

THE CORE REPORT

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Data Brief: Factors Influencing Access to Health Care

This is the second in a series of data briefs highlighting interesting trends in the Consumer Survey data collected as part of the National Core Indicators (www.hsri.org/nci). These briefs showcase provocative and/or unexpected findings. We leave the conclusions regarding what these data suggest to policy makers and stakeholders and introduce these observations in order to stimulate discussion.

This second data snapshot explores the factors that may be related to access to health care including race, access to transportation, presence of a mental health diagnosis and type of living arrangement. The analysis also compares findings from NCI to national norms. Based on an interest among member states to understand the connection between the indicators and results, this brief focuses on the indicators related to health and attempts to explore some of the variables that may be related to access to health care. The indicators covered in the report are:

INDICATORS:

People secure needed health services.

- The proportion of people who have had a physical exam in the past year
- The proportion of women who have had an OB/GYN exam in the past year
- The proportion of people who have had a routine dental exam in the past six months

Medications are managed effectively and appropriately.

- The proportion of people taking medications for mood, anxiety, or behavior problems

These data are presented in order to provoke states to ask additional questions about the implications of these trends. It is important to remember that the data from the National Core Indicators Consumer Survey offer evidence that something significant is happening but do not suggest why the data line up as they do. It is up to policy makers and stakeholders in each state to probe for the antecedent causes. All figures reported here are derived from the NCI Consumer Survey 2003-2004 data collection, which involved sixteen states plus one sub-state region and yielded a total sample size of 9192 respondents.

The results do reveal significant differences in health outcomes between consumers who are white and non-white, among those who live in structured settings and those who live at home, those who do and do not have access to transportation, and between those who have a mental health diagnosis and those who do not.

The results presented below are especially timely given the interest nationally in health outcomes for people with cognitive and other developmental disabilities and the evolving debate about public outlays for health care.

What percent of consumers secure needed health services?

Results for the entire sample are presented in Figure 1. Almost everybody in the NCI sample went to the doctor, and 68% of the women had an OB/GYN exam in the past year. 63% of respondents went to the dentist within the past six months.

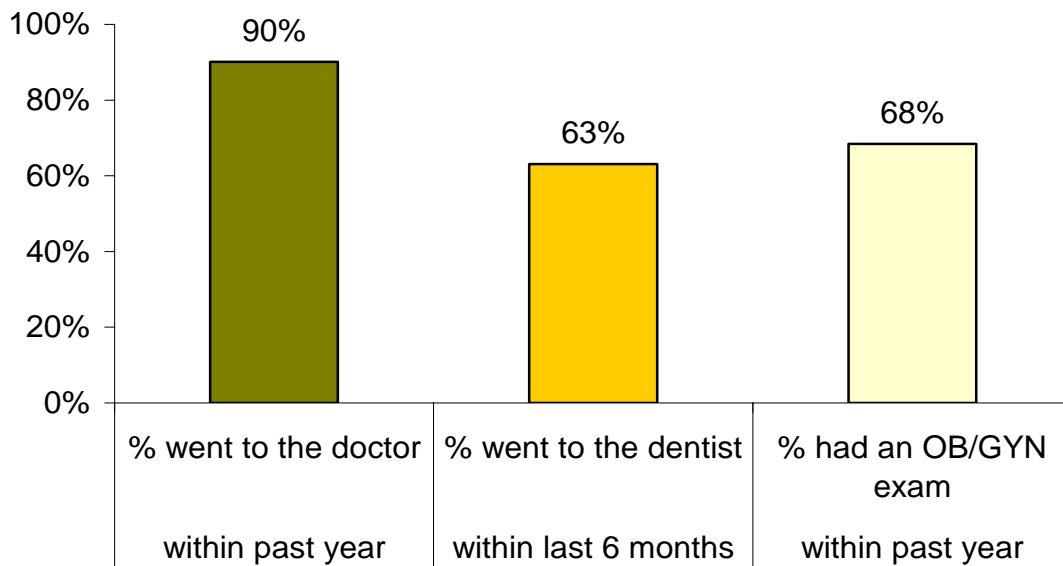


Figure 1. Percent of respondents who had recent physician, dentist and OB/GYN visits

How do NCI health outcomes compare with US general population?

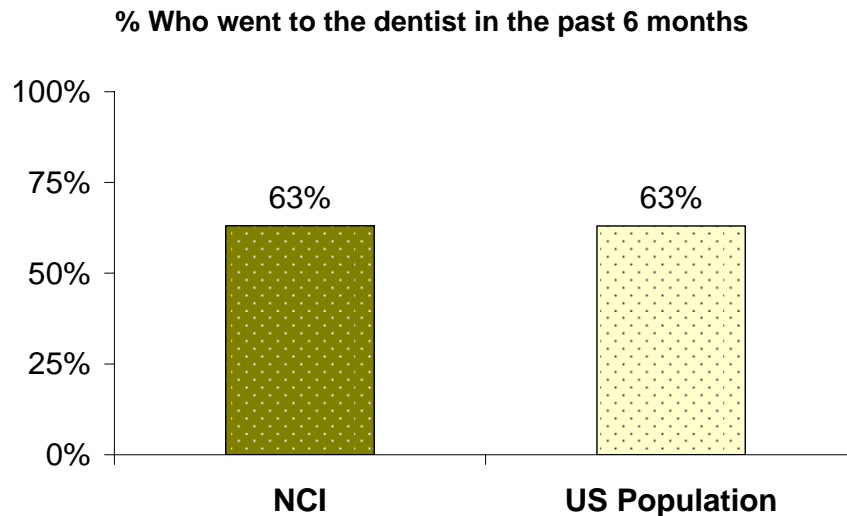


Figure 2. Frequency of dentist visits - NCI vs. US population

SOURCE: Joint Canada/United States Survey of Health, 2002-2003. Note: Survey asks about dentist visit within the past year.

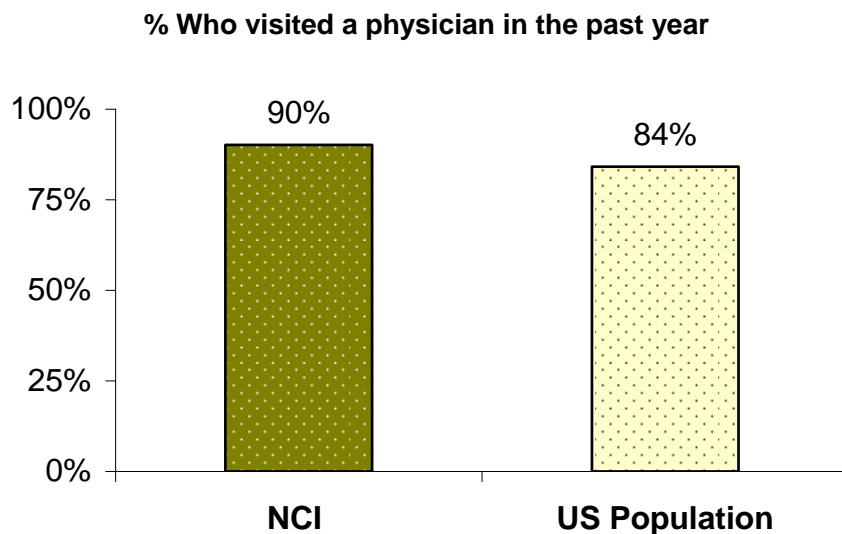


Figure 3. Frequency of visits to physician - NCI vs. US population

SOURCE: National Center for Health Statistics. Health, United States, 2004, With Chartbook on trends in the Health of Americans, Hyattsville, Maryland: 2004

These data strongly suggest that people with cognitive and other developmental disabilities served by public systems have comparable if not better access to health care than the general population (see Figures 2 and 3). However, for certain subgroups, such as racial and ethnic minorities and those individuals living with their families, access is less frequent. These factors are explored in greater detail in the next section.

Are there differences in health care access by type of residence or by race?

The data presented in Figure 4 suggest a connection between race and access to health care. That is, non-white consumers seem to wait longer between visits. Differences between white and non-white respondents are significantly different at the $p < 0.01$ level.

It is important to note that some NCI states have greater racial and ethnic diversity in their state populations and thus in their survey samples. It is not clear from the data whether the apparent racial differences in health care access are a function of racial disparities in health care access for this consumer population, overall disparities in health care access for traditionally disadvantaged minority groups (similar trends are seen in general population data), differences in access across state service systems, or some combination of factors.

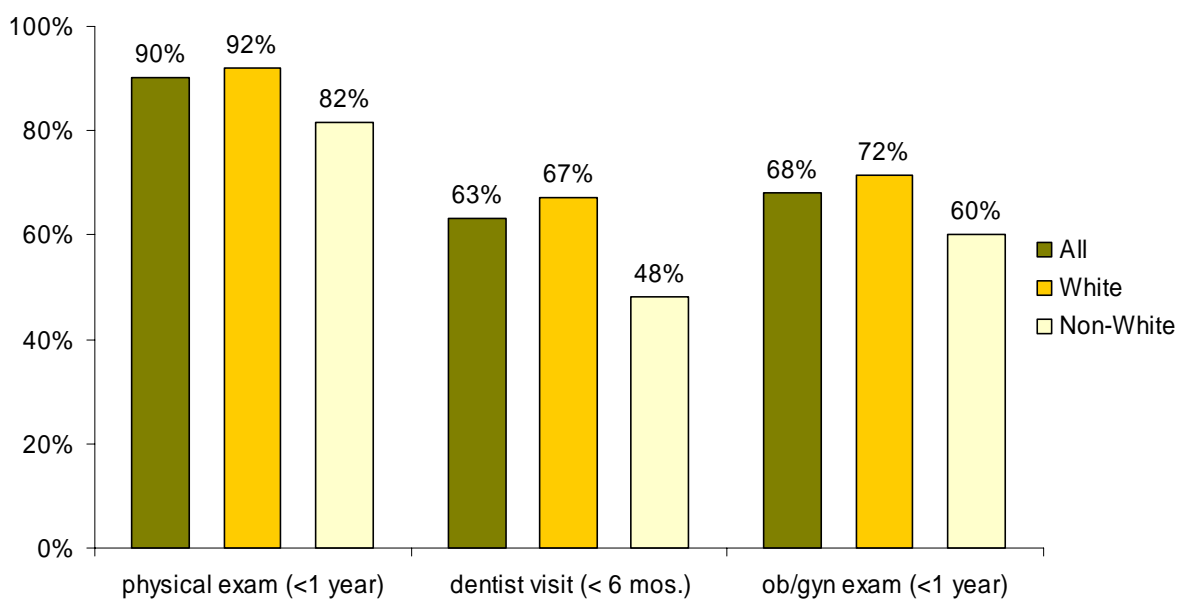


Figure 4. Frequency of physician, dentist and OB/GYN contact, by race of respondents

As shown in Figure 5, frequency of health care visits also seems to be linked to where people live. People living with their families are the least likely to have received health and dentist care in recent periods. Across residential settings the only people who are always significantly different from all others in terms of health care access are people who live with their families.

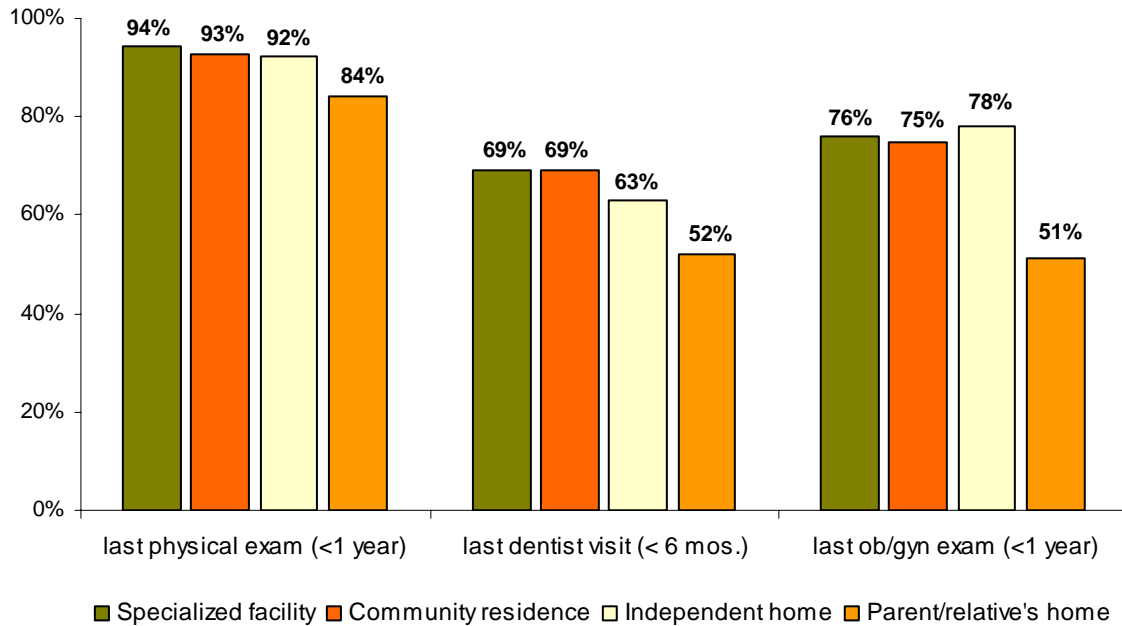


Figure 5. Frequency of physician, dentist and OB/GYN visits by residential setting

If we add race to this equation, health care access rates seem to drop even further for non-white consumers (see Figure 6).

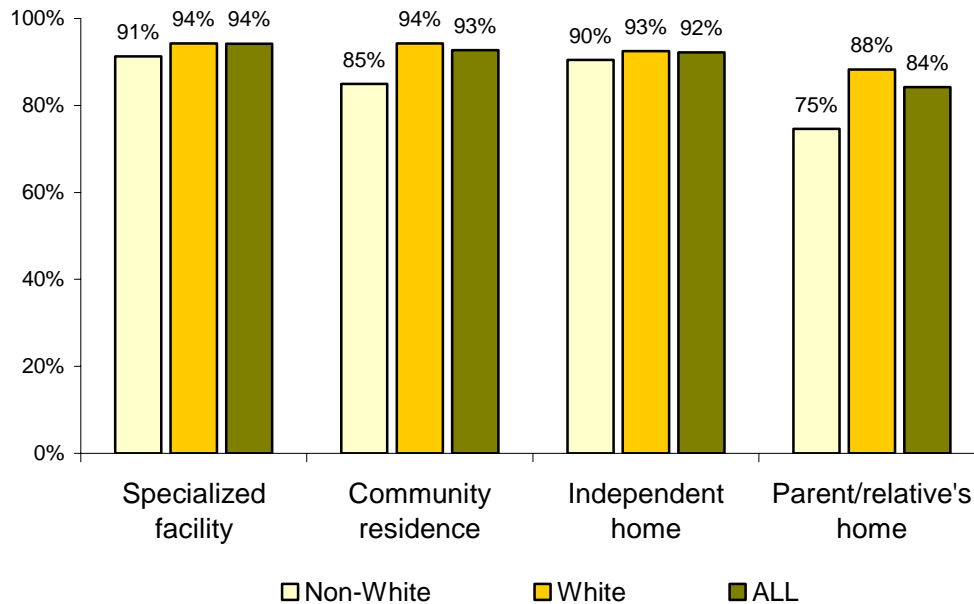


Figure 6. Recent physician visit by residential setting and race (<1 year)

White consumers in specialized facilities and independent homes do not significantly differ from their non-white counterparts when it comes to recent doctor's visits. However, for those living in community residences or parent's homes there is a significant race difference ($p=.05$).

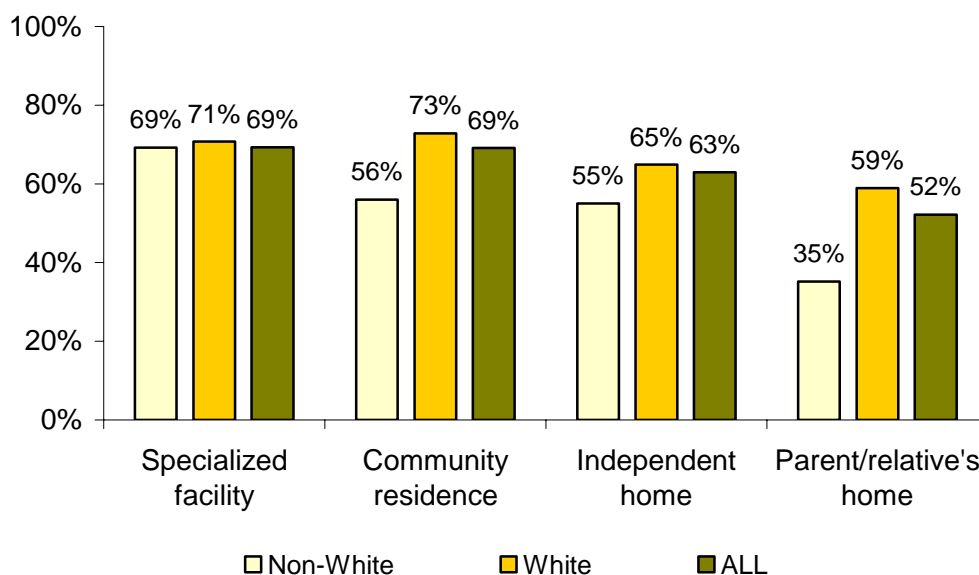


Figure 7. Recent dentist visit by residential setting and race (6 months)

White consumers in specialized facilities go to the dentist with the same frequency as do non-white consumers. However white people in community residences, independent homes or living with their parents are more likely to go to the dentist than non-white ($p=.05$).

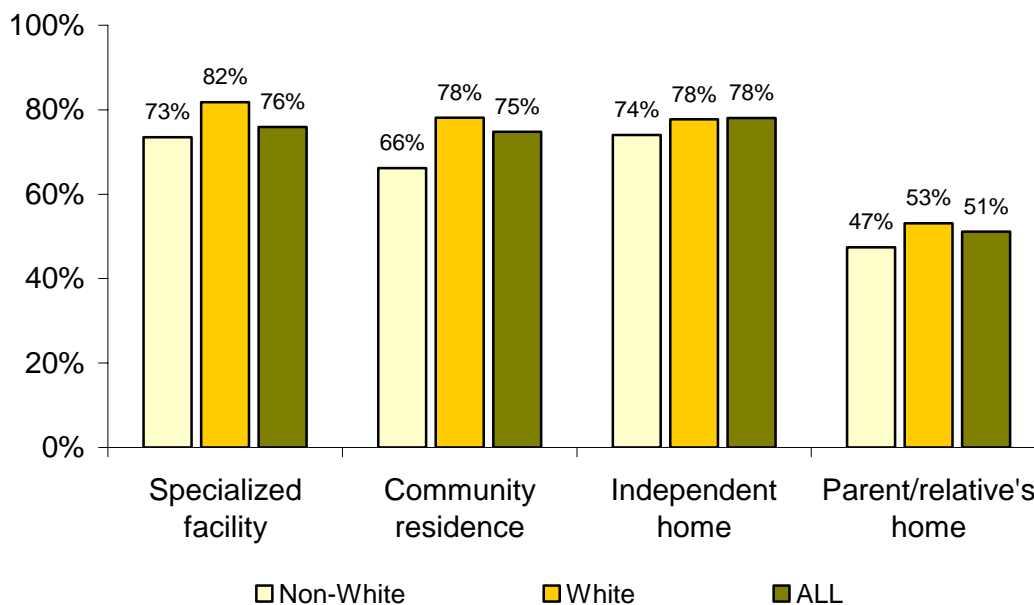


Figure 8. Recent OB/GYN visit by residential setting and race (<1 year)

Both white and non-white consumers living in independent homes are equally likely to have had a recent OB/GYN exam. However in other residential settings, white people are always more likely than their non-white counterpart to have had an OB/GYN exam in recent times ($P = .05$)

Access to Transportation and Health Care Access

Access to transportation may be another factor in limiting access to health care: 30% of people in the sample say they do not have access to transportation. When we align this finding with health care access, a pattern emerges, shown in Figure 9.

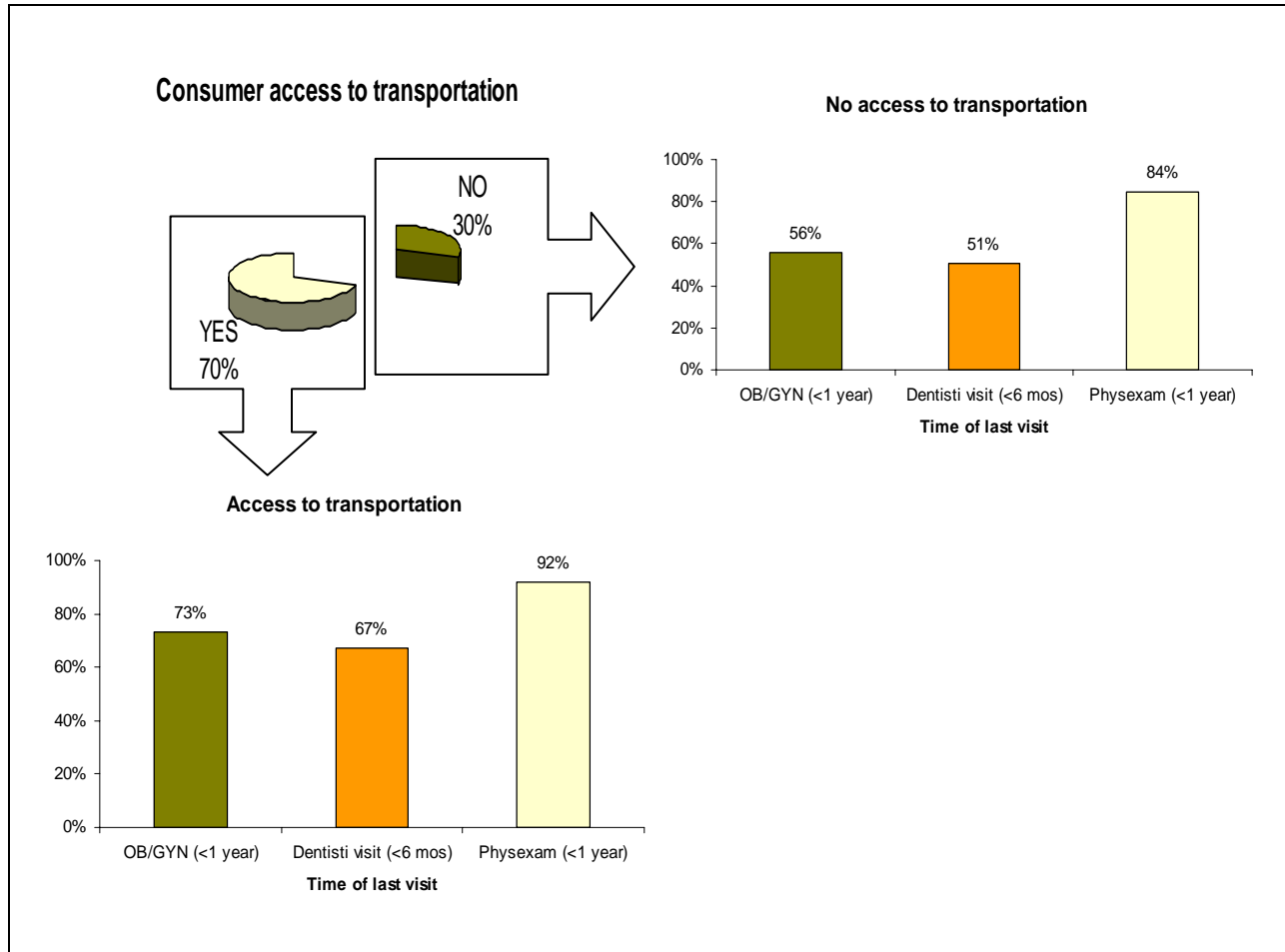


Figure 9. Health care exams received by those with and without access to transportation

Of those without access to transportation, fewer respondents reported having visits to OB/GYNs, physicians and dentists within the recommended time period.

Are there patterns in medication usage for consumers with and without dual diagnosis?

The following tables describe some differences in characteristics and health outcomes for people who have both a mental health diagnosis and a cognitive disability diagnosis.

■ Dual diagnosis ■ Cognitive disability only

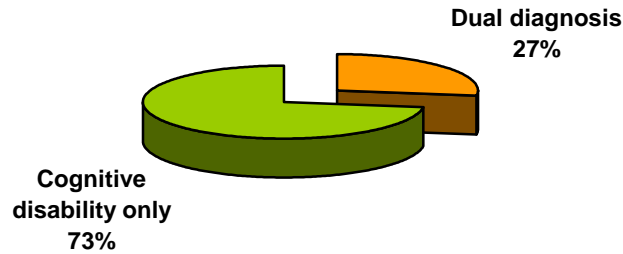


Figure 10. Distribution of Dual and Cognitive disability only diagnosis

As shown in Figure 10, 73% of the sample does not have a dual diagnosis. Figure 11 shows that those who do have a dual diagnosis are much less likely to live with their families than those with only a diagnosis of cognitive or other developmental disability (18% vs. 42%).

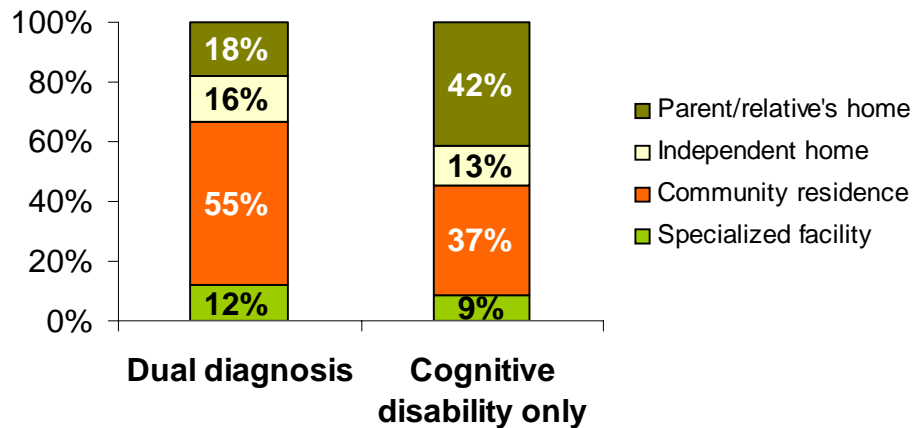


Figure 11. Type of diagnosis by residential setting

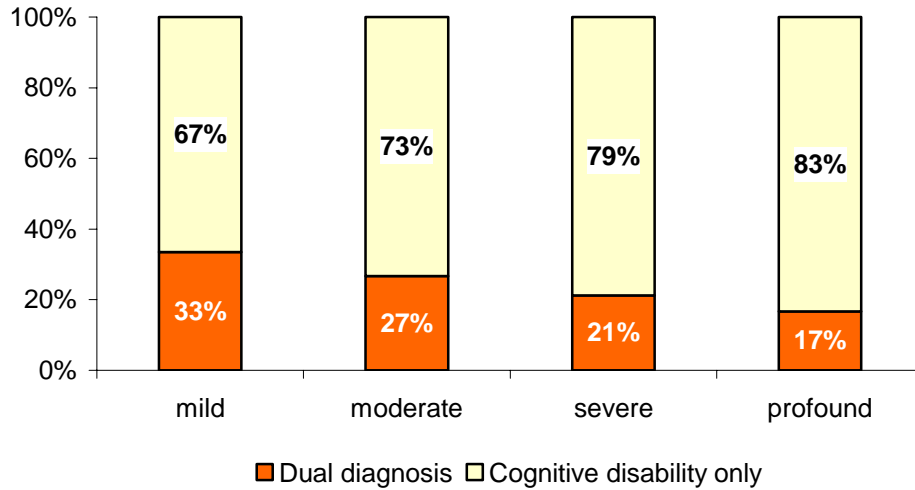


Figure 12. % Consumers with Dual or Cognitive only diagnosis by degree of cognitive limitation

Figure 12 presents the breakdown of the sample by diagnosis and by degree of cognitive limitation. People with mild cognitive disabilities are more likely to have been diagnosed with co-occurring mental illness.

Almost 2/3 (59%) of the sample do not take any kind of psychotropic medications. A little over 1/3 take psychotropic medications, either of one kind or a combination.

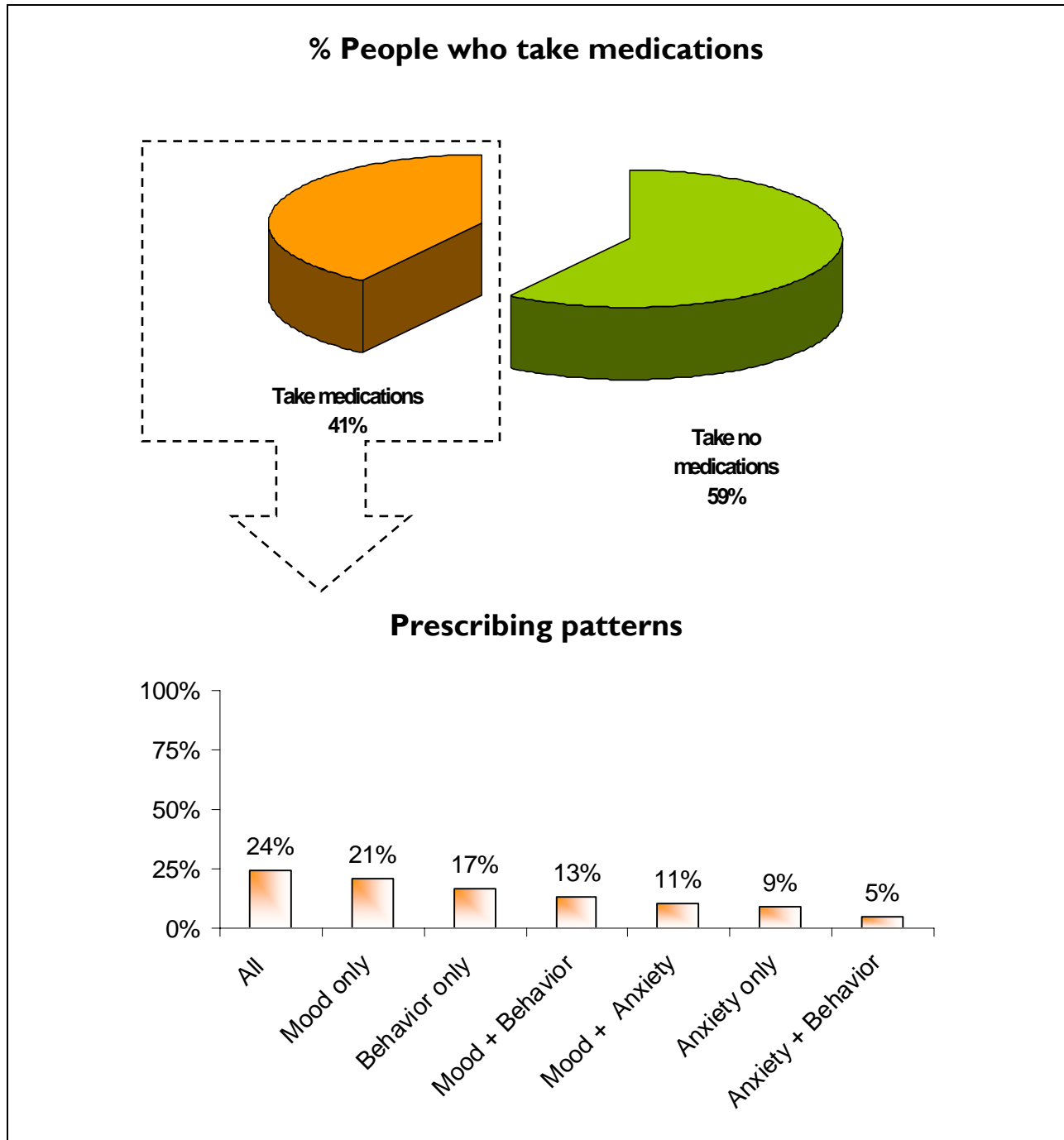


Figure 13. Patterns of medication usage

Three types of medications are asked about on the survey: medications for mood, behavior, or anxiety. If we focus in on those who **do** take medications, we see that the 24% of our sample takes all three types of psychotropic medications at the same time (see Figure 13). Mood and behavioral medications are also very commonly prescribed (21% and 17% respectively). Over the years, prescribing patterns for the NCI sample have varied very little.

If we break down the analysis to look at the dual diagnosis versus the cognitive disability only group, we observe that:

75% of the consumers with cognitive and other developmental disabilities only and 15% of those with dual diagnosis do not take any kind of psychotropic medication, while 85% of those with a dual diagnosis take at least one kind of psychotropic medication (see Figure 14).

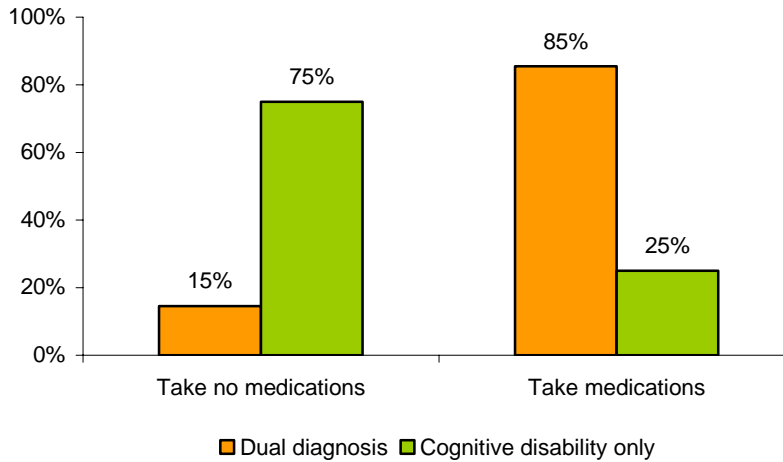


Figure 14. Psychotropic medication usage by type of diagnosis

Figure 15 shows that of those who take medications, it seems to be very common for people with dual diagnosis (23% of the sample) to take all three kinds of psychotropic medications, and 19% take medications for mood disorders alone. Three quarters of consumers with a cognitive disability only do not take any of the three types of psychotropic medications. Of the remaining consumers with a cognitive disability only, 5 percent reportedly take all three kinds of medications, and 6 percent take medication for behavior problems.

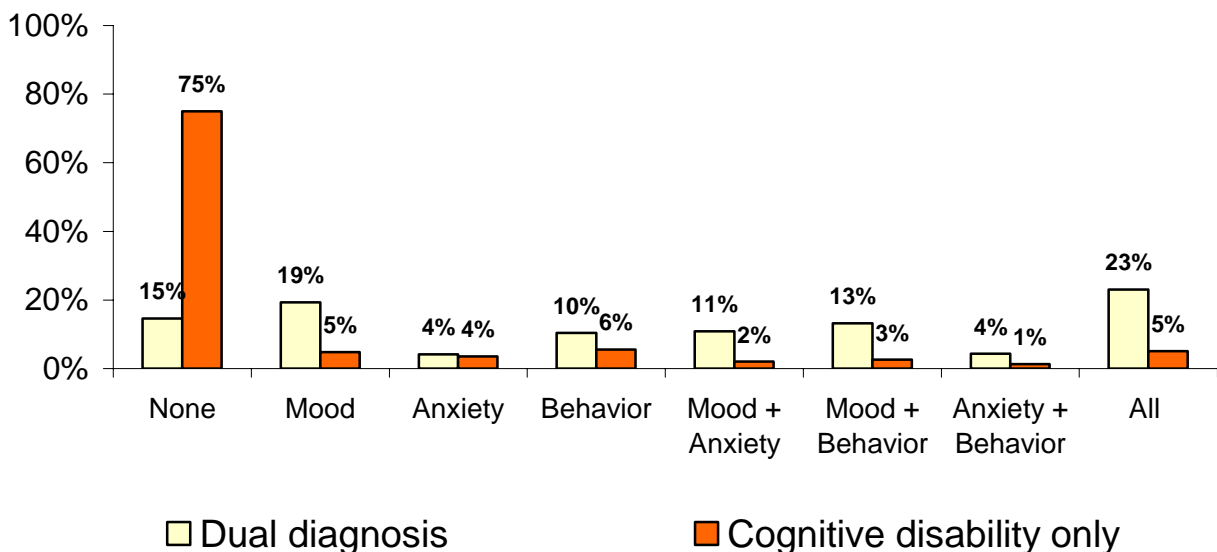


Figure 15. Type and number of medication(s) taken by type of diagnosis

Observations

These data present interesting questions about potential racial disparities in access to health care, the role of transportation in securing health care access, and the possible need to examine access for people living at home. They also pose important questions about the use of psychotropic medication for people with and without a mental health diagnosis.

For the first time, we have also presented comparisons with national norms, in this case with respect to health care utilization. The comparisons would suggest – at least with respect to these highly general measures – that people served by public agencies are getting at least the same level of access to health care that is experienced by the general population.

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