

## Racial/Ethnic Differences in Children's Access to Care

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### ABSTRACT

**Objectives.** This study explored reasons for racial and ethnic differences in children's usual sources of care.

**Methods.** Data from the 1996 Medical Expenditure Panel Survey were examined by means of logistic regression techniques.

**Results.** Black and Hispanic children were substantially less likely than White children to have a usual source of care. These differences persisted after control for health insurance and socioeconomic status. Control for language ability, however, eliminated differences between Hispanic and White children.

**Conclusions.** Results suggest that the marked Hispanic disadvantage in children's access to care noted in earlier studies may be related to language ability. (*Am J Public Health.* 2000;90:1771-1774)

High-quality health care is an important factor in the well-being of America's children. Recent policy changes, such as those represented by the State Children's Health Insurance Program, have attempted to increase children's health insurance coverage and their access to care to ensure that children obtain needed health care. However, a substantial number of children still lack health insurance and adequate access to health care, particularly a usual source of care.

Children without a usual source of care may be at increased risk of adverse outcomes, including not receiving needed immunizations.<sup>1</sup> Studies have shown that Black and Hispanic children are more likely to lack a usual source of care and less likely to have an office-based source of care than are White children<sup>2-4</sup>; such disadvantages may reduce Black and Hispanic children's continuity of care, with potential adverse outcomes. These differences may be due in part to the fact that Black and Hispanic children are more likely than White children to be uninsured.<sup>4</sup> Previous research indicates that children without health insurance are more likely to lack a usual source of care, a regular clinician, and access to after-hours medical care than are those with coverage.<sup>5</sup> However, even after insurance status has been controlled for, substantial differences by race and ethnicity remain in children's access to health care services.<sup>6,7</sup>

An alternative explanation for the relationship between race/ethnicity and health-related issues is socioeconomic status. Poverty, one measure of socioeconomic status, is a noted determinant of a number of health-related outcomes for children,<sup>3,8-11</sup> and Black and Hispanic children are substantially more likely than White children to be members of poor families.<sup>12</sup> Another potential explanation we consider here is language ability. For parents with limited English skills, the availability of health care providers and office staff who speak their native language and understand their knowledge and beliefs about health care may be indispensable for ensuring that their children have

adequate access to health care. In particular, children may lack a usual source of care if their parents cannot find a provider with whom they can clearly and comfortably communicate.

Because health differences between various racial and ethnic groups may be explained in part by accounting for health insurance and socioeconomic differences, and because race/ethnicity is used as a proxy for socioeconomic status in many health studies,<sup>13</sup> it is vital to assess the independent effects of race/ethnicity and socioeconomic status on health and access to care. In this report, we present both descriptive statistics and results of multivariate analyses that allowed us to examine racial and ethnic differences in children's usual source of care and to study the extent to which these differences may be explained by health insurance status, socioeconomic status, and language ability.

### Methods

Our data were derived from the 1996 Medical Expenditure Panel Survey (MEPS) Household Component. The goal of this survey was to provide information on the health care experiences of a representative sample of the civilian, noninstitutionalized US population.<sup>14-16</sup> The sample included nearly 6900 children younger than 18 years, more than 90% of whom had data reported by one of their parents.

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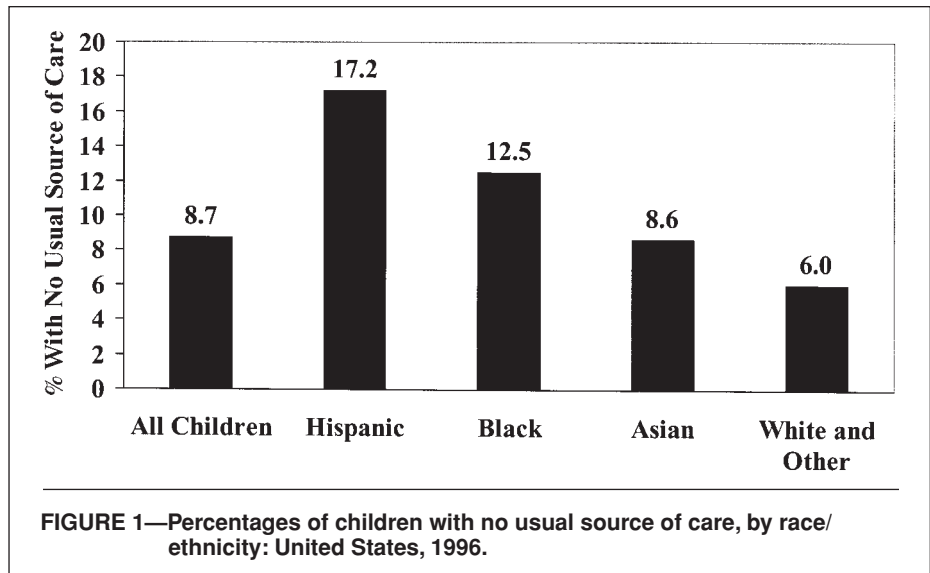
**Note.** The views expressed in this report are the authors'. No official endorsement by the Agency for Healthcare Research and Quality or the Department of Health and Human Services is intended or should be inferred.

Our dependent variable was derived from the MEPS access to health care supplement,<sup>17</sup> which measures whether children have a usual source of care by asking the question “Is there a particular doctor’s office, clinic, health center, or other place that [the child] usually goes if [the child] is sick or needs advice about health?” MEPS also asks about racial identification and Hispanic ethnicity. Our classification involved a set of mutually exclusive categories: Hispanic, Black, Asian, and White. The group designated “White” also included a small number of children of other racial and ethnic groups; data for these children are not shown separately owing to the small sample sizes.

Our measure of health insurance represented coverage during the first half of 1996 and included 3 categories: any private coverage, public coverage only, and uninsured throughout the first half of 1996.<sup>18</sup> Socioeconomic status measures included family income relative to the federal poverty line for calendar year 1996, whether or not the child’s mother was working, and the mother’s level of education. Additional demographic variables included in our analysis were age of the child’s oldest parent (<30 years, ≥30 years), child’s sex and age (0–5, 6–12, 13–17 years), whether the child was living with both of his or her parents, number of children living in the household, region of the country (Northeast, Midwest, South, West), and whether the child resided in a metropolitan statistical area.

Our final key variable of interest was the language in which the MEPS interviews were conducted. MEPS is a complex survey concerning the health and health care experiences of family members. While some respondents who have difficulty speaking English are able to communicate about basic issues, a respondent in need of another interview language would probably require health care providers and office staff who speak that language or the services of an interpreter. Nearly all MEPS non-English interviews (more than 98%) were conducted in Spanish by bilingual interviewers. Among the Hispanic children in our sample, 40.7% had interviews conducted in Spanish, and the remaining 59.3% had interviews conducted in English.

Both the descriptive data and the logistic regression results presented here were weighted to be nationally representative. Our standard errors accounted for the complex design of the survey. These adjustments to address the geographic clustering of the sample also accounted for intrafamilial correlation resulting from the inclusion of multiple children within the same family in our analyses.<sup>19</sup>



## Results

Figure 1 shows the percentages of children in each racial and ethnic group without a usual source of care. A large majority of children (91.3%) had a usual source of care in 1996, but approximately 6.2 million American children (nearly 9%) lacked a usual place to go if they were sick or in need of health advice. This represented a small improvement from 1987, when 10.8% of children had no usual source of care (data not shown). Although there were no significant differences between Asian and White children, Black children (12.5%) were more than twice as likely as White children (6.0%) to lack a usual source of care. An even more striking contrast was evident for Hispanic children (17.2%), who were nearly 3 times as likely as White children to lack a usual source of care.

These racial and ethnic differences remained strong and statistically significant in logistic regression models controlling for a wide variety of demographic characteristics (see Table 1). Black and Hispanic children were considerably less likely to have a usual source of care than were White children (model A). In addition, older children were less likely, and those living with 2 parents were more likely, to have a usual source of care. While there were no significant differences between children residing and not residing in metropolitan statistical areas, children living in the South and West were less likely than those residing in the Northeast to have a usual source of care. The effects of these demographic characteristics remained fairly constant across all of our models.

Model B added health insurance and our socioeconomic measures—income, mother’s education, and mother’s employment status—to the regression analysis. The addition of these variables did little to affect the relationship between race/ethnicity and our outcome. All racial

and ethnic effects that were statistically significant in model A remained significant with the controls for socioeconomic status, and their magnitudes were fairly similar. These health insurance and socioeconomic status effects were quite robust and remained fairly constant in the model discussed next. Uninsured children were substantially less likely to have a usual source of care, while those with more educated mothers were more likely to have a usual source of care. Children in low-income families (families with income between 125% and 200% of the poverty line) were consistently less likely to have a usual source of care.

Finally, in model C we added language of interview along with all of the variables included in the previous models. The effect was quite striking: children whose MEPS interview was conducted in English were 2.6 times more likely to have a usual source of care than children whose interview was conducted in Spanish. In addition, the effect of Hispanic ethnicity was statistically nonsignificant in this model. This result strongly suggests that the frequently observed finding that Hispanic children are less likely to have a usual source of care than White children is related to language ability rather than to ethnic group membership. Additional multivariate analyses (data not shown) indicated that Hispanic children whose MEPS interview was conducted in Spanish were only 27% as likely as White children to have a usual source of care, while there were no significant differences between White children and Hispanic children whose MEPS interview was conducted in English.

## Discussion

Our main goal in this report was to examine racial and ethnic differences in children’s

**TABLE 1—Odds Ratios for Presence of a Usual Source of Care (Logistic Regression Results): United States, 1996**

	Model A	Model B	Model C
<b>Race/ethnicity</b>			
Hispanic	0.35***	0.52***	0.71
Black	0.54**	0.57**	0.55**
Asian	0.85	0.84	0.80
White and other	1.00	1.00	1.00
<b>Health insurance and socioeconomic status</b>			
<b>Health insurance</b>			
Any private	...	1.00	1.00
Public only	...	1.02	1.11
Uninsured	...	0.45***	0.47***
<b>Income</b>			
Poor ( $\leq 100\%$ FPL)	...	0.67	0.74
Near poor ( $100\% < \text{FPL} \leq 125\%$ )	...	0.47*	0.52
Low income ( $125\% < \text{FPL} \leq 200\%$ )	...	0.58*	0.61*
Middle income ( $200\% < \text{FPL} \leq 400\%$ )	...	0.80	0.80
High income ( $> 400\%$ FPL)	...	1.00	1.00
<b>Mother's education, y</b>			
<12	...	0.82	0.96
12	...	1.00	1.00
>12	...	1.63*	1.65*
<b>Mother's employment status</b>			
Works	...	1.10	1.14
Does not work	...	1.00	1.00
<b>Interview language</b>			
English	...	...	2.62***
Other	...	...	1.00
<b>Demographic characteristics</b>			
<b>Child's age, y</b>			
0 to 5	1.00	1.00	1.00
6 to 12	0.71*	0.73*	0.69*
13 to 17	0.34***	0.37***	0.34***
<b>Child's sex</b>			
Male	1.00	1.00	1.00
Female	1.04	1.01	1.02
<b>Age of oldest parent, y</b>			
<30	1.00	1.00	1.00
$\geq 30$	1.02	0.85	0.88
<b>Child lives with 2 parents</b>			
Yes	1.58**	1.33	1.43*
No	1.00	1.00	1.00
<b>No. of children in family</b>			
	0.95	1.03	1.02
<b>Region of country</b>			
Northeast	1.00	1.00	1.00
Midwest	1.12	1.12	1.14
South	0.55**	0.60*	0.57*
West	0.42***	0.44***	0.43***
<b>Residence in metropolitan statistical area</b>			
Yes	1.08	0.86	0.91
No	1.00	1.00	1.00
<b>Regression statistics</b>			
No.	6108.00	6108.00	6096.00
-2 log-likelihood	3125.92	3027.26	2973.43
P	.00	.00	.00

Note. Data were derived from the 1996 Medical Expenditure Panel Survey Household Component (rounds 1 and 2). FPL=federal poverty line.

\* $P < .05$ ; \*\* $P < .01$ ; \*\*\* $P < .001$ .

usual source of health care and to gauge the extent to which they are related to differences in health insurance status, socioeconomic status, and language ability. Our study showed that Black and Hispanic children are at a substantial disadvantage and that these differences persist even when health insurance and socioeconomic status are held constant. When lan-

guage ability is held constant, however, we find that differences between Hispanic and White children become negligible and that the lower likelihood of having a usual source of care previously found among Hispanic children is largely attributable to those whose parents have difficulty communicating about health care in English. Our results strongly suggest that the

marked Hispanic disadvantage in access to care noted in previous studies may be related to language ability and characteristics associated with being a non-English speaker, including differing knowledge of and beliefs about the health care system and primary care.

Children's health care is a prominent issue on our national health agenda. The State Children's Health Insurance Program devotes \$24 billion to extending health insurance coverage to uninsured children, and this program may help reduce racial and ethnic disparities in children's health by reducing the disproportionately high rates of noncoverage among Black and Hispanic children. The program may have the greatest impact if the coverage provided is implemented so as to ensure that children have a usual source of care, particularly an office-based primary care practitioner, to encourage continuity of care.

In 1998, President Clinton introduced a plan to eliminate health status differences among racial and ethnic groups.<sup>20</sup> While the provision of health insurance may help improve children's health and allow some progress toward reducing racial/ethnic disparities in health, our findings indicate that substantial racial and ethnic differences in children's access to care persist after control for health insurance and socioeconomic status. This suggests that programs aimed at reducing racial and ethnic disparities may most profitably target other characteristics in addition to family income and lack of health insurance. In particular, our findings imply the need for interpreters and bilingual health care providers and office staff to meet the needs of children whose parents are not comfortable interacting with the health care system in English. If one of our national goals is to eliminate racial and ethnic disparities in health care and health status, further study is needed to explore additional societal and health care system factors that may explain these differentials and prove amenable to intervention. □

## Contributors

Both authors planned the study and wrote the paper. R. M. Weinick analyzed the data.

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