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“Even with ‘tweaks’ to level the financial playing field, the individual insurance market is unlikely to solve access and uninsurance problems.”
— Mark Doescher,
University of
Washington

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HEALTH CARE FINANCING & ORGANIZATION FINDINGS BRIEF

Community Characteristics Unable to Explain Disparities in Purchase of Individual Insurance by Minorities

Many uninsured individuals in the United States today do not enjoy the benefits of employer-sponsored insurance because their employers do not offer it. Others are offered a plan, but cannot afford to pay their share of the premiums. Given evidence that people without insurance get less needed care, the uninsured will continue to suffer both economically and physically. Unfortunately, low-income racial and ethnic minorities are particularly disadvantaged because they are disproportionately represented among the uninsured.

Some observers have proposed creating incentives – financial and other – for these disadvantaged populations¹ to purchase insurance in the individual (or non-group) market. In a project at the University of Washington, Barry Saver, M.D., Mark Doescher, M.D., and colleagues studied the interplay of individual- and community-level factors in health care issues facing the uninsured. They focused specifically on whether community-level factors (such as the presence and strength of local safety nets, housing segregation, and income inequality) could explain racial/ethnic disparities in the purchase of non-group insurance and access to health care. They found that with few exceptions, community-level factors do not explain these disparities; individual-level factors, such as age, income, and education, may play greater roles.²

According to Saver, the findings show that voluntary enrollment and financial incentives to purchase individual insurance plans, while likely to decrease the number of uninsured, will nonetheless increase the disparity in purchasing practices between disadvantaged minorities and others. He says that policymakers need to understand that the problem of the uninsured is more complex than simply the numbers themselves, and that reliance on voluntary approaches to individ-

ual insurance uptake is simply widening the gap between the “haves” and “have-nots.”

“Even with ‘tweaks’ to level the financial playing field,” says Doescher, “the individual insurance market is unlikely to solve access and uninsurance problems [for these groups].”

Background

For their analyses, the researchers used data primarily from The Robert Wood Johnson Foundation’s Community Tracking Study (CTS) Household Survey, a telephone survey of more than 60,000 individuals from 60 communities. They also used data from the Bureau of the Census, the Area Resource File, and Medicare cost reports from community and migrant health centers.

The researchers focused first on African-American and Hispanic adults under age 65 who had no employer or public-sponsored insurance. After adjusting for individual-level factors, the researchers found that these groups are less likely to purchase individual health insurance than non-Hispanic whites. Non-English-speaking Hispanics were even less likely to make this purchase than other minority group members.

Minority individuals with more education were more likely to buy individual insurance than minority members with less education, as were those with higher incomes. For example, English-speaking Hispanics who were college graduates were substantially more likely to purchase individual insurance than all other English-speaking Hispanics. Better-educated minorities, however, generally remained substantially less likely to purchase individual health insurance than similarly educated, non-Hispanic whites.

The research team also examined whether individuals living in communities with extensive safety nets were less likely to purchase individual

health insurance than those in areas with fewer safety-net services. They used five measures to identify the strength of a community's safety net:

- per capita visits to community and migrant health centers;
- per capita visits to public and teaching hospital outpatient departments;
- per capita number of physicians in the community;
- state and federal funding for primary care services for the medically underserved; and
- average hours per month of physician charity care.

Of these five measures, increased per capita visits to public and teaching hospital outpatient departments was associated with slightly lower odds of purchasing individual insurance. Therefore, these site-level factors provided little evidence that a stronger local safety net substituted for the purchase of individual insurance.

Access and Continuity of Care

The researchers explored whether the uninsured living in communities with significant safety-net services had better access to care than those in communities with less extensive safety nets. Using the CTS data, they examined responses concerning a usual source of care within a safety-net system (excluding emergency departments) and doctor visits within the previous 12 months. Community characteristics that decreased the chances that people would have a usual source of care or annual physician visits included increased managed care penetration, greater cost of living, and increased proportions of uninsured individuals.

In contrast, having a usual source of care was positively associated with larger per capita numbers of physicians in a community and greater teaching hospital capacity. Because uninsured minority group members generally have substantial difficulty accessing care, the research team explored whether community factors might improve or worsen this situation. They noted that racial and ethnic disparities in access to care among uninsured persons were not significantly affected by community-level factors.

Using the CTS data, the researchers determined that minorities are not only less likely to report having a regular site of care than non-minorities, but are also less often seen by the

same provider when they do have a regular site of care. This is because health care for minorities is more often administered outside of a physician's office (e.g., in hospital outpatient departments and community health centers).

Minorities were also found to be less trusting of their physicians and less satisfied with interactions they have with their physicians.

In a related analysis, the researchers found that continuity of care with a single provider is positively associated with preventive care, including smoking cessation and influenza immunization. Advice to quit smoking was less likely to be reported by male patients who were young, African-American, uninsured, healthy, light smokers, and low health care services users. This advice was more likely to be reported by those with military insurance, who attended hospital outpatient clinics, or who belonged to a health maintenance organization.

Lessons for Research and Policy

The goal for researchers is to identify the obstacles underlying the racial/ethnic disparities in the purchase of non-group insurance and access to care that persist after accounting for differences in income, educational attainment, and other factors. For example, other studies might examine how low provider continuity affects quality of care, and whether this influences health outcomes or satisfaction.

Understanding the obstacles to insurance for these groups will help policymakers alter current programs accordingly, and ensure that programs relying on the voluntary purchase of insurance do not selectively exclude the most vulnerable Americans: minorities, the poor, and persons with less education.

"Although the current climate of increasing health care costs and a dim economic outlook make it unlikely that sufficient societal resources for these groups will be forthcoming any time soon," concludes Saver, "there must be a willingness to direct such resources to the underserved in this nation." ■

¹ For the purposes of this study, disadvantaged populations are defined as low-income, uninsured African-Americans and Hispanics.

² Housing segregation was highly significant for African-Americans and of borderline significance for Hispanics in predicting the purchase of non-group insurance.



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