual source of care whose health providers sometimes or never asked for help to make treatment decisions was lower for Whites compared with Hispanics and Blacks. From 2002 to 2007, the percentage decreased for all racial and ethnic groups.
- Among those with private insurance, in nearly all years from 2002 to 2007, the percentage of children with a usual source of care whose health providers sometimes or

never asked for help to make treatment decisions was lower for Whites than for Hispanics and Blacks. From 2002 to 2007, the percentage decreased for all racial and ethnic groups with private insurance.

- Although there were no statistically significant racial or ethnic disparities among children with Medicaid in 2002, the percentage of children with Medicaid whose health providers sometimes or never asked for help to make treatment decisions was lower for Whites in 2007 compared with Hispanics and Blacks. From 2002 to 2007, the percentage decreased for all racial and ethnic groups with Medicaid.
- The percentage of uninsured children whose health providers sometimes or never asked for help to make treatment decisions decreased for Hispanics from 2002 to 2007 and for Whites from 2002 to 2004.

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Racial and Ethnic Disparities

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) are disproportionately represented among those with access problems.

Facilitators and Barriers to Health Care

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

Usual Source of Care

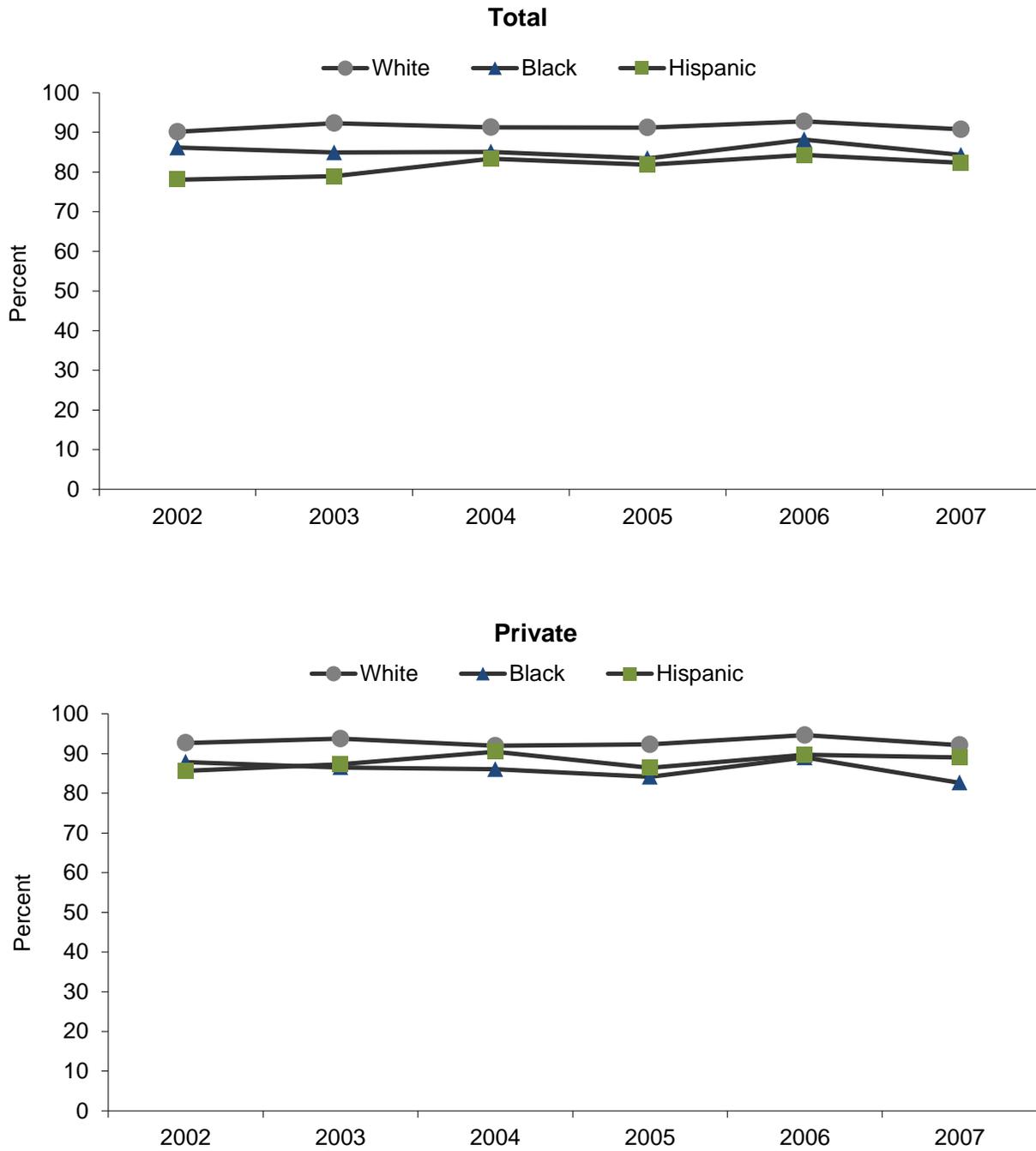
People with a usual source of care (a provider or facility where one regularly receives care) experience improved health outcomes and reduced disparities (smaller differences between groups)¹ and costs.² Evidence suggests that the effect on quality of the combination of health insurance and a usual source of care is additive.³ In addition, people with a usual source of care are more likely to receive preventive health services.⁴

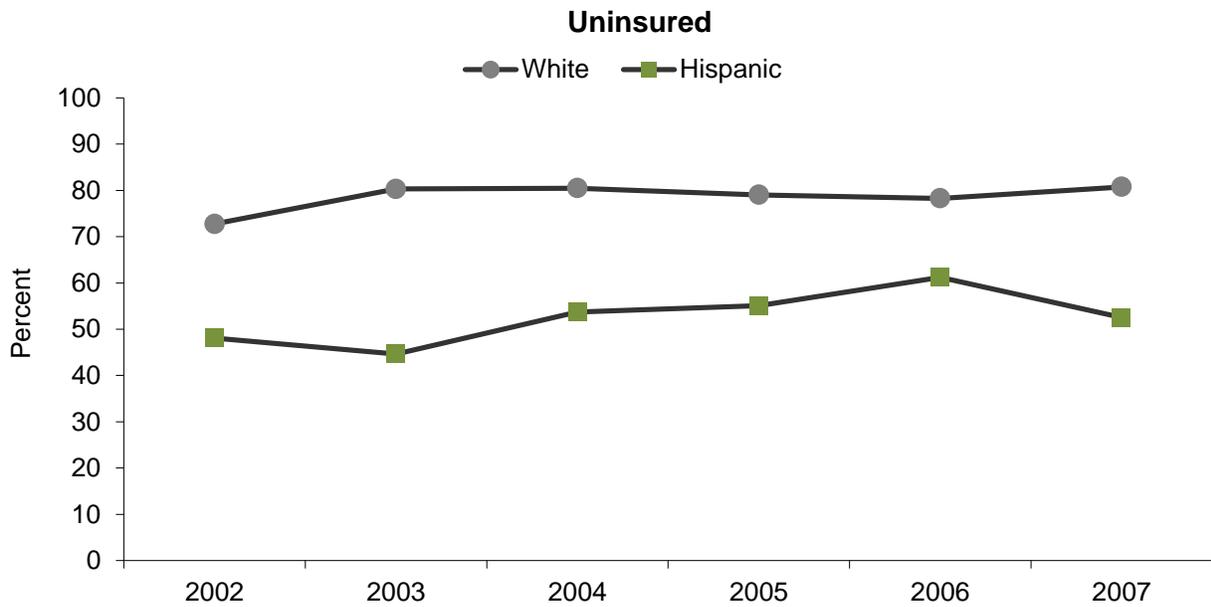
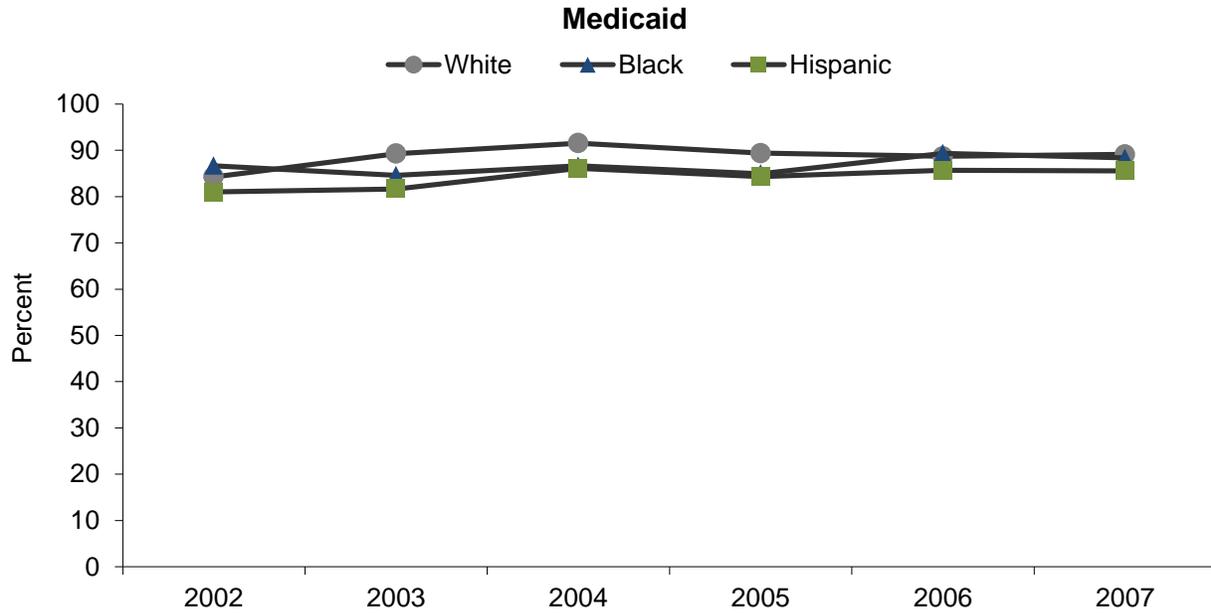
The 2002-2007 sample sizes for children without a usual source of care were not large enough to reliably compare racial and ethnic subgroups. Therefore, the usual source of care measure for children is not presented.

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 provider⁵ and with good provider-patient communication. These factors increase the likelihood that patients receive appropriate care.⁶ 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.⁷ Having a usual primary care provider correlates with receipt of higher quality care.^{8,9}

Figure 9.1. Children ages 2-17 with a usual primary care provider, by race/ethnicity, stratified by insurance status, 2002-2007





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

Note: Data for uninsured Black children from 2002 to 2007 do not meet the criteria for statistical reliability, data quality, or confidentiality.

- From 2002 to 2007, Hispanic and Black children ages 2-17 were less likely to have a usual primary care provider than White children. During this time, the percentage of children ages 2-17 with a usual primary care provider increased for Whites and Hispanics but did not change for Blacks.
- Black children with private insurance were less likely to have a usual primary care provider than White children from 2002 to 2007. Hispanic children with private insurance were less likely to have a usual primary care provider than White children with

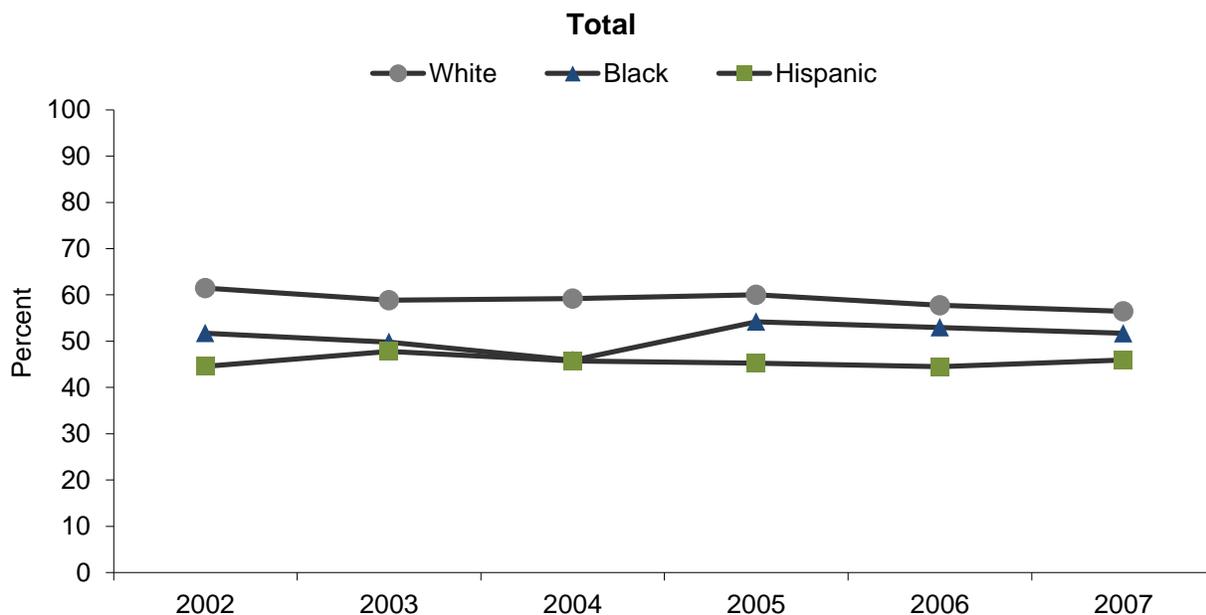
private insurance in 2002. However, the percentage of Hispanic children with a usual primary care provider increased over time, and there were no statistically significant differences between Whites and Hispanics in 2007.

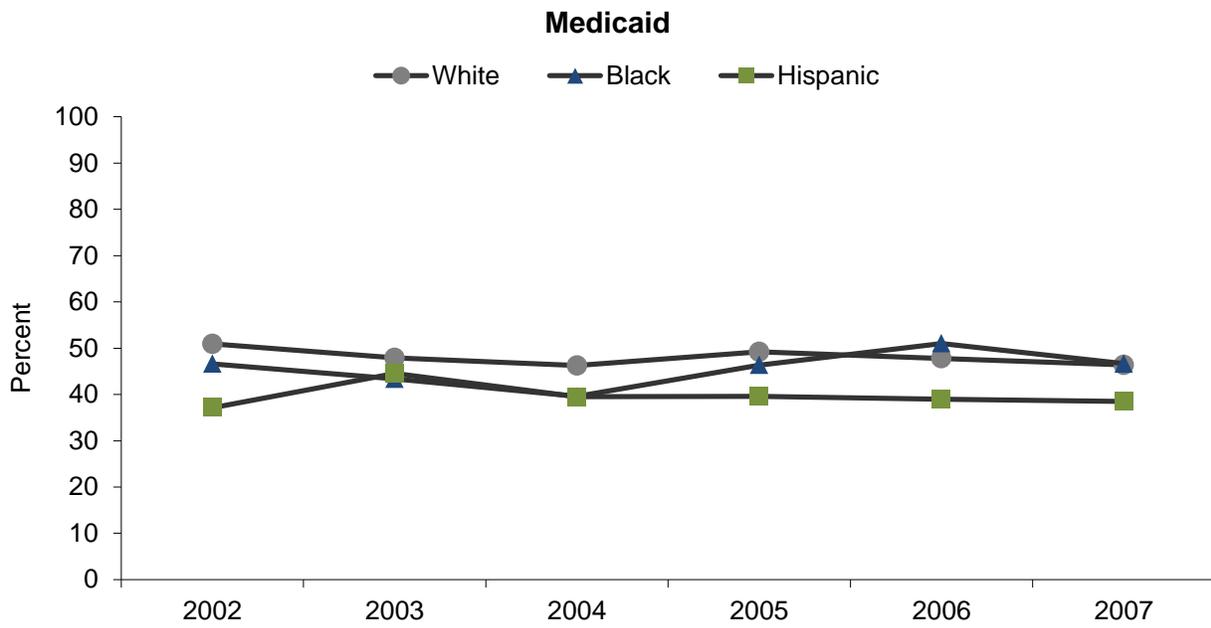
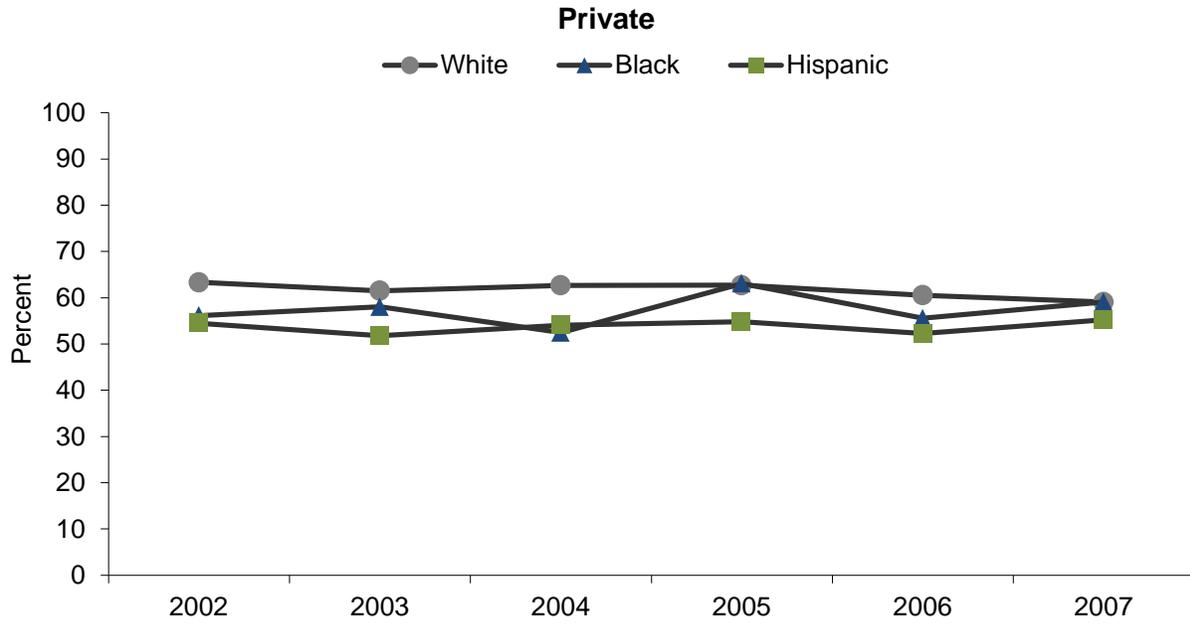
- From 2002 to 2007, the percentage of children with Medicaid who had a usual primary care provider increased for Whites and Hispanics. Hispanic children with Medicaid were less likely to have a usual primary care provider than Black children in 2002, but there were no statistically significant racial or ethnic differences in 2007.
- Uninsured Hispanic children were less likely to have a usual primary care provider than uninsured White children from 2002 to 2007. During this time, the percentage of children with a usual primary care provider increased for Whites and Hispanics.

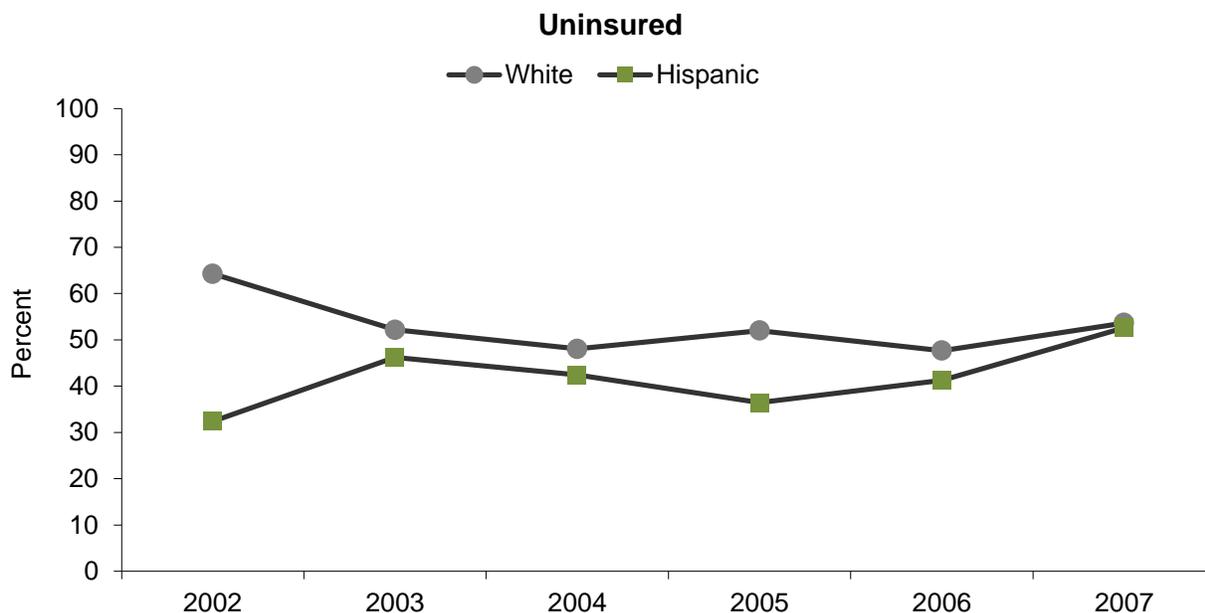
Provider With Night or Weekend Hours

The health care delivery system’s structure and organization are critical factors for 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 and helping people who cannot afford time off to see their doctor after hours.

Figure 9.2. Children ages 2-17 with a usual source of care, excluding hospital emergency rooms, who has office hours nights or weekends, by race/ethnicity, stratified by insurance status, 2002-2007







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

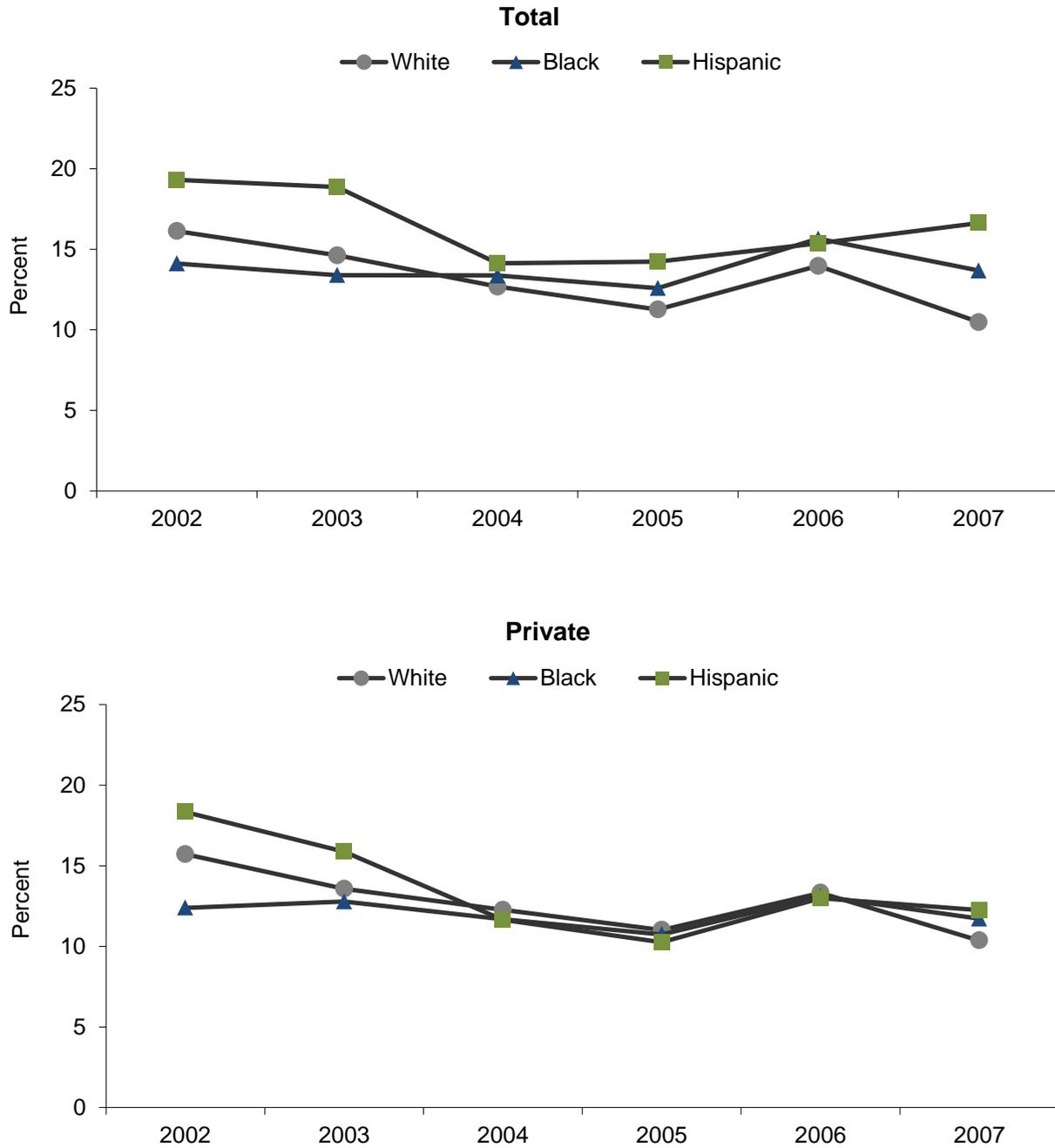
Note: Data for uninsured Black children from 2002 to 2007 do not meet the criteria for statistical reliability, data quality, or confidentiality.

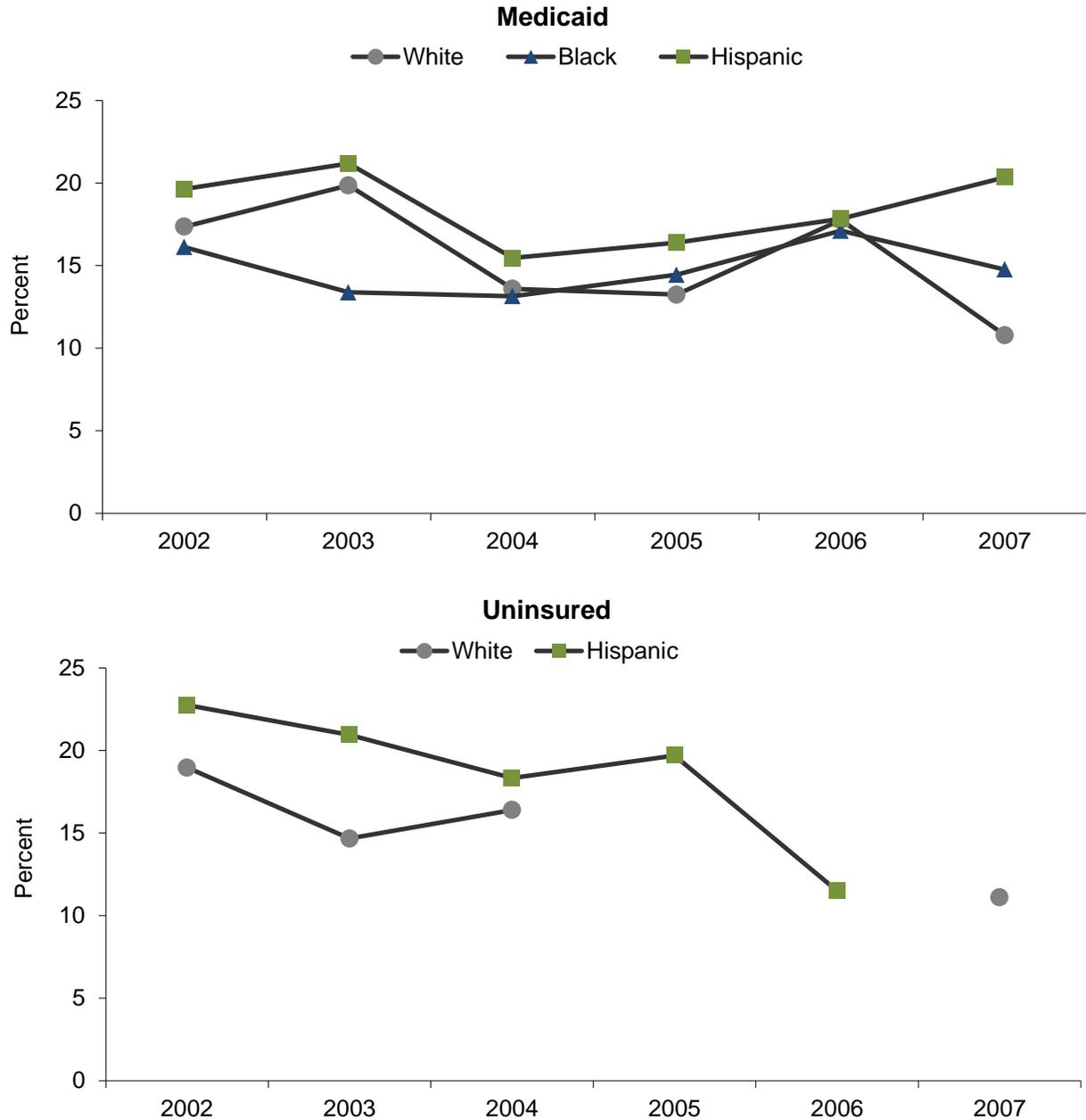
- In 2002, White children were more likely than Black and Hispanic children to have a usual source of care with office hours nights or weekends. In 2007, the disparities between White and Hispanic children persisted, but there were no statistically significant differences between White children and Black children.
- In 2002, White children with private insurance were more likely to have a usual source of care who had office hours nights or weekends than Black and Hispanic children, but there were no statistically significant differences in 2007.
- From 2002 to 2007, among children with Medicaid, the percentage with a usual source of care who had office hours nights or weekends decreased for Whites and stayed the same for Blacks and Hispanics. During this time, White children were more likely to have a usual source of care who had office hours nights or weekends than Hispanic children.
- Among uninsured children, in 2002, Whites were more likely than Hispanics to have a usual source of care with office hours nights or weekends. In 2007, there was no statistically significant difference between the two groups.

Difficulty Contacting Provider by Telephone

Patients cannot always meet a health care provider in person. Ensuring health care provider availability via telephone facilitates access to health care by increasing convenience and making providers available to patients who cannot travel to providers' offices.

Figure 9.3. Children ages 2-17 with difficulty contacting their usual source of care over the telephone, by race/ethnicity, stratified by insurance status, 2002-2007





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

Note: For this measure, lower rates are better. A parent, guardian, or other caregiver may have attempted to contact the child’s usual source of care. Data for uninsured Black children from 2002 to 2007, uninsured White children in 2005 and 2006, and uninsured Hispanic children in 2007 do not meet the criteria for statistical reliability, data quality, or confidentiality.

- In 2002, the percentage of children who had difficulty contacting their usual source of care over the telephone was higher for Hispanics than for Blacks. In 2007, however, the percentage was higher for Hispanics than for Whites. The percentage of children who had difficulty contacting their usual source of care over the telephone decreased for Hispanic and White children from 2002 to 2007. There were no statistically significant changes in the percentage for Black children.

- From 2002 to 2007, the percentage of children with private insurance who had difficulty contacting their usual source of care over the telephone decreased for Hispanics and Whites. Among children with private insurance, Hispanics were more likely to have difficulty than Blacks in 2002, but there were no statistically significant racial or ethnic differences in 2007.
- From 2002 to 2007, the percentage of children with Medicaid who had difficulty contacting their usual source of care over the telephone decreased for Blacks and Whites. There were no statistically significant changes for Hispanics. In 2002, there were no statistically significant racial or ethnic disparities. In 2007, however, Hispanic children with Medicaid were more likely to have difficulty contacting their usual source of care over the telephone than both White and Black children with Medicaid.
- The percentage of uninsured children who had difficulty contacting their usual source of care over the telephone decreased for Hispanics from 2002 to 2006 and for Whites from 2002 to 2007. There were no statistically significant differences between Whites and Hispanics during this time.

Financial Burden of Health Care

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.¹⁰ High premiums and out-of-pocket payments can be a significant barrier to accessing needed medical treatment and preventive care.¹¹ One way to assess the extent of financial burden is to determine the percentage of children unable to get or delayed in getting needed care for financial or insurance reasons.

The 2002-2007 sample sizes for children were not large enough to reliably compare racial and ethnic subgroups. Therefore, the financial burden of health care measure for children is not presented.

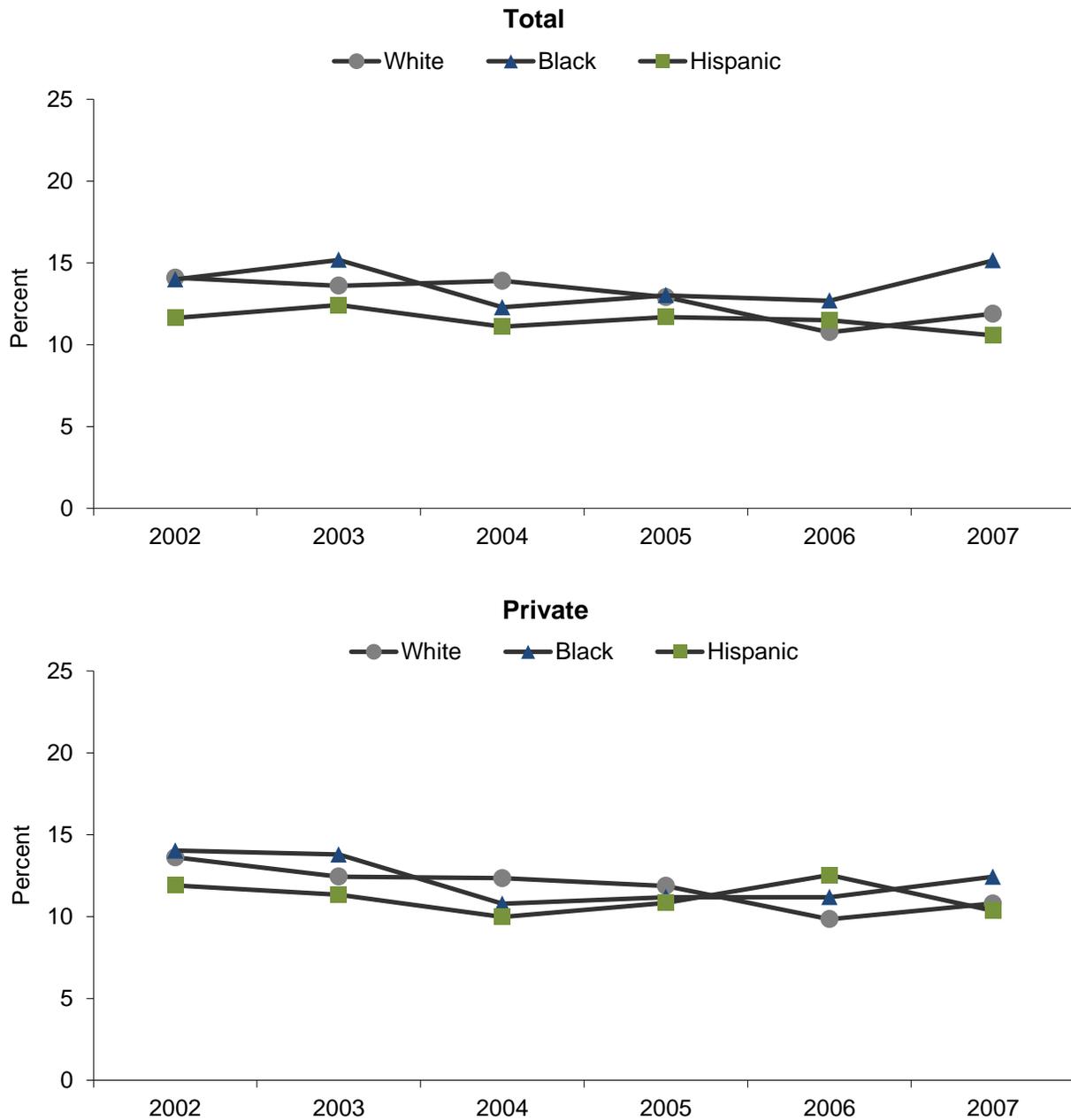
Utilization

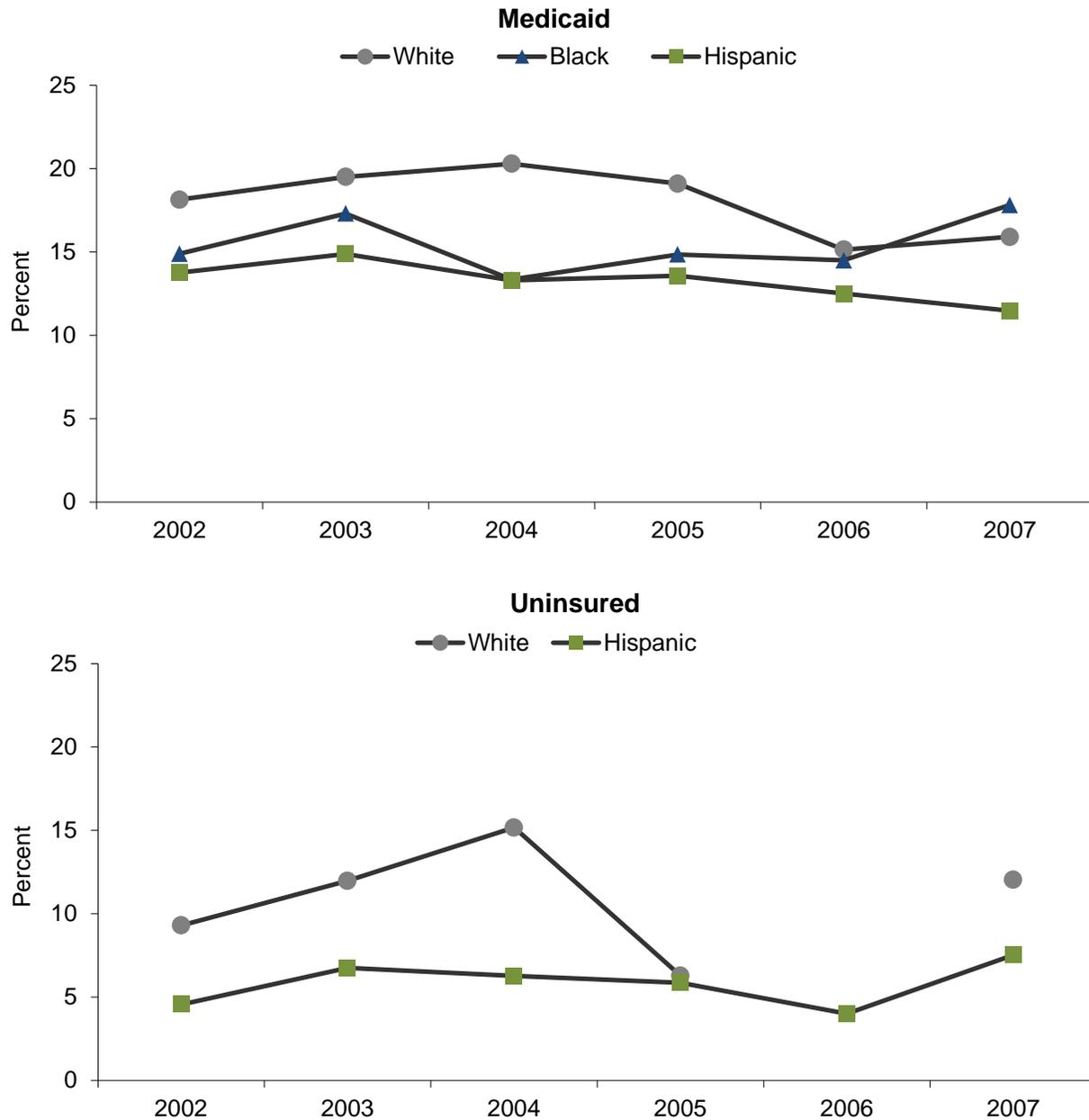
This section considers measures of health care use. Some differences in receipt of care reflect individual needs, health status, preferences, type of care available, economic factors, and behaviors. However, regular use of medical care is important for preserving health and functioning, while high rates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

Emergency Room Visits

Without good access to health care, people sometimes resort to using the emergency department when care is needed. Delaying care until the need is urgent often results in poorer health outcomes and increased health costs.

Figure 9.4. Children ages 2-17 who had a hospital emergency room visit in the calendar year, by race/ethnicity, stratified by insurance status, 2002-2007





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

Note: For this measure, lower rates are better. Data for uninsured Black children from 2002 to 2007 and uninsured White children in 2006 do not meet the criteria for statistical reliability, data quality, or confidentiality.

- The percentage of Hispanic and White children who had a hospital emergency room visit decreased from 2002 to 2007, while there were no statistically significant changes for Black children. In 2002, Hispanic children were less likely to have a hospital emergency room visit in the calendar year than White children. In 2007, Black children were more likely to have a hospital emergency room visit than Hispanic and White children.
- Among children with private insurance, the percentage who had a hospital emergency room visit decreased from 2002 to 2007 for Blacks and Whites but did not change for

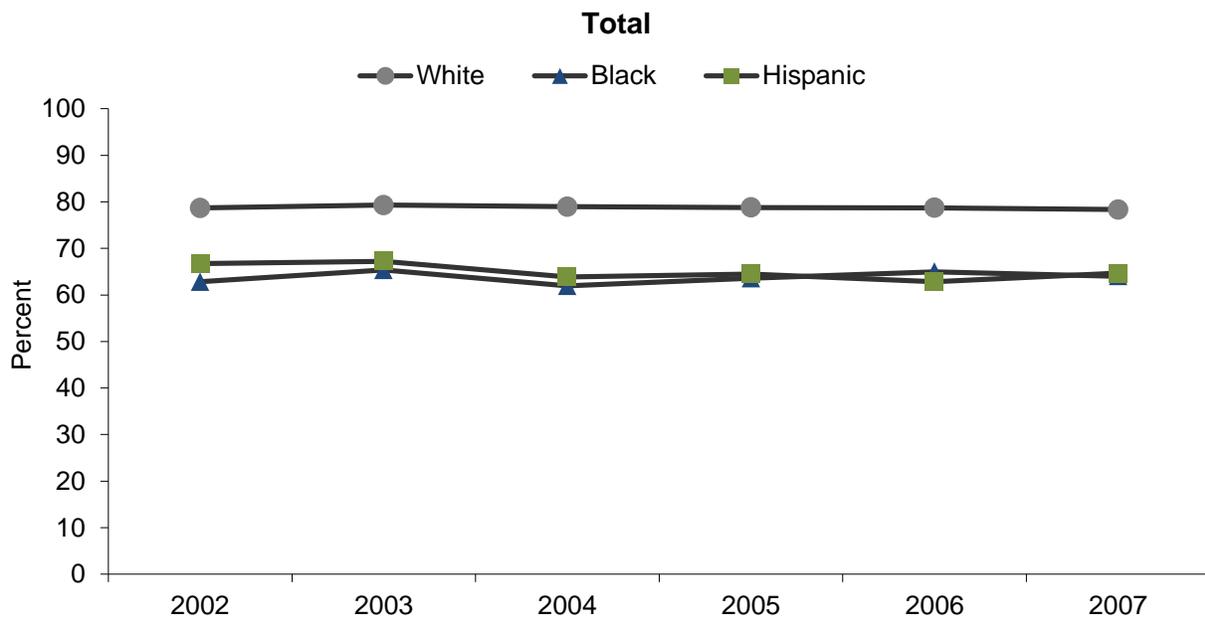
Hispanics. During this time, there were no statistically significant racial or ethnic differences.

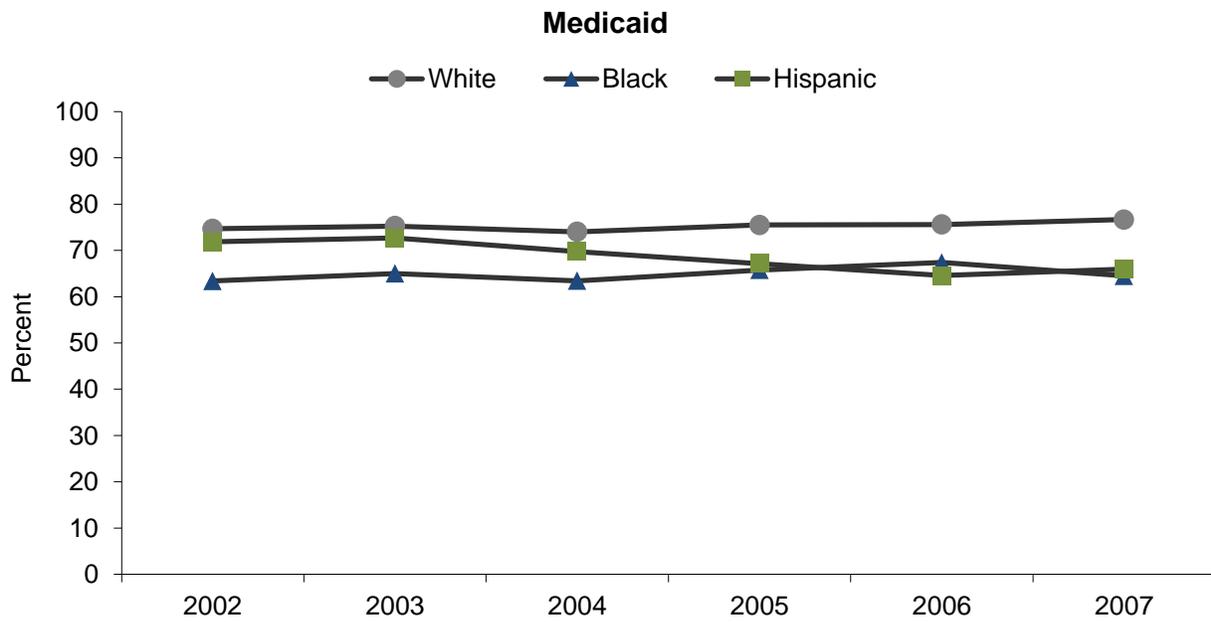
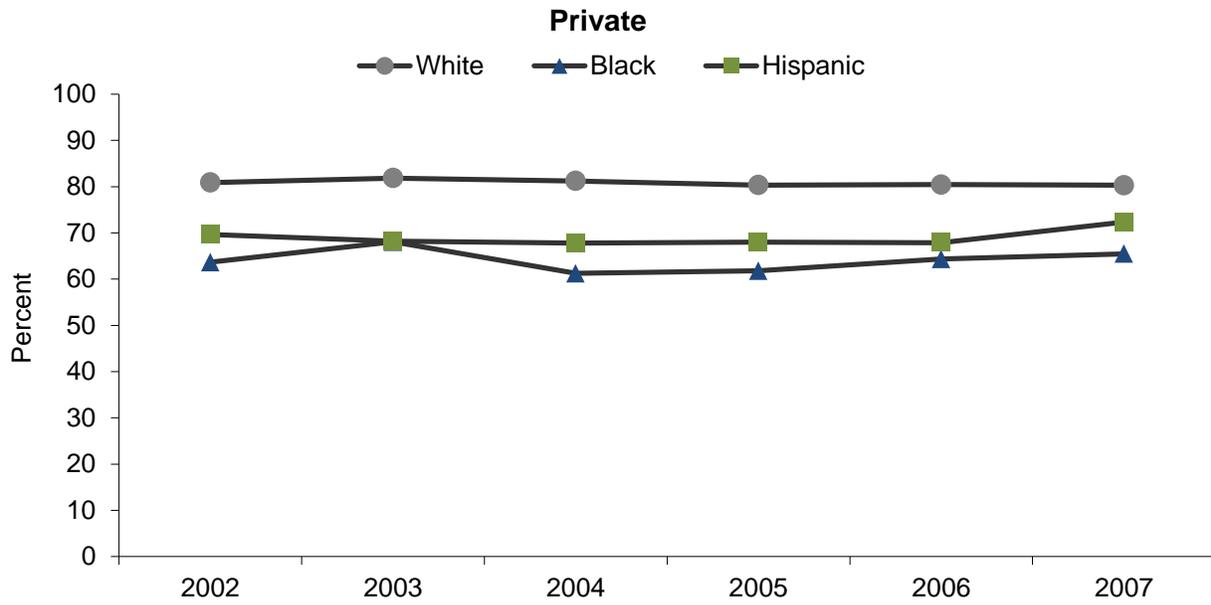
- Among children with Medicaid, the percentage who had a hospital emergency room visit increased for Blacks from 2002 to 2007, while the percentage decreased for Whites and Hispanics. In 2002, Hispanics were less likely than Whites to have a hospital emergency room visit in the calendar year. In 2007, Hispanics were less likely than Whites and Blacks to have a hospital emergency room visit.
- From 2002 to 2007, the percentage of uninsured children who had a hospital emergency room visit increased for Hispanics, while the changes for Whites were not statistically significant. In 2002, Hispanic uninsured children were less likely to have a hospital emergency room visit in the calendar year than White uninsured children, but there was no statistically significant difference between the two groups in 2007.

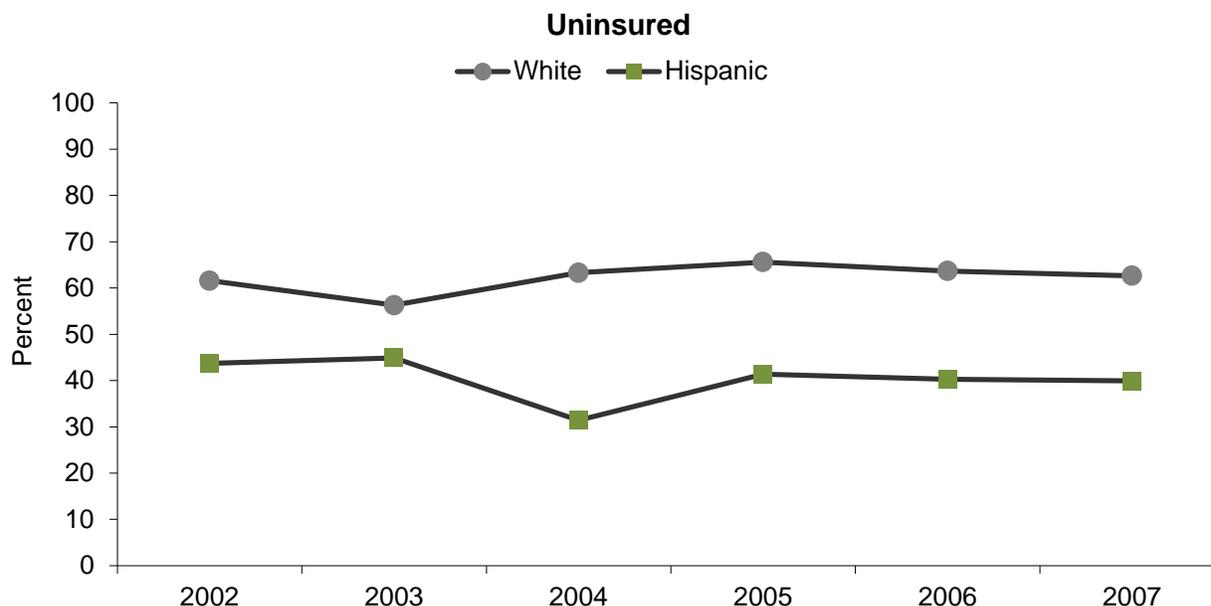
Outpatient Visits

In addition to seeing providers when sick, children visit providers to receive recommended screenings, vaccines, and counseling. There are several schedules for well-child visits, most of which recommend at least one visit per year.

Figure 9.5. Children ages 2-17 who had a physician office or hospital outpatient department visit in the calendar year, by race/ethnicity, stratified by insurance status, 2002-2007







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

Note: Data for uninsured Black children from 2002 to 2007 do not meet the criteria for statistical reliability, data quality, or confidentiality.

- From 2002 to 2007, there were no statistically significant changes in the percentage of children who had a physician office or hospital outpatient department visit for Blacks and Whites. The percentage decreased for Hispanics. During this time, White children were more likely to have a physician office or hospital outpatient department visit than Black and Hispanic children.
- Among children with private insurance, there were no statistically significant changes in the percentage who had a physician office or hospital outpatient department visit for Blacks and Hispanics from 2002 to 2007. The percentage decreased for Whites. During this time, White children with private insurance were more likely to have a physician office or hospital outpatient department visit than Black and Hispanic children with private insurance.
- Among children with Medicaid, Whites were more likely to have a physician office or hospital outpatient department visit than Blacks in 2002 and more likely to have a visit than Blacks and Hispanics in 2007. The disparity between Hispanic children and White children with Medicaid increased over time.
- From 2002 to 2007, White uninsured children were more likely to have a physician office or hospital outpatient department visit than Hispanic uninsured children. During this time, the percentage decreased for uninsured Hispanic children but increased for uninsured White children.

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