Chapter 4. Access to Health Care

Introduction

Access to health care is a central aspect of health care quality.[1] Defined as "the timely use of personal health services to achieve the best health outcomes,"[2] access to care is essential to receive quality care, increase the quality and years of healthy life and to eliminate health disparities. Indeed, a recent IOM report asserts that "access-related factors may be the most significant barriers to equitable care, and must be addressed as an important first step toward eliminating healthcare disparities."[3]

To understand the current state of health care disparities, it is also important to consider receipt of care. Many of the landmark reports on disparities relied on measures of receipt of heath care.[4, 5, 6] However, while easier access and better quality of care are obviously more desirable, greater utilization is more ambiguous. This section clarifies this by comparing data for various demographic groups and identifying differences in access to and receipt of care.

The key presented in each summary table in this chapter signifies the amount of care received by selected racial, ethnic, and socioeconomic subpopulations relative to the amount received by other groups and by the general population. With input from the IOM, the public, and the NHDR Interagency Work Group, access measures were selected and organized into four main categories:

- Entry into the health care system—these measures focus on ease of gaining initial entrance into the health care system itself.
- Structural barriers within the system—these measures focus on the difficulty of getting care (e.g., transportation, ability to quickly schedule convenient appointments, and excessive wait times).
- Ability of provider to address patient needs— these measures focus on patient-provider communication and relationships, cultural competency, and health information.
- Utilization of care—these measures focus on receipt of health care (i.e., routine, acute, and chronic care) mental health care and substance abuse treatment, and HIV care.

This chapter focuses on only a small subset of the data analyzed for this report and highlights areas where disparities are prevalent either across multiple populations or across several related measures. It also illustrates disparities with specific examples of data that are representative of the observed trends. Where *Healthy People 2010* measures are available, these measures are presented in graphs.

Finally, because racial and ethnic minorities are disproportionately represented among low socioeconomic populations, health care disparities among racial and ethnic minorities are often highly correlated with disparities that fall along socioeconomic lines. It is vital that we understand the relative impact that race, ethnicity, and socioeconomic status have on disparities in access to health care. Without teasing out the independent effects of race, ethnicity, and socioeconomic status (SES), policymakers lack critical insight into where to apply focused interventions to best help eliminate health care disparities. The NHDR analysis concluded that the impact of race, ethnicity, and socioeconomic position on access to health care are significant.

For an analysis of disparities in access to health care as they relate to priority populations, as defined in AHRQ's authorizing legislation, please see Chapter 5. Because many disparities cut across multiple priority populations, that chapter focuses on any disparities that are unique for each population group.

Entry Into the Health Care System

NHDR's first set of measures begins with primary access by looking at initial entry into the system. The measures of entry into the system include health insurance coverage, having a usual source of care, and patient perceptions of need (Tables 1 and 2). Health insurance and a usual source of care are two factors that can greatly facilitate entry into the health care system, and unmet needs result from difficulty in gaining entry into the system.

Health Insurance Coverage

Key Findings:

- Racial and ethnic minorities are significantly less likely to have health insurance
- Minorities are more likely to have public insurance (e.g., Medicare and SCHIP).

Why health insurance coverage is important

Differences between those with and without health insurance coverage are profound and well documented. The Institute of Medicine concluded that providing health insurance to uninsured adults would result in improved health, including greater life expectancy. In particular, increasing the rate of health insurance coverage would "especially improve the health of those in the poorest health and most disadvantaged in terms of access to care and thus would likely reduce health disparities among racial and ethnic groups."[9]

Other research suggests that, compared with covered individuals, the uninsured:

- Receive less preventive care, are diagnosed at more advanced disease stages and, once diagnosed, tend to receive less therapeutic care (drugs and surgical interventions)[10]
- Are more likely both to be sicker upon hospital admission and to die while hospitalized[12]
- Are more likely to have poor health status[15,16]
- Are more likely to receive their care in a hospital outpatient clinic or emergency room
- Are more likely to report needing (but not receiving) medical care, primarily for economic reasons
- Have higher out-of-pocket medical expenses, despite generally being poorer.[17]

How the Nation is doing

Most of the population has some kind of health insurance. Approximately 83% of the general under-65 population[i] has health insurance at a given point in time (Figure 1), and 17% are uninsured. However, the uninsured are not equally divided among all demographic groups. Specifically, blacks (20%) and American Indians or Alaska Natives (AI/AN) (38%) are more likely than whites (15%) to lack health insurance. Hispanics (35%) are more likely than non-Hispanic whites (12%) to lack health insurance. Similarly, poor[ii] (34%), near poor[iii] (32%), and middle income[iv] (14%) persons are more likely than high income[v] persons (5%) to be uninsured (NHIS, 2000).

There are also differences in public insurance. Blacks (28%) and AI/ANs (33%) are more likely than whites (12%) to be publicly insured at some time during the year. Similarly, Hispanics (23%) are more likely to have public coverage than non-Hispanic whites (10%). Because having a low income is one of the prerequisites for participation in many public health care programs, poor (56%), near poor (27%), and middle income (6%) Americans are considerably more likely than high income individuals (2%) to have public coverage at any time during the year. Individuals with less than 12 years of education (23%) are also more likely to have public coverage than those with more than 12 years of schooling (3%) (MEPS, 1999).

In summary, while most Americans have health insurance, many minority groups and poor patients are more likely to be uninsured or insured through public programs. No group achieves the *Healthy People 2010* target of total coverage.

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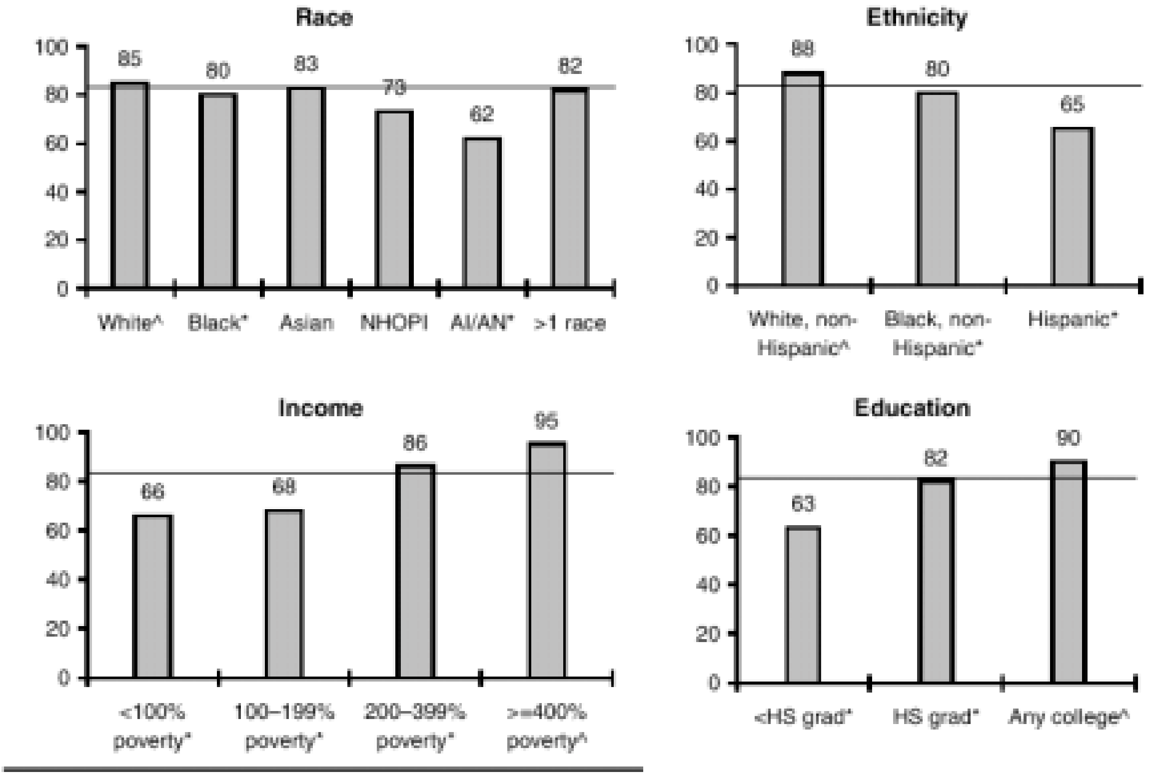
[i] "General under-65 population" refers to the under-65 civilian noninstitutionalized population.
[ii] "Poor" is defined as persons with family incomes less than 100% of the Federal poverty threshold.
[iii] "Near poor" is defined as persons with family incomes between 100% and 199% of the Federal poverty threshold.
[iii] "Middle income" is defined as persons with family incomes between 200% and 399% of the Federal poverty threshold.
[v] "High income" is defined as persons with family incomes of 400% or more of the Federal poverty threshold.

Figure 1. Percent of persons under age 65 with health insurance, age adjusted [U.S. total = 83%]



^ Indicates reference group.
* p<0.05 and relative rate >10% for comparison of group with reference group. Note that a relative rate >10% is achieved for the inverse of this measure, percent of persons <65 without health insurance.
Key: NHOPI=Native Hawaiian or Other Pacific Islander; AI/AN=American Indian/Alaska Native; HS=high school
Source: National Center for Health Statistics, National Health Interview Survey, 2000.

Usual Source of Care

Key Findings:

- Racial and ethnic minorities and individuals of lower socioeconomic status are less likely to have a usual source of care.
- Many racial and ethnic minorities and individuals of lower socioeconomic status are more likely to lack a source of ongoing care or identify a hospital, clinic, or emergency department as their usual source of care.

Why having a usual source of care is important

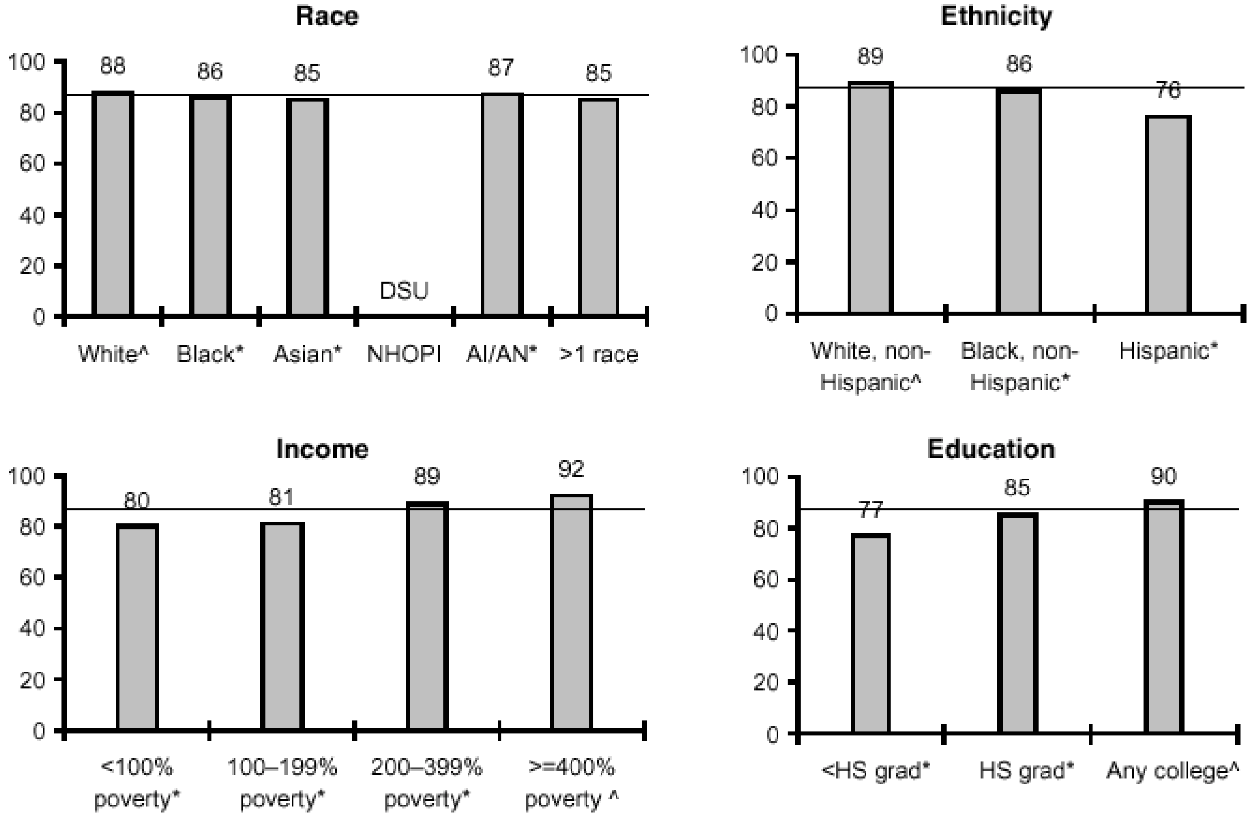
Having a "medical home," or a distinct location where one can obtain integrated health care services, offers patients an opportunity to develop relationships with accessible clinicians who are accountable for addressing most health care needs. It greatly increases the likelihood that a patient will receive preventive care, such as blood pressure and cholesterol monitoring; receive flu shots; and have prostate exams or Pap smears and mammograms.[18]

MEPS respondents with a usual source of care are less likely to report having difficulty obtaining care or going without needed services.[19] Data indicate that the uninsured, lower SES persons, and residents of rural areas particularly benefit from having a usual source of care,[20, 21] although the uninsured are still much less likely than the insured to have a regular source of care.[22] In addition to better outcomes, having a primary care provider as one's usual source of care also leads to lower long-term health care costs.[23] According to *Healthy People 2010*, more than 40 million Americans do not have a specific usual source of care.[24]

How the Nation is doing

In general, racial and ethnic minorities and individuals of lower socioeconomic status are less likely to have a usual source of care. For instance, approximately 87% of the population has a specific source of ongoing care (Figure 2) and 13% lack such a source of care. Hispanics (24%) are more likely than non-Hispanic whites (11%) to lack a source of ongoing care. Similarly, the poor (20%) are more likely than those with high incomes (8%) to report no ongoing source of care. The differences are less pronounced between the races: blacks (14%) and Asians (15%) are only slightly more likely than whites (12%) to lack a specific source of ongoing care (NHIS, 2000).

Figure 2. Percent of persons with a usual source of care, age adjusted (U.S. total = 87%)



^ Indicates reference group.
*p<0.05 and relative rate >10% for comparison of group with reference group. Note that a relative rate >10% is achieved for the inverse of this measure, percent of persons without a source of ongoing care.
Key: NHOPI=Native Hawaiian or Other Pacific Islander; AI/AN=American Indian/Alaska Native; HS=High School
DSU=Data do not meet the criteria for statistical reliability, data quality, or confidentiality.
Source: National Center for Health Statistics, National Health Interview Survey, 2000.

Racial and ethnic minorities and people with low incomes are also more likely to report having a clinic, hospital outpatient department or emergency department (ED) as their usual source of care (NHIS, 2000). These institutional providers are often suboptimal sources of primary care. Because they are not structured to offer effective continuity of care, primary care services provided in hospital EDs are far more expensive than those delivered in an office setting. Despite these concerns, many individuals without alternate sources of care frequently rely on hospital EDs to meet essential health care needs.

In summary, many racial and ethnic minorities and individuals of lower socioeconomic status are more likely to lack a source of ongoing care or identify institutional providers as their source of care. No group achieves the *Healthy People 2010* target of 96% of persons with a source of ongoing care. Given the critical role that a usual source of care plays in the delivery of high-quality health care, these population differences require further attention.

Patient Perceptions of Inadequate Access and Need

Key Finding:

- Hispanics and people of lower socioeconomic status are more likely to report unmet health care needs, while racial differences tend to be smaller.

For information on patient perceptions of inadequate access and need, please refer to the Quality chapter of the NHDR.

Structural Barriers Within the System

Having insurance coverage and a regular doctor does not guarantee that individuals will receive necessary medical treatment. All too frequently, structural barriers—poor transportation, inability to get care (e.g., schedule appointments quickly or during convenient hours), and excessive time spent in the waiting room—affect a person's ability and willingness to obtain and adhere to needed care[25] (Tables 3 and 4).

Difficulty Getting Care

Key Findings:

- There are few racial, ethnic, or socioeconomic differences in barriers to getting care.
- All priority populations experience significant difficulties obtaining access to specialty care.

Patients feel the impact of obstructions to health care differently. Transportation to providers may pose the greatest problem for the elderly or disabled, while working adults may only be able to get care on evenings and weekends. Many are frustrated by difficulties contacting their providers by telephone and by discourteous office staff. These obstacles can lead affected persons to defer or delay needed care or to seek care in inappropriate settings.

One important structural barrier is the ability to gain referral to a specialist. In this era of managed care, primary care providers are often called upon to monitor, approve, and coordinate referrals to other providers. About a quarter of patients report difficulty getting referrals, and these patients tend to have less trust, confidence and satisfaction with their providers.[26] Many primary care providers experience pressure from managed care organizations to limit referrals, and 17% of primary care providers believe such pressure compromises patient care.[27]

How the Nation is doing

In general, racial, ethnic, and socioeconomic differences in barriers to getting care are not particularly striking. Asians and Pacific Islanders and Hispanics express less satisfaction with professional staff (MEPS, 1999). Lower income and less educated persons are less likely to have providers with hours on nights and weekends (MEPS, 1999).

Minorities and low income populations are more likely to have trouble getting referrals to specialists. One exception relates to specialty referral. In the general population[i], 79% of persons have no problem obtaining referrals to specialists (Figure 3) (MEPS, 2000) while 21% report some difficulty. However, problems with access to specialists are disproportionately borne by priority populations. For example, 31% of Hispanics, compared with 19% of non-Hispanic whites, report trouble obtaining referrals. Similarly, 26% of blacks, compared with 20% of whites, have some problem obtaining referrals. Low income populations, too, experience difficulties: the poor (29%) and the near poor (26%) are more likely to report some problem getting referrals than those with high incomes (18%).

In summary, there are few racial, ethnic, and socioeconomic differences in barriers to getting care. There are significant differences in specialty referral. However, these perceived problems with specialty referral may be related to patient health care needs, knowledge, expectations, and preferences. The clinical consequences of barriers to specialty referral are unclear.

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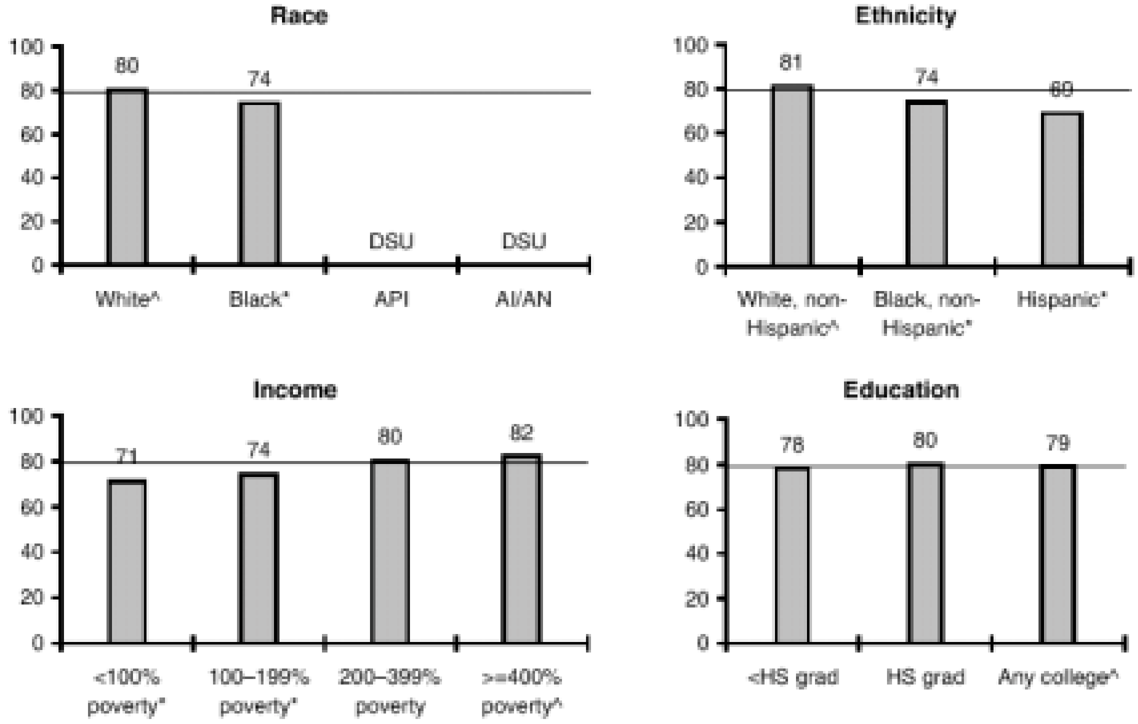
[i] "General population" refers to the noninstitutionalized civilian population.

Figure 3. Percent of adults without problem getting referral to a specialist
[U.S. total = 79%]



^ Indicates reference group.
* p<0.05 and relative rate >10% for comparison of group with reference group. Note that a relative rate >10% is achieved for the inverse of this measure, percent of persons <u>with</u> problem getting referral to a specialist.
Key: API=Asian or Pacific Islander; AI/AN=American Indian/Alaska Native; HS=high school
DSU=Data do not meet the criteria for statistical reliability, data quality, or confidentiality.
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2000.

Waiting Times

Key Findings:

- Blacks and the uninsured are more likely to report waiting over 1 hour at the ER for semi-urgent/non-urgent care, and to report leaving the ER without being seen.

For information on waiting times, please refer to the Quality chapter of the NHDR.

Patient's Perceptions of Providers Ability to Address Their Needs

Successfully gaining entry into the health care system and navigating structural barriers may not yield optimal care if patients and providers do not communicate effectively. This section considers the ability of providers to address patient needs and includes measures of patient-provider communication, the patient-provider relationship, cultural competency, and health information (Tables 5 and 6).

Patient-Provider Communication

Key Finding:

- Many racial and ethnic groups, as well as poor and less educated patients, are more likely to report poor communication with their physicians.

Why patient-provider communication is important

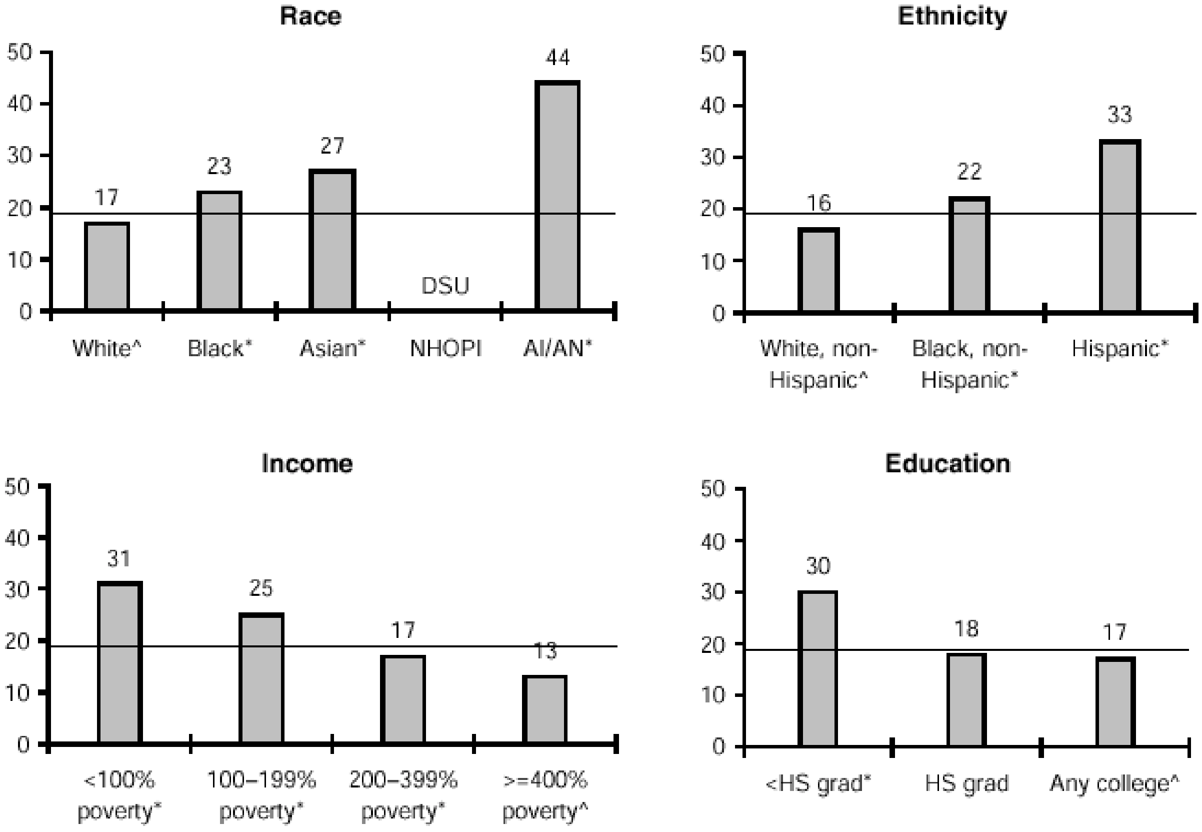
One of the *Healthy People 2010* goals is to "use communication strategically to improve health," and it defines health communication as "the use of communication strategies to inform and influence individual and community decisions that enhance health."[29] Patient-provider communication increases awareness of both health risks and risky behaviors, helps patients make complex choices by clarifying complicated issues (such as selecting the best treatment plans), and increases the likelihood that patients understand and adhere to multifaceted treatment regimens. Additionally, it simultaneously increases demand for appropriate health services and lowers demand for inappropriate services. Several studies affirm the relationship between the quality of the patient-provider interaction, patient behavior, and outcomes.[30]

Communication can be impaired by such factors as differences in language, a patient's degree of literacy (and "health literacy," described in more detail under "health information," below), pressure on providers to see patients quickly, and a patient's hesitancy to discuss sensitive issues. Indeed, data from the Commonwealth Fund's 2001 Health Care Quality Survey indicate that, while all demographic groups reported problems with patient-physician communication and interaction, difficulties were most pronounced for minority patients, even among those whose primary language is English.[31] (Language barriers are discussed in more detail in Chapter 5.)

How the Nation is doing

American Indians and Alaska Natives, Asians, blacks, Hispanics, low-income populations, and the less-educated are more likely to report poor communication with their physicians. Priority populations are overrepresented among the 19% of Americans that believe they had "poor communication"[i] with their physician during their last health care visit. Specifically, 44% of AI/ANs, 27% of Asians, and 23% of blacks, compared with 17% of whites; 33% of Hispanics, compared with 16% of non-Hispanic whites; 31% of the poor, 25% of near poor, and 17% of those with middle incomes compared with 13% of those with high incomes; and 30% of those without a high school diploma, compared to 17% of those who attended college, report poor communication during their most recent clinical encounter (Figure 4) (Commonwealth Fund Health Care Quality Survey, 2001).

Figure 4. Percent of adults with one or more indicators of poor communication at their last health care visit
[U.S. total = 19%]



^ Indicates reference group.
* p<0.05 and relative rate >10% for comparison of group with reference group.
Key: NHOPI=Native Hawaiian or Other Pacific Islander; AI/AN=American Indian/Alaska Native; HS=high school
DSU=Data do not meet the criteria for statistical reliability, data quality, or confidentiality.
Source: The Commonwealth Fund Health Care Quality Survey, 2001.

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[i] In this interview survey, measures of poor communication included: reporting that the provider did not listen to everything, that the patient did not understand everything, or that the patient had questions that they did not ask.

Patient-Provider Relationship

Key Finding:

- Many racial and ethnic minorities and lower socioeconomic position persons report more problems with some aspects of the patient-provider relationships.

Why the patient-provider relationship is important

Strong patient-provider communication is just one aspect of effective care. The patient-provider relationship should include mutual trust, respect, confidence, and shared decisionmaking. Relationships that lack these dimensions may limit the clinician's ability to provide care and the patient's willingness and ability to follow the clinician's recommendations. This ultimately can lower the quality of care.

Ideally, a provider helps a patient translate values into treatment decisions. In this way, clinicians discuss not only the treatment, but also tease out the values inherent in the available options. The physician plays the role of a teacher or friend by "engaging the patient in dialogue on what course of action would be best."[32]

The provider assists patients to select interventions that reflect the patients' health-related values, and patients and providers collaboratively rank health-related values as they pertain to the decisions at hand, weighing available treatments with patient preferences.[33]

How the Nation is doing

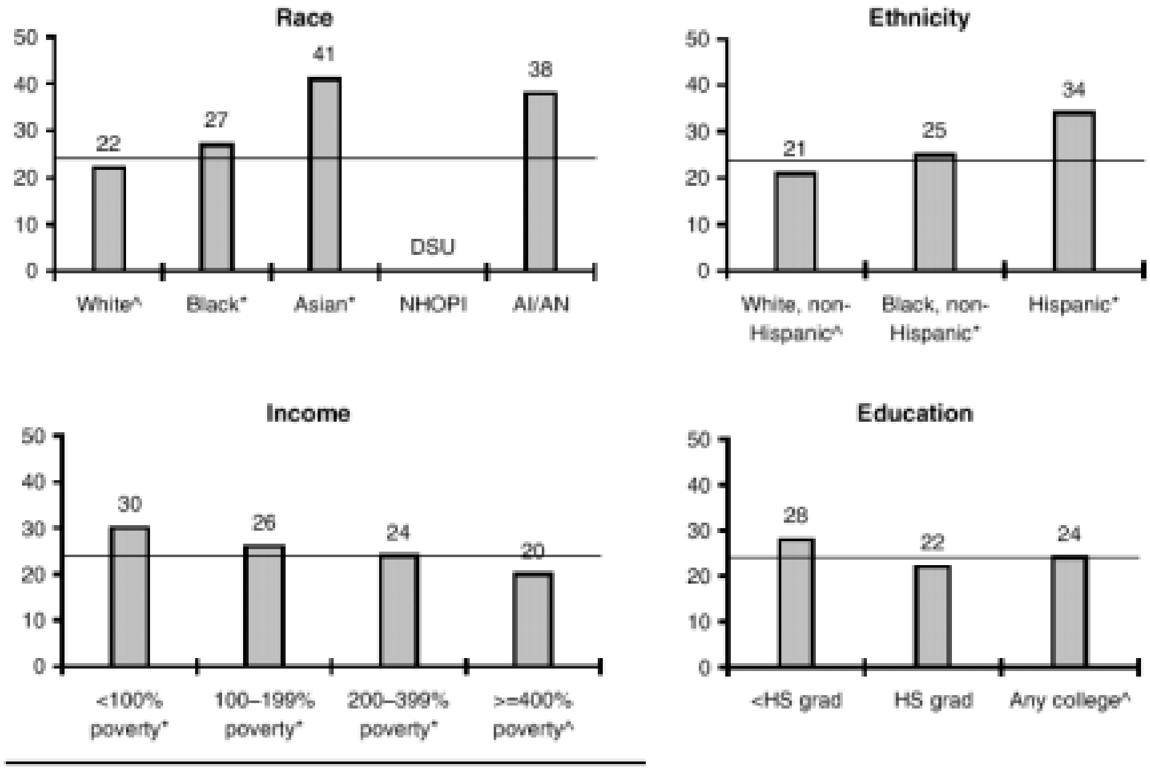
Blacks, Asians, Hispanics, and low income populations are more likely to feel disenfranchised in the decisionmaking process. Nationwide, nearly one out of four people report that they are not involved in health care decisions as much as they would like (Commonwealth Fund Health Care Quality Survey, 2001). Compared to whites (22%), blacks (27%) and Asians (41%) more frequently report under-involvement in the health care decisionmaking process. Similarly, Hispanics (34%) compared with non-Hispanic whites (21%), and low income populations (30% of the poor, 26% of the near poor, and 24% of the middle income category) compared with high income populations (20%) are more likely to feel disenfranchised in the decisionmaking process. (Figure 5).

Blacks, Asians and Pacific Islanders, Hispanics, and those of low socioeconomic status are less satisfied with their health care. Similarly, 16% of adults were less satisfied with their health care (rating it at a "6 or below" on a scale of "0 to 10") (MEPS, 2000). Racial minorities (20% of blacks and 28% of APIs vs. 16% of whites), ethnic minorities (19% of Hispanics vs. 15% of non-Hispanic whites), lower income persons (24% of the poor, 19% of the near poor and 17% of those with middle income vs. 13% of those with high income), and less educated persons (21% of persons with less than a high school education and 17% of high school graduates vs.

14% of college attendees) are all more likely to rate their overall health care more negatively (Figure 6).

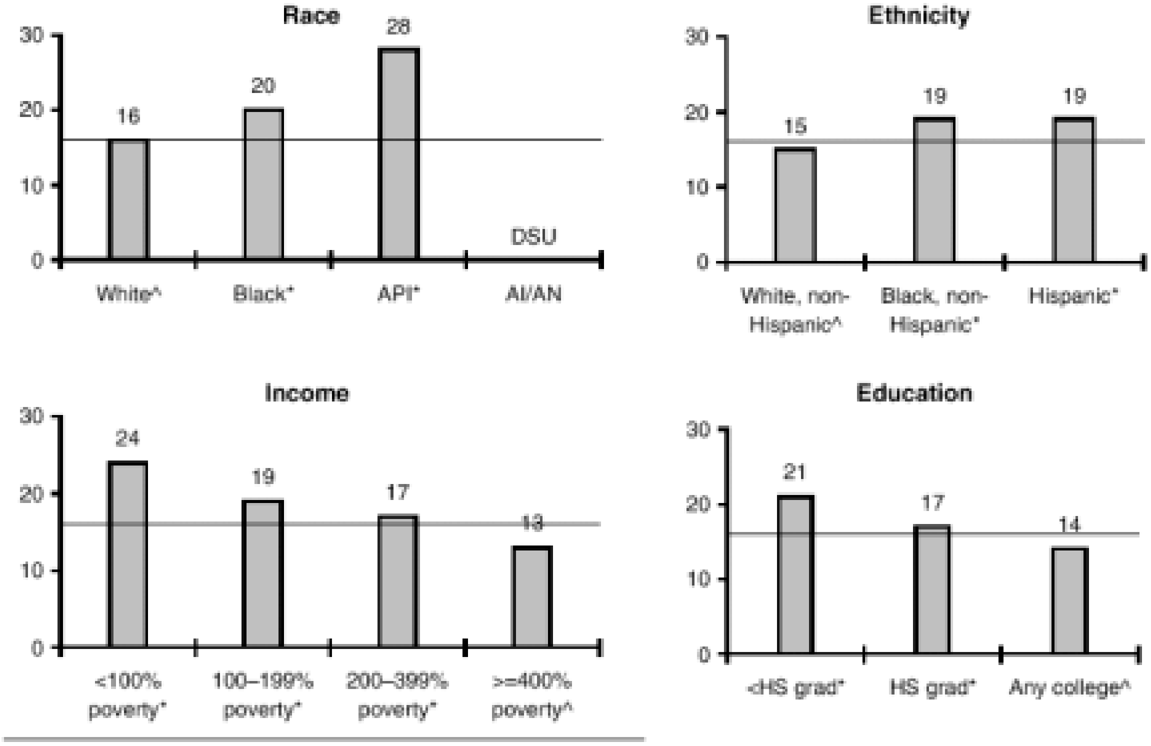
In summary, many racial and ethnic minorities and lower socioeconomic position persons report more difficult patient-provider relationships. Patient concerns regarding the decision-making process may result in receipt of care that does may not meet patients' perceived needs. When coupled with low patient satisfaction, these represent significant opportunities for improvement.

Figure 5. Percent of adults not involved as much as wanted in decisionmaking [U.S. total = 24%]



^ Indicates reference group.
* p<0.05 and relative rate >10% for comparison of group with reference group.
Key: NHOPI=Native Hawaiian or Other Pacific Islander; AI/AN=American Indian/Alaska Native; HS=high school
DSU=Data do not meet the criteria for statistical reliability, data quality, or confidentiality.
Source: The Commonwealth Fund Health Care Quality Survey, 2001.

Figure 6. Percent of adults who have low patient satisfaction[i] for their overall health care [U.S. total = 16%]



^ Indicates reference group.
*p<0.05 and relative rate >10% for comparison of group with reference group.
[i] Patients ranked their overall health care satisfaction from “0 to 6” on a scale of “0 to 10.”
Key: API=Asian or Pacific Islander; AI/AN=American Indian/Alaska Native; HS=high school
DSU=Data do not meet the criteria for statistical reliability, data quality, or confidentiality.
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2000.

Cultural Competency

Key Finding:

- Only 5% of the population report that their health care is affected by race or ethnicity but differences by race, ethnicity, and socioeconomic status are large.

Why cultural competency is important

Cultural values and ideas about what constitutes good health can vary between demographic groups. “Cultural competency” implies an awareness of health beliefs and behaviors, disease prevention and incidence, and treatment outcomes for different populations.[34] It can be defined as: “The design, implementation, and evaluation process that accounts for special issues of select population groups (ethnic and racial, linguistic) as well as differing educational levels and physical abilities."[35] Health care experts discern a link between cultural competence, quality improvement, and the elimination of racial and ethnic disparities.[36] Because culture and language affect how both the patient and the provider perceive health care, incorporating cultural and linguistic awareness can support patients' health more effectively. Studies also suggest that earlier detection and more appropriate treatment brought about by culturally competent health care delivery is cost effective.[40] Furthermore, researchers note that culturally sensitive care is an effective means of expanding market share and appears to reduce the likelihood of malpractice claims.[41] As a result, medical schools have begun introducing cultural competence formally into their curricula.[42] It is, however, important to note that we have much to learn about how to operationalize cultural competency.

How the Nation is doing

Although only 5% of the population report that their health care is affected by race or ethnicity, priority populations more frequently cite this sentiment than their comparison groups. For example, blacks (17%) and Asians (13%) believe that their race affects their care more often than whites (3%). Hispanics (15%) more frequently believe that their race and ethnicity affects their care than non-Hispanic whites (1%). The poor (9%) and near poor (8%) are more likely than persons in high income families (3%); and persons with less than a high school education (10%) are more likely than college attendees (5%) to share this belief (Commonwealth Fund Health Care Quality Survey, 2001). The greater attention to cultural competency within the health care system and health professions training may reduce some of these differences.

Health Information

Key Finding:

- **Asians, Hispanics, and those of lower socioeconomic status have greater difficulty accessing health care information, including information on prescription drugs.**

Why health information is important

Health care consumers need health information to decide when to seek medical care, choose appropriate providers, and adhere to treatment recommendations. Such information may be distributed via caregivers, direct-to-consumer advertisements, public health campaigns, or publications from health-focused associations. Additionally, computer-related sources include interactive health communication software and the Internet. Yet frequently, the very populations with the greatest needs have the least access to information. Differences in access to computers are of particular concern as the delivery of information grows more reliant on electronic dissemination (e.g., the "digital divide").

Another aspect of health information is health literacy, or "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."[43] In the U.S., health literacy is often difficult without English literacy—or the ability to read, write, and speak English. In fact, an estimated 75% of those with chronic physical or mental health problems in the U.S. have limited literacy.[44] Research indicates that those with low levels of health literacy are more likely to report poor health, lack a full understanding of their health problems and treatment, and be at a greater risk of hospitalization.[45] Moreover, studies suggest that limited literacy among those with asthma, hypertension, and diabetes is correlated with lower levels of understanding of these chronic conditions.[47, 48]

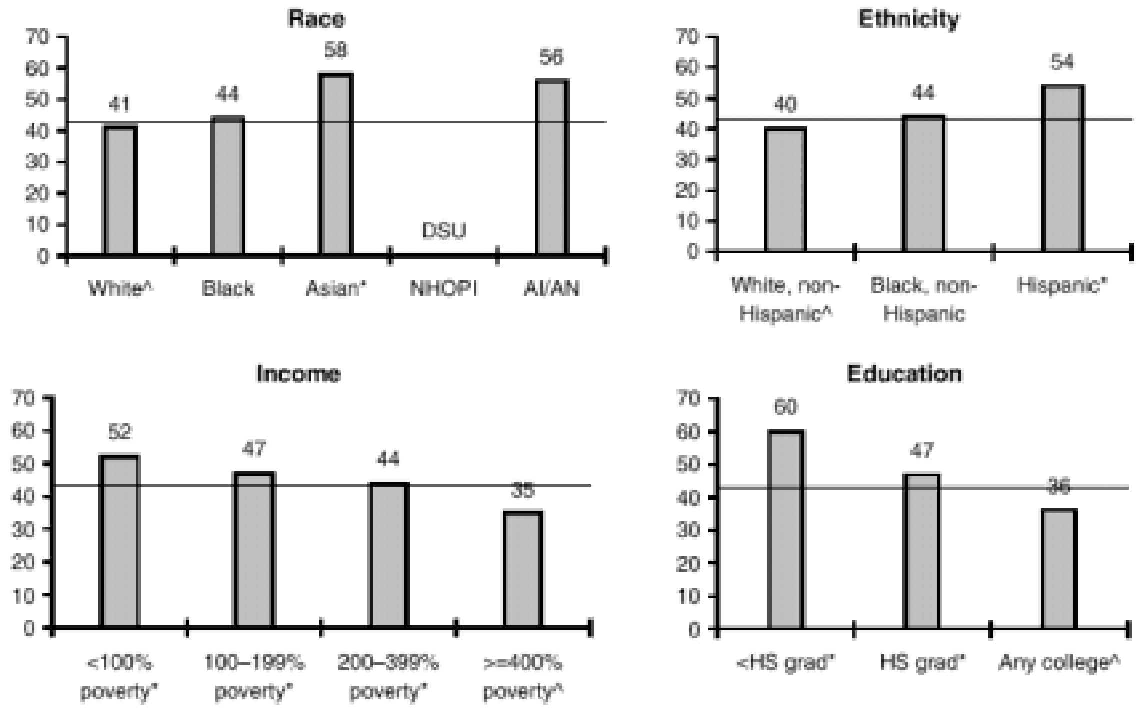
Low levels of health literacy affect all Americans, but certain priority populations are at increased risk. For example, one study found that 81% of patients age 60 and older at a public hospital could not read or understand basic materials, such as prescription labels.[49]

How the Nation is doing

In general, Hispanics, Asians, and those of lower socioeconomic status have greater difficulty accessing health care information. About 43% of adults report that it is "not very easy" to understand information from their doctor's offices. Differences between racial and ethnic group data indicate that Asians (58%, compared with 41% of whites) and Hispanics (54%, compared with 40% of non-Hispanic whites) have a harder time comprehending doctor-provided health information.

The data also reveal a gradient effect with respect to income: 52% of the poor, 47% of the near poor, and 44% of those with middle incomes vs. 35% of those with high incomes report difficulty understanding health information provided by their clinician. Those with low levels of education are also more likely to report this problem (60% of persons with less than a high school education and 47% of high school grads compared with 36% of college attendees) (Figure 7) (Commonwealth Fund Health Care Quality Survey, 2001).

**Figure 7. Percent of adults who report it is not very easy to understand information from doctor's office
[U.S. total = 43%]**



^ Indicates reference group.
* p<0.05 and relative rate >10% for comparison of group with reference group.
Key: NHOPI=Native Hawaiian or Other Pacific Islander; AI/AN=American Indian/Alaska Native; HS=high school
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Source: The Commonwealth Fund Health Care Quality Survey, 2001.

Similarly, Hispanics and Asians, as well as those with the lowest socioeconomic status, more frequently find prescription drug-related instructions difficult to understand. Hispanics, those with low incomes and those with no college education are less likely to use the Internet, read printed material, or contact their doctor to obtain information on issues affecting their health.

In summary, many racial and ethnic minorities and persons of lower socioeconomic position report problems understanding health information. Health information more tailored to patients' needs, including appropriate literacy level, could have significant benefits on health costs and outcomes.

Utilization of Care

This section considers measures of receipt of health care (i.e., routine care, acute care, and chronic care) as well as mental health care and substance abuse treatment, and HIV care.

Receipt of Health Care

Key Findings:

- Racial and ethnic minorities are generally less likely to report routine health care.
- Racial and ethnic differences in acute care tend to be less pronounced than differences in routine care.
- Racial and ethnic differences in chronic care tend to be small.

While some differences in receipt of care are likely to reflect individual needs, preferences, and behaviors, not all differences can be fully explained by these factors. Regardless of the reason, failure to receive needed health care may have severe consequences. Many studies have demonstrated racial, ethnic, and socioeconomic differences in use of office[51] and outpatient department[52] care, prescription medications, and dental care.[53, 54, 55, 56]

How the Nation is doing

Blacks, Hispanics, and those of low socioeconomic status are less likely than whites, non-Hispanic whites, and those of high socioeconomic status to report having a routine office or outpatient visit in the past year (MEPS, 1999). Racial and ethnic minorities also have fewer overall outpatient visits (NHAMCS, 1999-2000) and are less likely to report receipt of prescription medications and dental visits (MEPS, 1999).

Those with lower incomes and less education are less likely to receive routine care, but are more likely to receive acute care. For example, the poor (17%) and high school dropouts (16%) are more likely to make emergency room visits, respectively, than high income persons (10%) and those with any college education (10%). These differences exist both among persons in poor or fair health, as well as among persons in good or excellent health. Individuals of lower socioeconomic status are also more likely than their high socioeconomic counterparts to report inpatient hospitalizations (MEPS, 1999).

Racial and ethnic differences in chronic care tend to be small. Hispanics are less likely to receive home health care than non-Hispanics whites (MEPS, 1999), but racial differences are not noted. Among persons aged 18 to 64, rates of nursing home discharge are higher among blacks than whites (NNHS, 1999). Among persons aged 65 and over, rates of hospice discharge are lower among blacks (890 per 100,000 population) compared with whites (1,425 per 100,000) (NHHCS, 2000). Lower income and less educated persons are more likely than the affluent and better educated to receive chronic care services (MEPS, 1999).

Mental Health Care and Substance Abuse Treatment

Key Findings:

- Mental health treatment or counseling is reported less often by racial and ethnic minorities. Among adults with serious mental illness, blacks and Hispanics are less likely to receive any kind of mental health treatment.
- Among those who need care for illicit drug or substance abuse, blacks and people with less education are more likely than whites or college attendees to receive treatment.

Why mental health care and substance abuse treatment are important

Over 40 million persons ages 18 to 64, or 22% of the adult population, experienced a mental disorder in the past year.[57] This does not include the large and increasing number of children and adolescents who are treated for mental disorders, especially attention deficit disorder (ADD). An estimated 7% of the adult population is considered to have a serious mental illness that substantially limits activities.[58]

Although the prevalence of mental disorders for racial and ethnic minorities in the United States is similar to that for whites,[60] differences in provision of care can be observed. Compared with whites, minorities have less access to mental health care, are less likely to receive needed mental health care services, and often receive poorer quality mental health care when in treatment.[61] Racial, ethnic, and socioeconomic differences in the use of psychiatric medications[63] and of psychiatric outpatient,[64] emergency,[65] and inpatient services[66] have also been documented.

How the Nation is doing

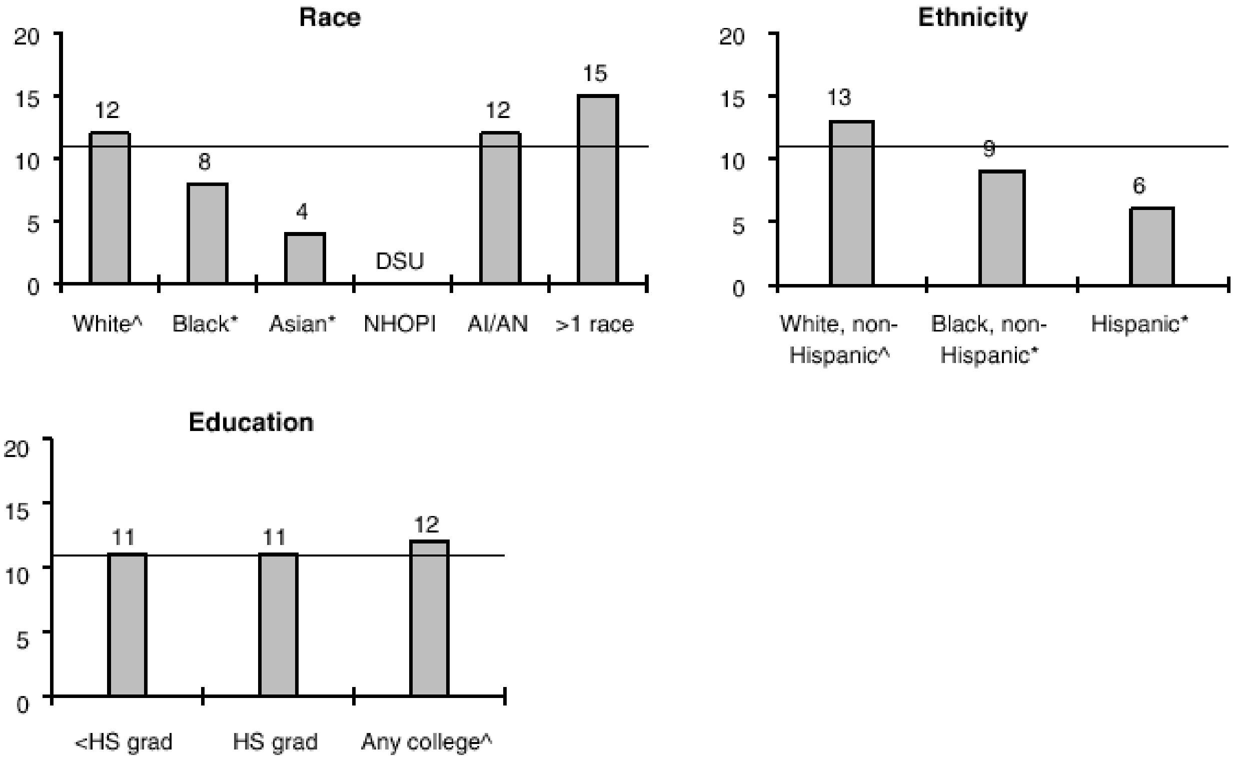
Mental health treatment or counseling is reported less often by racial and ethnic minorities. Blacks (8%) and Asians (4%) are less likely than whites (12%), and Hispanics (6%) are less likely than non-Hispanic whites (13%) to receive any kind of mental health treatment or counseling (Figure 8) (NHSDA, 2001).

Similar differences are noted for receipt of outpatient mental health care and for receipt of prescription medications as part of mental health treatment. Even among adults with serious mental illness, blacks and Hispanics are less likely to receive any kind of mental health treatment. In contrast, blacks are more likely than whites to be hospitalized for mental health treatment and have higher rates of admission to specialty mental health organizations (SAMHSA's Client/Patient Survey Sample [CPSS], 1997).

Socioeconomic status is also associated with differences in care for mental health conditions. While differences in overall mental health care are not noted, adults who attended college are more likely to receive outpatient mental health care and less likely to receive inpatient mental health care compared with high school dropouts and those whose educations ended with high school graduation (NHSDA, 2001).

Differences in treatment for illicit drug use are also noted. Among persons 12 and over who meet criteria for needing treatment for illicit drug use, blacks are more likely than whites to receive such treatment. Similarly, less educated persons in need of substance abuse treatment are more likely to receive such care compared with persons with any college education (NHSDA, 2001).

Figure 8. Percent of adults who received outpatient mental health treatment or counseling in the past year
[U.S. total = 11%]



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^ Indicates reference group.
* $p<0.05$ and relative rate >10% for comparison of group with reference group.
Key: NHOPI=Native Hawaiian or Other Pacific Islander; AI/AN=American Indian/Alaska Native; HS=high school
DSU=Data do not meet the criteria for statistical reliability, data quality, or confidentiality.
Source: Substance Abuse and Mental Health Services Administration, National Household Survey on Drug Abuse, 2001.

HIV Care

Key Findings:

- Non-Hispanic black and Hispanic HIV patients experience more inpatient hospitalizations than non-Hispanic white HIV patients.
- Those HIV patients with no health insurance (or Ryan White coverage only) are less likely than HIV patients with private health insurance to receive four or more ambulatory visits per year or to be hospitalized.

Why HIV care is important

Human immunodeficiency virus (HIV) infection and its late-stage manifestation as acquired immune deficiency syndrome (AIDS) are among the most devastating global infectious disease pandemics in history. Between 850,000 and 950,000 U.S. residents are estimated to be infected,[67] and each year, about 40,000 persons acquire the infection.[68] Educational campaigns have brought down infection rates in the United States, and new treatments have transformed the disease from a death sentence into a chronic condition. Vaccines for the virus are under development.[70]

HIV incidence and death rates vary by race and ethnicity. For example, blacks comprise about 12% of the U.S. population, but accounted for half of the new HIV cases reported in the U.S. in 2001.[71] AIDS is the leading cause of death among black women aged 25 to 34 and among black men aged 35 to 44.[72] Hispanics also have higher AIDS incidence rates than whites.[73]

Differences in receipt of antiretroviral therapy and prophylactic therapy to prevent *Pneumocystis carinii* pneumonia (PCP),[74] receipt of highly-active antiretroviral therapy,[75] and management of PCP[76] have also been demonstrated.

How the Nation is doing

Blacks have higher rates of hospitalization for HIV than whites (NHDS, 2000).[i] Non-Hispanic black (18%) and Hispanic (17%) HIV patients experience more inpatient hospitalizations than

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[i] With the exception of hospitalization rates, nationally representative data on HIV care that include race and ethnicity are not available. To fill this important gap, the NHDR uses data from the HIV Research Network. Although the network spans the Nation, members tend to be large, urban academic medical centers that treat large numbers of HIV patients. Findings are therefore not generalizable to all HIV patients.

The HIV Research Network collects race and ethnicity data as a single item as follows: non-Hispanic white, non-Hispanic black, Hispanic, Asian or Pacific Islander, and American Indian or Alaska Native. In lieu of patient income and education data, the NHDR compares HIV services provided to uninsured patients with services provided to privately insured patients as a proxy of socioeconomic position. Furthermore, since Ryan White coverage may be available to individuals with no other health insurance, it is difficult to differentiate them from the uninsured. Persons with no health insurance and persons with Ryan White coverage only are therefore aggregated in these analyses.

non-Hispanic white HIV patients (11%). HIV patients with no health insurance or Ryan White coverage only are less likely than HIV patients with private health insurance to receive four or more ambulatory visits per year or to be hospitalized. These differences are observed both among the sickest AIDS patients (with CD4 count below 50), as well as among less immunocompromised HIV patients.

Avoidable Admissions

Key Findings:

- Compared with whites, blacks typically have higher rates of avoidable admissions; Asians and Pacific Islanders typically have lower rates.
- Rates of avoidable admissions are higher for persons who live in low-income areas compared with persons who live in higher income neighborhoods.

Why avoidable admissions are important

Avoidable admissions (also called "admissions of ambulatory care sensitive conditions") are hospitalizations for health conditions that, in the presence of comprehensive primary care, rarely require hospitalization. High rates of avoidable admissions suggest impaired access to or quality of ambulatory care.

Racial, ethnic, and socioeconomic differences in avoidable admissions are well documented, and are higher for blacks and low-income persons (compared with whites and high-income individuals).[77, 78, 79] As the numbers of such hospitalizations has increased over time, the gap between these demographic groups has widened.[80]

How the Nation is doing

Nationally representative data on hospitalizations are often limited by sample size and variations in the quality of race and ethnicity reporting from different States. The NHDR uses data from the 16 States that collect fairly complete race and ethnicity data and that participate in the Healthcare Cost and Utilization Project State Inpatient Databases (HCUP SID).[i] In aggregate, these hospitalizations account for over half of the hospitalizations in the Nation. Avoidable admissions examined include hospitalizations for hypertension, angina, chronic obstructive pulmonary disease, and bacterial pneumonia.

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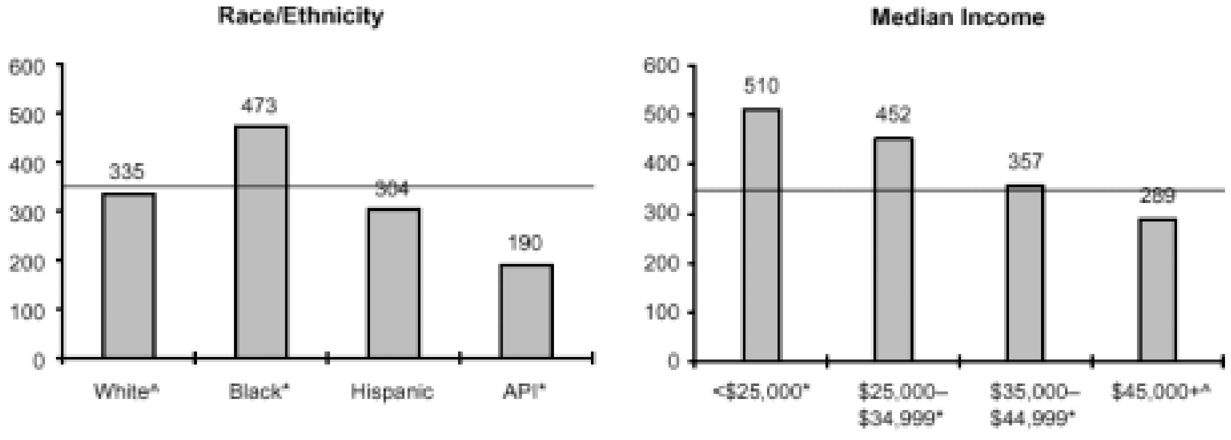
[i] The HCUP State Inpatient Databases collect race and ethnicity data as a single item. The categories are as follows: non-Hispanic white, non-Hispanic black, Hispanic, Asian or Pacific Islander, and American Indian or Alaska Native. Because it does not collect information on patient income and education, the NHDR uses median income of patient's ZIP Code as a crude proxy of socioeconomic position.

Compared with non-Hispanic whites, non-Hispanic blacks typically have higher rates of avoidable admissions while Asians and Pacific Islanders typically have lower rates. Rates of admission for bacterial pneumonia are higher among non-Hispanic blacks (473 per 100,000 population) and lower among APIs (190 per 100,000) compared with non-Hispanic whites (335 per 100,000) (Figure 9) (HCUP SID 16-State database, 2000).

Figure 9. Avoidable admissions for bacterial pneumonia per 100,000 population [Total, 16 States = 349 per 100,000]



^ Indicates reference group.
* p<0.05 and relative rate >10% for comparison of group with reference group.
Key: API=Asian or Pacific Islander
Source: Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project State Inpatient Databases, 16-State database, 2000.

Rates of avoidable admissions are also higher for persons who live in poorer neighborhoods. For example, rates of admission for bacterial pneumonia are higher among persons who live in poor areas[i] (510 per 100,000 population), near-poor areas[ii] (452 per 100,000), and medium-income areas[iii] (357 per 100,000), than for high-income area[iv] residents (289 per 100,000). Similar differences are noted for other avoidable admissions.

Tracking avoidable admissions is important because such hospitalizations may reflect, in part, the adequacy of primary care. When health care needs are not met by the primary health care

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[i] "Poor areas" are defined as having ZIP Codes with median incomes of under $25,000.
[ii] "Near-poor areas" are defined as having ZIP Codes with median incomes of $25,000-$34,999.
[iii] "Medium income areas" are defined as having ZIP Codes with median incomes of $35,000-$44,999.
[iv] "High-income areas" are defined as having ZIP Codes with median incomes of $45,000 and higher.

system, rates of avoidable admissions may rise. Higher rates of avoidable admissions by blacks and persons of lower socioeconomic position may be explained, in part, by lower receipt of routine care by these populations. However, avoidable admissions may be influenced by many other factors, such as comorbidities and patient preferences.

Table 1. Racial and Ethnic Differences in Entry into the Health Care System

Measure	Racial Difference[i]					Ethnic Difference[ii]	
	Black	Asian	NHOPI	AI/AN	>1 Race	NHB	Hispanic
Health Insurance Coverage							
% of persons, ages <65, with health insurance[iii]	◒	●	●	◒	●	◒	◒
% of persons, ages <65, with public health insurance only[3]	◒	●	○	◒	◒	◒	◒
% of persons, ages <65, with any private health insurance[3]	◒	◒	◒	◒	◒	◒	◒
% of persons, ages 65+, with any private health insurance[3]	◒	◒	○	○	●	◒	◒
% of persons uninsured all year[iv]	◒	●[4]		◒		◒	◒
% of persons with any period of uninsurance during the year[4]	◒	●[4]		◒		◒	◒
% of persons with any period of public insurance during the year[4]	◒	●[4]		◒		◒	◒
Usual Source of Care							
% of persons who have a specific source of ongoing care[3]	◒	◒	○	●	●	◒	◒
% of persons in fair or poor health who have a specific source of ongoing care[3]	●	●	○	○	●	◒	◒
% of persons with a hospital, emergency room, or clinic as source of ongoing care[3]	◒	●	○	◒	◒	◒	◒
% of persons with a community health center as source of ongoing care[v]	●	●	○	○		◒	◒
% of persons without a usual source of care who indicate a financial or insurance reason for not having a source of care[4]	●	●[4]		○		●	◒
% of persons who have a usual primary care provider[4]	◒	◒[4]		●		◒	◒
% of adults who report very little or no choice in source of care[5]	●	◒	●	●		●	◒
% of adults who have had a regular doctor for more than 5 years[5]	●	◒	●	●		●	◒

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[i] Compared with whites.

[ii] Compared with non-Hispanic whites.

[iii] Source: National Center for Health Statistics, National Health Interview Survey, 2000.

[iv] Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 1999. This source did not collect information on Asians and NHOPIs separately but in aggregate as Asians or Pacific Islanders. This source did not collect information for >1 race.

[v] Source: The Commonwealth Fund Health Care Quality Survey, 2001. This source did not collect information for >1 race separately.

Table 1. Racial and Ethnic Differences in Entry into the Health Care System (continued)

Measure	Racial Difference[i]					Ethnic Difference[ii]	
	Black	Asian	NHOPI	AI/AN	>1 Race	NHB	Hispanic
Patient Perceptions of Need							
% of families that experience difficulties or delays in obtaining health care or do not receive needed care[iii]	◓	●[3]		○		◓	◒
% of families that experience difficulties or delays in obtaining health care due to financial or insurance reasons[3]	●	○[3]		○		●	◒
% of families that did not receive a doctor's care or prescription medications because the family needed the money[3]	●	●[3]		○		●	◒
% of families not very satisfied that they can get health care if they need it[3]	●	◒[3]		○		●	◒
% of persons who can always get appointments for routine care as soon as wanted[iv]	●	◒[4]		○		●	◒
% of persons who can always get care for illness or injury as soon as wanted[4]	●	○[4]		○		●	◒

Key to Access to Health Care Tables:
●: Selected population and comparison population receive about same access to health care
◓: Selected population receives better access to care than the comparison population
◒: Selected population receives worse access to care than the comparison population
○: Data are collected but do not meet criteria for statistical reliability
NHOPI=Native Hawaiian or Other Pacific Islander; AI/AN=American Indian or Alaska Native; NHB=non-Hispanic black

---

[i] Compared with whites.

[ii] Compared with non-Hispanic whites.

[iii] Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 1999. This source did not collect information on Asians and NHOPIs separately but in aggregate as Asians or Pacific Islanders. This source did not collect information for >1 race.

[iv] Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2000. This source did not collect information on Asians and NHOPIs separately but in aggregate as Asians or Pacific Islanders. This source did not collect information for >1 race.

Table 2. Socioeconomic Differences in Entry into the Health Care System

Measure	**Income Difference**[i]			**Educational Difference**[ii]		**Insurance Difference**[iii]
	<100%	**100-199%**	**200-399%**	**<HS**	**HS Grad**	**Uninsured**
Health Insurance Coverage						
% of persons, ages <65, with health insurance[iv]	◒	◒	◒	◒	◒	
% of persons, ages <65, with public health insurance only[4]	◒	◒	◒	◒	◒	
% of persons, ages <65, with any private health insurance[4]	◒	◒	◒	◒	◒	
% of persons, ages 65+, with any private health insurance[4]	◒	◒	◉	◒	◒	
% of persons uninsured all year[v]	◒	◒	◒	◒	◒	
% of persons with any period of uninsurance during the year[5]	◒	◒	◒	◒	◒	
% of persons with any period of public insurance during the year[5]	◒	◒	◒	◒	◒	
Usual Source of Care						
% of persons who have a specific source of ongoing care[4]	◒	◒	◒	◒	◒	◒
% of persons in fair or poor health who have a specific source of ongoing care[4]	◒	◒	◒	◒	◒	◒
% of persons with a hospital, emergency room, or clinic as source of ongoing care[4]	◒	◒	◒	◒	◒	◒
% of persons with a community health center as source of ongoing care[vi]	◒	◒	◒	◒	◒	◒
% of persons without a usual source of care who indicate a financial or insurance reason for not having a source of care[5]	◒	◒	◒	◒	◒	◒
% of persons who have a usual primary care provider[5]	◒	◒	◒	◒	◒	◒
% of adults who report very little or no choice in source of care[6]	◒	◒	◒	◉	◉	◒
% of adults who have had a regular doctor for more than five years[6]	◉	◒	◉	◉	◉	◉

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[i] Compared with persons with family incomes 400% of Federal poverty threshold or above.
[ii] Compared with persons with any college education.
[iii] Compared with persons under 65 with any private health insurance.
[iv] Source: National Center for Health Statistics, National Health Interview Survey, 2000.
[v] Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 1999.
[vi] Source: The Commonwealth Fund Health Care Quality Survey, 2001.

Table 2. Socioeconomic Differences in Entry into the Health Care System (continued)

Measure	**Income Difference[i]**			**Educational Difference[ii]**		**Insurance Difference [iii]**
	<100%	**100-199%**	**200-399%**	**<HS**	**HS Grad**	**Uninsured**
Patient Perceptions of Need						
% of families that experience difficulties or delays in obtaining health care or do not receive needed care[iv]	◒	◒	◒	◒	●	◒
% of families that experience difficulties or delays due to financial or insurance reasons[4]	◒	◒	◒	●	●	◒
% of families that did not receive a doctor's care or prescription medications because the family needed the money[4]	◒	◒	◒	◒	◒	◒
% of families not very satisfied that they can get health care if they need it[4]	◒	◒	◒	◒	◒	◒
% of persons who can always get appointments for routine care as soon as wanted[v]	◒	●	●	◒	●	●
% of persons who can always get care for illness or injury as soon as wanted[5]	◒	●	●	●	●	◒

Key to Access to Health Care Tables:
●: Selected population and comparison population receive about same access to health care
◓: Selected population receives better access to care than the comparison population
◒: Selected population receives worse access to care than the comparison population
○: Data are collected but do not meet criteria for statistical reliability
HS=high school

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[i] Compared with persons with family incomes 400% of Federal poverty threshold or above.
[ii] Compared with persons with any college education.
[iii] Compared with persons under 65 with any private health insurance.
[iv] Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 1999.
[v] Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2000.

Table 3. Racial and Ethnic Differences in Structural Barriers within the Health Care System

Measure	Racial Difference[i]					Ethnic Difference[ii]	
	Black	Asian	NHOPI	AI/AN	>1 Race	NHB	Hispanic
Barriers to Getting Care							
% of persons with provider who has office hours nights or weekends[3]	●	◓[3]		●		●	●
% of persons with difficulty getting appointments on short notice[3]	●	●[3]		◒		●	●
% of persons with difficulty contacting provider over the telephone[3]	●	●[3]		●		●	◒
% of adults without problems getting referral to a specialist in past year[iii]	◒	○[4]		○		◒	◒
% of persons not very satisfied with professional staff at provider's office[3]	●	◒[3]		●		●	◒
Waiting Times							
% of persons who usually wait >30 minutes before seeing provider[3]	◒	●[3]		○		◒	◒
% of emergent/urgent emergency department visits with wait >=1 hour[iv]	●	●[4]		○			
% of semi-urgent/non-urgent emergency department visits with wait >=1 hour [4]	◒	●[4]		○			
% of emergency department visits in which the patient left without being seen[4]	◒	○[4]		○			

Key to Access to Health Care Tables:
●: Selected population and comparison population receive about same access to health care
◓: Selected population receives better access to care than the comparison population
◒: Selected population receives worse access to care than the comparison population
○: Data are collected but do not meet criteria for statistical reliability
NHOPI=Native Hawaiian or Other Pacific Islander; AI/AN=American Indian or Alaska Native; NHB=non-Hispanic black

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[i] Compared with whites.

[ii] Compared with non-Hispanic whites.

[iii] Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2000. This source did not collect information on Asians and NHOPIs separately but in aggregate as Asians or Pacific Islanders. This source did not collect information for >1 race.

[iv] Source: National Center for Health Statistics, National Hospital Ambulatory Medical Care Survey-Emergency Department, 2000. This source did not collect information on Asians and NHOPIs separately. This source did not collect information for >1 race. Missing rates preclude analysis by ethnicity.

Table 4. Socioeconomic Differences in Structural Barriers within the Health Care System

Measure	Income Difference[i]			Educational Difference[ii]		Insurance Difference[iii]
	<100%	100-199%	200-399%	<HS	HS Grad	Uninsured
Barriers to Getting Care						
% of persons with provider who has office hours nights or weekends[4]	◒	◒	●	◒	●	◒
% of persons with difficulty getting appointments on short notice[4]	●	●	●	●	●	●
% of persons with difficulty contacting provider over the telephone[4]	●	●	●	●	●	●
% of adults without problems getting referral to a specialist in past year[iv]	◒	◒	●	●	●	◒
% of persons not very satisfied with professional staff at provider's office[4]	◒	●	●	●	●	●
Waiting Times						
% of persons who usually wait >30 minutes before seeing provider[4]	◒	◒	◒	◒	◒	◒
% of emergent/urgent emergency department visits with wait >=1 hour[v]						●
% of semi-urgent/non-urgent emergency department visits with wait >=1 hour[5]						◒
% of emergency department visits in which the patient left without being seen[5]						◒

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[i] Compared with persons with family incomes 400% of Federal poverty threshold or above.
[ii] Compared with persons with any college education.
[iii] Compared with persons under 65 with any private health insurance.
[iv] Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2000.
[v] Source: National Center for Health Statistics, National Hospital Ambulatory Medical Care Survey-Emergency Department, 2000. This source did not collect information about income or education. Insurance contrast compares uninsured with persons with any private insurance including all ages.

Key to Access to Health Care Tables:
◉: Selected population and comparison population receive about same access to health care
◓: Selected population receives better access to care than the comparison population
◒: Selected population receives worse access to care than the comparison population
○: Data are collected but do not meet criteria for statistical reliability
HS=high school

Table 5. Racial and Ethnic Differences in Ability of Provider to Address Patient Needs

Measure	Racial Difference[i]					Ethnic Difference[ii]	
	Black	**Asian**	**NHOPI**	**AI/AN**	**>1 Race**	**NHB**	**Hispanic**
Patient-Provider Communication							
% of persons with provider who generally listens and gives needed information about health/health care[iii]	●	●[3]		○		●	◒
% of persons with provider who usually asks about medications and treatments other doctors may give[3]	◓	●[3]		●		◓	◓
% of adults whose providers always listened carefully to them[iv]	◓	●[4]		○		◓	◒
% of adults whose providers always explained things in a way they could understand[4]	◓	●[4]		○		◓	◒
% of adults whose providers always showed respect for what they had to say[4]	◓	●[4]		○		◓	●
% of adults with one or more indicators of poor communication at their last visit[v]	◒	◒	○	◒		◒	◒
Patient-Provider Relationship							
% of persons not satisfied with quality of care received from provider[3]	●	◒[3]		●		●	◒
% of persons not confident in provider's help when they have a medical problem[3]	●	○[3]		○		●	●
% of adults whose providers always spent enough time with them[4]	◓	●[4]		○		●	◒
% of adults who rate their health care in the past year <6 on a scale from 0 to 10[4]	◒	◒[4]		○		◒	◒
% of adults not treated with a great deal of dignity and respect[5]	●	◒	○	●		●	●
% of adults not involved as much as wanted in decision-making[5]	◒	◒	○	●		◒	◒
% of adults not with as much time as wanted with doctor[5]	●	◒	●	●		●	◒
% of adults with incident in past two years when they did not follow doctor's advice[5]	●	●	○	○		●	●
% of adults with family member who got sick due to doctor or hospital mistake[5]	●	●	○	○		●	◓
Cultural Competency[5]							
% of adults who believe they would have gotten better care if different race/ethnicity	◒	◒	○	○		◒	◒
% of adults who felt treated with disrespect because of race/ethnicity	◒	○	○	○		◒	◒
% of adults who do not strongly agree that doctor understands background and values	●	◒	○	●		●	●

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[i] Compared with whites.

[ii] Compared with non-Hispanic whites.

[iii] Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 1999. This source did not collect information on Asians and NHOPIs separately but in aggregate as Asian or Pacific Islander. This source did not collect information for >1 race.

[iv] Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2000. This source did not collect information on Asians and NHOPIs separately but in aggregate as Asian or Pacific Islander. This source did not collect information for >1 race.

[v] Source: The Commonwealth Fund Health Care Quality Survey, 2001. This source did not collect information for >1 race separately

Table 5. Racial and Ethnic Differences in Ability of Provider to Address Patient Needs (continued)

Measure	Racial Difference[i]					Ethnic Difference[ii]	
	Black	Asian	NHOPI	AI/AN	>1 Race	NHB	Hispanic
Health Information[iii]							
% of adults who did not find prescription bottle very easy to understand	◉	◒	○	○		◉	◒
% of adults who did not find information from doctor's office very easy to understand	◉	◒	○	◉		◉	◒
% of adults who do not use web for health information	◒	◉	◉	◉		◒	◒
% of adults who do not use printed material for health information	◉	◉	○	◉		◉	◒
% of adults who do not call their doctor for health information	◉	◉	◉	◉		◉	◒

Table 6. Socioeconomic Differences in Ability of Provider to Address Patient Needs

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[i] Compared with whites.
[ii] Compared with non-Hispanic whites.
[iii] Source: The Commonwealth Fund Health Care Quality Survey, 2001. This source did not collect information for >1 race separately

Key to Access to Health Care Tables:
◉: Selected population and comparison population receive about same access to health care
◓: Selected population receives better access to care than the comparison population
◒: Selected population receives worse access to care than the comparison population
○: Data are collected but do not meet criteria for statistical reliability
NHOPI=Native Hawaiian or Other Pacific Islander; AI/AN=American Indian or Alaska Native; NHB=non-Hispanic black

Measure	**Income Difference**[i]			**Educational Difference**[ii]		**Insurance Difference**[iii]
	<100%	**100-199%**	**200-399%**	**<HS**	**HS Grad**	**Uninsured**
Patient-Provider Communication						
% of persons with provider who generally listens and gives needed information about health/health care[iv]	●	●	●	◒	◒	●
% of persons with provider who usually asks about medications and treatments other doctors may give[7]	●	●	●	●	●	◓
% of adults whose providers always listened carefully[v]	●	●	●	◓	●	●
% of adults whose providers always explained things in a way they could understand[8]	●	●	●	●	●	◒
% of adults whose providers always showed respect for what they had to say[8]	●	●	●	●	●	●
% of adults with one or more indicators of poor communication at their last visit[vi]	◒	◒	◒	◒	●	◒

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

[ii] Compared with persons with any college education.

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

[iv] Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 1999.

[v] Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2000.

[vi] Source: The Commonwealth Fund Health Care Quality Survey, 2001.

Table 6. Socioeconomic Differences in Ability of Provider to Address Patient Needs (continued)

Measure	Income Difference[i]			Educational Difference[ii]		Insurance Difference[iii]
	<100%	100-199%	200-399%	<HS	HS Grad	Uninsured
Patient-Provider Relationship						
% of persons not satisfied with quality of care from provider[iv]	●	●	●	●	●	●
% of persons not confident in provider's help when they have a medical problem[4]	◒	●	●	●	●	●
% of adults whose providers always spent enough time[v]	●	●	●	◒	●	●
% of adults who rate their health care in the past year <6 on a scale from 0 to 10[5]	◒	◒	◒	◒	◒	◒
% of adults not treated with a great deal of dignity and respect[vi]	◒	◒	●	●	●	◒
% of adults not involved as much as wanted in decisionmaking[6]	◒	◒	◒	●	●	◒
% of adults who did not have as much time as wanted with doctor[6]	◒	●	●	●	●	◒
% of adults with incident in past 2 years when they did not follow doctor's advice[6]	●	●	●	●	◓	●
% of adults with family member who got sick due to doctor or hospital mistake[6]	●	●	●	●	●	◒
Cultural Competency[6]						
% of adults who believe would have gotten better care if different race/ethnicity	◒	◒	●	◒	●	◒
% of adults who felt treated with disrespect because of race/ethnicity	◒	◒	◒	◒	●	◒
% of adults who do not strongly agree that doctor understands background and values	●	●	●	◓	●	◒
Health Information[6]						
% of adults who do not find prescription bottle very easy to understand	◒	◒	●	◒	●	◒
% of adults who do not find information from doctor's office very easy to understand	◒	◒	◒	◒	◒	◒
% of adults who do not use web for health information	◒	◒	◒	◒	◒	◒
% of adults who do not use printed material for health information	◒	◒	◒	◒	◒	◒
% of adults who do not call doctor for health information	◒	●	●	◒	◒	◒

Key to Access to Health Care Tables:
●: Selected population and comparison population receive about same access to health care
◓: Selected population receives better access to care than the comparison population
◒: Selected population receives worse access to care than the comparison population
○: Data are collected but do not meet criteria for statistical reliability
HS=high school

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[i] Compared with persons with family incomes 400% of Federal poverty threshold or above.
[ii] Compared with persons with any college education.
[iii] Compared with persons under 65 with any private health insurance.
[iv] Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 1999.
[v] Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2000.
[vi] Source: The Commonwealth Fund Health Care Quality Survey, 2001.

Table 7. Racial and Ethnic Differences in Health Care Utilization

Measure	Racial Difference[i]					Ethnic Difference[ii]	
	Black	Asian	NHOPI	AI/AN	>1 Race	NHB	Hispanic
Routine Health Care							
% of persons with office or outpatient visit[iii]	◒	◒[3]		●		◒	◒
% of persons with prescription medications[3]	◒	◒[3]		◒		◒	◒
% of persons with dental visit[3]	◒	◒[3]		◒		◒	◒
Outpatient visits per population[iv]	◒	●[4]		◒			
Acute Care							
% of persons with emergency room visit[3]	●	◒[3]		●		●	◒
% of persons with inpatient discharge[3]	●	●[3]		●		●	●
Emergency department visits per population[4]	◓	◒[4]		●			
Total hospitalizations per population[v]	◓	○	○	○			
Chronic Care							
% of persons with home health visit[3]	●	○[3]		○		●	◒
Home health care discharges per population 18-64[vi]	●[6]						
Home health care discharges per population 65 and older[6]	●[6]						
Nursing home discharges per population 18-64[vii]	◓[7]						
Nursing home discharges per population 65 and older[7]	●[7]						
Hospice discharges per population 18-64[6]	●[6]						
Hospice discharges per population 65 and older[6]	◒[6]						
Avoidable Admissions[viii]							
Avoidable admissions for hypertension per population 18 and older	*[8]	◒[8]				◓	◓
Avoidable admissions for angina per population 18 and older	*[8]	◒[8]				◓	●
Avoidable admissions for chronic obstructive pulmonary disease per population 18 and older	*[8]	◒[8]				●	◒
Avoidable admissions for bacterial pneumonia per population	*[8]	◒[8]				◓	●

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[i] Compared with whites.

[ii] Compared with non-Hispanic whites.

[iii] Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 1999. This source did not collect information on Asians and NHOPIs separately but in aggregate as Asians or Pacific Islandesr. This source did not collect information for >1 race.

[iv] Source: National Center for Health Statistics, National Ambulatory Medical Care Survey/National Hospital Ambulatory Medical Care Survy, 1999-2000. This source did not collect information on Asians and NHOPIs separately but in aggregate as Asians or Pacific Islanders. This source did not collect information for >1 race. Missing rates preclude analysis by ethnicity.

[v] Source: National Center for Health Statistics National Hospital Discharge Survey, 2000. This source did not collect information for >1 race separately. Missing rates preclude analysis by ethnicity.

[vi] Source: National Center for Health Statistics, National Home and Hospice Care Survey, 2000. Sample size constraints permit black-white comparisons only.

[vii] Source: National Center for Health Statistics, National Nursing Home Survey, 1999. Sample size constraints permit black-white comparisons only.

[viii] Source: Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project State Inpatient Databases, 16-State database, 2000. This source categorizes race/ethnicity very differently from other sources. Race/ethnicity information is categorized as a single item: non-Hispanic white, non-Hispanic black, Hispanic, Asian or Pacific Islander. These contrasts compare each group with non-Hispanic whites. An * is inserted in the black column to indicate that estimates for this group could not be produced.

Table 7. Racial and Ethnic Differences in Health Care Utilization (continued)

Measure	Racial Difference[i]					Ethnic Difference[ii]	
	Black	Asian	NHOPI	AI/AN	>1 Race	NHB	Hispanic
Mental Health Care and Substance Abuse Treatment							
% of adults who received mental health treatment or counseling in the past year[iii]	◒	◒	○	●	●	◒	◒
% of adults who received outpatient mental health treatment or counseling[3]	◒	◒	○	●	●	◒	◒
% of adults who received prescription medications for mental health treatment[3]	◒	○	○	●	●	◒	◒
% of adults who received inpatient mental health treatment or counseling[3]	◓	○	○	○	○	◓	●
% of adults with serious mental illness who received mental health treatment or counseling[3]	◒	○	○	○	○	◒	◒
% of persons 12 and older who received illicit drug or alcohol abuse treatment in the past year[3]	●	○	○	○	○	◓	●
% of persons 12 and older who needed treatment for illicit drug use and who received such treatment in the past year[3]	◓	○	○	○	○	◓	●
Inpatient admissions to specialty mental health organizations per population[iv]	◓	○[4]		○		◓	◒
Residential care admissions to specialty mental health organizations per population[4]	◓	○[4]		○		◓	●
<24 hour admissions to specialty mental health organizations per population[4]	◓	◒[4]		◓		◓	●
HIV Care							
Hospitalizations for HIV per population[v]	◓	○	○	○			
% of HIV patients with 4+ ambulatory visits in the past year[vi]	*[6]	●[6]		●		◒	●
% of HIV patients with CD4 <50 with 4+ ambulatory visits in the past year[6]	*[6]	○[6]		○		◒	●
% of HIV patients with inpatient hospitalization in the past year[6]	*[6]	●[6]		●		◓	◓
% of HIV patients with CD4 <50 with inpatient hospitalization in the past year[6]	*[6]	○[6]		○		◓	◓

Key to Health Care Utilization Tables:

●: Selected population and comparison population receive about same amount of health care
◓: Selected population receives more care than the comparison population
◒: Selected population receives less care than the comparison population
○: Data are collected but do not meet criteria for statistical reliability
NHOPI=Native Hawaiian or Other Pacific Islander; AI/AN=American Indian or Alaska Native; NHB=non-Hispanic black

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[i] Compared with whites.

[ii] Compared with non-Hispanic whites.

[iii] Source: Substance Abuse and Mental Health Services Administration, National Household Survey on Drug Abuse, 2001.

[iv] Source: Substance Abuse and Mental Health Services Administration, Client/Patient Survey Sample, 1997. This source did not collect information on Asians and NHOPIs separately but in aggregate as Asians or Pacific Islanders. This source did not collect information for >1 race.

[v] Source: National Center for Health Statistics, National Hospital Discharge Survey, 2000. This source did not collect information for >1 race separately. Missing rates preclude analysis by ethnicity.

[vi] Source: HIV Research Network, 2000. This source categorizes race/ethnicity very differently from other sources. Race/ethnicity information is categorized as a single item: non-Hispanic white, non-Hispanic black, Hispanic, Asian or Pacific Islander American Indian or Alaska Native. These contrasts compare each group with non-Hispanic whites. An * is inserted in the black column to indicate that estimates for this group could not be produced.

Table 8. Socioeconomic Differences in Health Care Utilization

Measure	**Income Difference**[i]			**Educational Difference**[ii]		**Insurance Difference**[iii]
	<100%	**100-199%**	**200-399%**	**<HS**	**HS Grad**	**Uninsured**
Routine Health Care[iv]						
% of persons with office or outpatient visit	◒	◒	◒	◒	◒	◒
% of persons with prescription medications	◒	◒	◒	◒	◉	◒
% of persons with dental visit	◒	◒	◒	◒	◒	◒
Acute Care[4]						
% of persons with emergency room visit	◓	◓	◓	◓	◓	◉
% of persons with inpatient discharge	◓	◓	◓	◓	◓	◒
Chronic Care[4]						
% of persons with home health visit	◓	◓	◉	◓	◓	○
Mental Health Care and Substance Abuse Treatment[v]						
% of adults who received mental health treatment or counseling in the past year				◉	◉	
% of adults who received outpatient mental health treatment or counseling				◒	◒	
% of adults who received prescription medications for mental health treatment				◉	◉	
% of adults who received inpatient mental health treatment or counseling				◓	◓	
% of adults with serious mental illness who received mental health treatment or counseling				◒	◉	
% of persons age 12 and older who received illicit drug or alcohol abuse treatment in the past year				◓	◓	
% of persons age 12 and older who needed treatment for illicit drug use and who received such treatment in the past year				◉	◓	
HIV Care[vi]						

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

[ii] Compared with persons with any college education.

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

[iv] Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 1999.

[v] Source: Substance Abuse and Mental Health Services Administration, National Household Survey on Drug Abuse, 2001. Income and insurance disparities were not analyzed.

[vi] Source: HIV Research Network, 2000. This source did not collect information about income or education. Because Ryan White covers HIV patients who otherwise would be uninsured, this insurance contrast compares HIV patients who are uninsured or have no coverage other than Ryan White with patients with private health insurance.

% of HIV patients with 4+ ambulatory visits in the past year						◒[6]
% of HIV patients with CD4 <50 with 4+ ambulatory visits in the past year						◒[6]
% of HIV patients with inpatient hospitalization in the past year						◒[6]
% of HIV patients with CD4 <50 with inpatient hospitalization in the past year						◒[6]

Key to Health Care Utilization Tables:
◉: Selected population and comparison population receive about same amount of health care
◓: Selected population receives more care than the comparison population
◒: Selected population receives less care than the comparison population
○: Data are collected but do not meet criteria for statistical reliability

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