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Access to Health Care Services for Adults in Maine

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Access to Health Care Services for Adults in Maine

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INTRODUCTION

The ability to access needed health care services is an important factor in the health and well-being of Maine's residents. Having a personal doctor, obtaining regular preventive check-ups and screenings, and being able to see a provider when health care is needed are each associated with better health outcomes. Yet, access to care is not uniform across all Maine populations, and some groups are at high risk of not getting the care that they need. This may, in turn, lead to unequal health care outcomes for these groups over the long-term.

This brief uses Maine's Behavioral Risk Factor Surveillance System (BRFSS) data for the years 2012-2014 to examine disparities in health care access among Maine adults ages 18-64. BRFSS is Maine's longest running and largest survey used to monitor population health statistics over time for a wide range of topics including chronic disease prevalence, health behaviors, and health care access. More details about the BRFSS and the analyses used for this project are available in the Methods Note at the end of this brief.

FINDINGS

Lower Incomes are Associated with Lower Health Care Access

Income is strongly associated with a wide variety of health care access measures, including whether or not an individual has a regular health care provider—a cornerstone of receiving ongoing and appropriate care (Figure 1). Compared to those in households earning \$50,000 per year or more, individuals with household incomes below \$25,000 are more than twice as likely to lack a regular provider (17.3% versus 7.5% for those with higher incomes).

In addition to lacking a regular health care provider, individuals at lower ends of the income scale are much more likely to go without health care services. For example, individuals in households earning below \$25,000 are more than three times as likely as those in households with income of at least \$50,000 to have delayed seeking health care services that they needed because of the cost (18.5% versus 5.2%; Figure 2). Lower income is also strongly associated with an individual being unable to take a medication as prescribed because of the cost (only 3% of those in the highest bracket experienced this problem, compared to nearly 15% in the lowest income bracket).

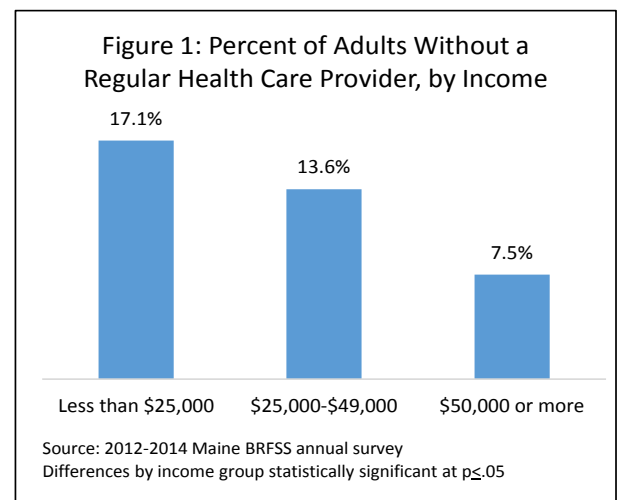


Figure 2: Percent of Adults Going Without Care or Paying Health Care Bills Over Time, by Income			
	Family Income		
	<\$25,000	\$25,000-49,999	\$50,000+
Delayed needed care because of cost*	18.5%	11.9%	5.2%
Did not take medication because of cost* [^]	14.6%	9.2%	3.1%
Delayed needed care because of non-cost reason* [^]	24.3%	16.0%	11.1%
Health care bills being paid off over time* [^]	26.7%	28.6%	19.6%

Source: 2012-2014 Maine BRFSS
 * Statistically significant income differences at $p \leq .01$
 ^ Available in 2014 only

These problems of delayed medical services and barriers to prescription use among individuals with low income are almost certainly related to high uninsured rates. Compared to individuals in households of \$50,000 or more, those whose families earn less than \$25,000 are more than five times as likely to be uninsured (4.5% versus 23.4%).

In addition to barriers related to the cost of care, individuals with low income report other challenges to obtaining needed health care services (24.3% and 11.1% for the lowest and highest income groups, respectively). These barriers include problems with transportation, with getting appointments at a time when individuals can get there, and having to wait too long for an appointment (see Methods Note for more detail on this measure). Although not directly related to the cost of care, individuals in low income households may have unreliable vehicles, or may work in jobs that don't offer paid time off or flexible hours for medical care.

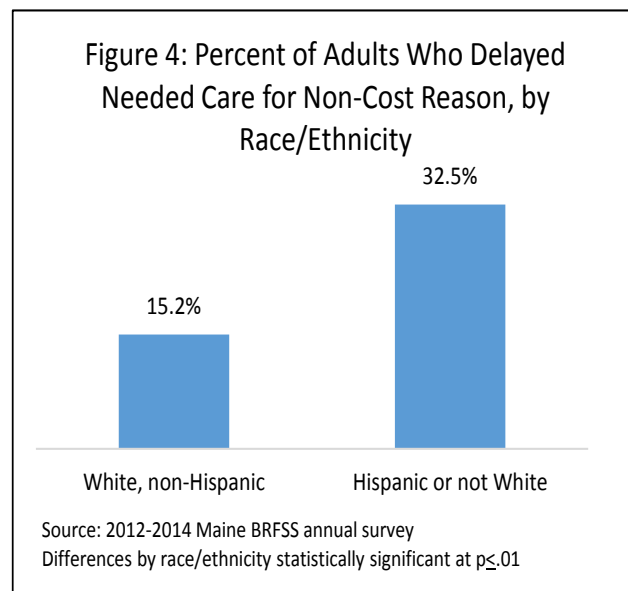
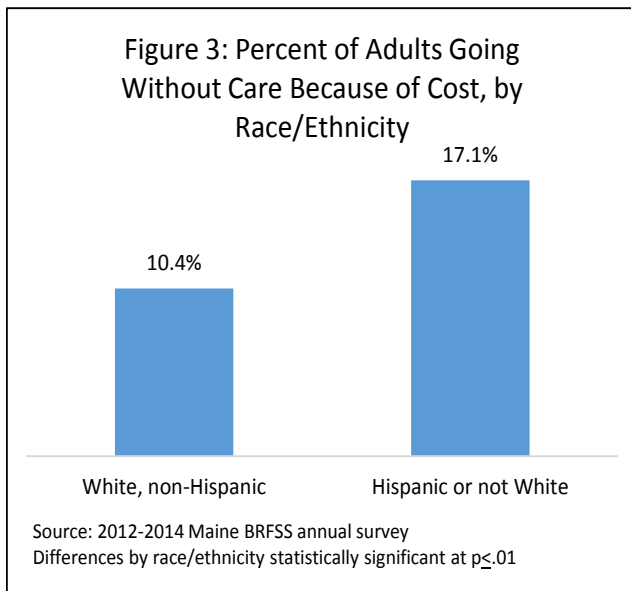
Interestingly, individuals of all income levels report problems with paying medical bills over time. While the rates for individuals with incomes below \$25,000 (26.7%) and those between \$25,000 and \$50,000 (28.6%) aren't statistically different from each other, each is higher than the rate for those earning above \$50,000 (19.6%). Still, the fact that between one-fourth and just over one-fifth of each income

group is paying for medical care over time suggests that medical debt is an issue for a large segment of Maine's adult population.

Mainers from Racial or Ethnic Minorities have Poorer Health Care Access

The BRFSS survey asks individuals to identify their race from an extensive list of options, and also to indicate whether or not they are of Hispanic ethnicity. Given Maine's demographics and the number of BRFSS respondents, these analyses could not support a nuanced examination of different racial and ethnic minority groups. Instead, those reporting a race other than White, or reporting Hispanic ethnicity are aggregated into the category "Hispanic or Not White." Thus, to the extent that different minority groups have different health care experiences (e.g., tribal populations versus refugee or immigrant groups), those differences are not able to be shown.

Compared to White, non-Hispanic adults, members of racial or ethnic minority groups are twice as likely to lack a regular health care provider (21% versus 12%). They are also less likely to have had a check-up in the prior year (66% versus 72%). As shown in Figure 3, 17% of racial and ethnic minorities have gone without care in the prior year because of cost, compared to 10% of non-Hispanic Whites.



Some of this disparity in access may be driven by health insurance coverage since racial and ethnic minority groups have a higher uninsured rate than non-Hispanic Whites (19% versus 12% in 2013-2014). Even more striking than cost barriers, however, is that close to one-third of non-White or Hispanic adults indicate that they have delayed care for reasons other than cost (33% versus 15% for White, non-Hispanic adults, see Figure 4). The reported reasons for these delays include problems reaching the provider or getting an appointment as well as lack of transportation. This suggests that individuals from racial and ethnic minority groups face structural as well as financial barriers to care.

Because of insufficient numbers, the role of race/ethnicity in paying medical bills over time or in not using medication as prescribed could not be tested.

Individuals with Lower Education Have Poorer Health Care Access

Similar to household income, an adult’s educational attainment is associated with his or her access to health care services. For example, 19% of adults who have not

graduated from high school lack a personal health care provider, compared to 14% of high school graduates and only 8% of college graduates (Figure 5).

Individuals with greater education also were more likely to have a routine check-up in the past year (75% of college graduates versus only 67% of those who didn’t graduate from high school, data not shown).

Education is also associated with delays in getting needed health care, both because of costs and for other reasons (Figure 6). For each of these two measures, statistical tests suggest that there may not be real differences between those with less than a high school education, those who graduated from high school, and those with some college. However, being a college graduate places a Maine adult at much lower risk of delaying care for cost and non-cost reasons compared to each of the other three groups.

As with income, the strong association between education level and uninsured rates is likely a factor in poorer access for those with less education. As education level increases across the four groups, the uninsured rate decreases, ranging from 23% among those with less than a

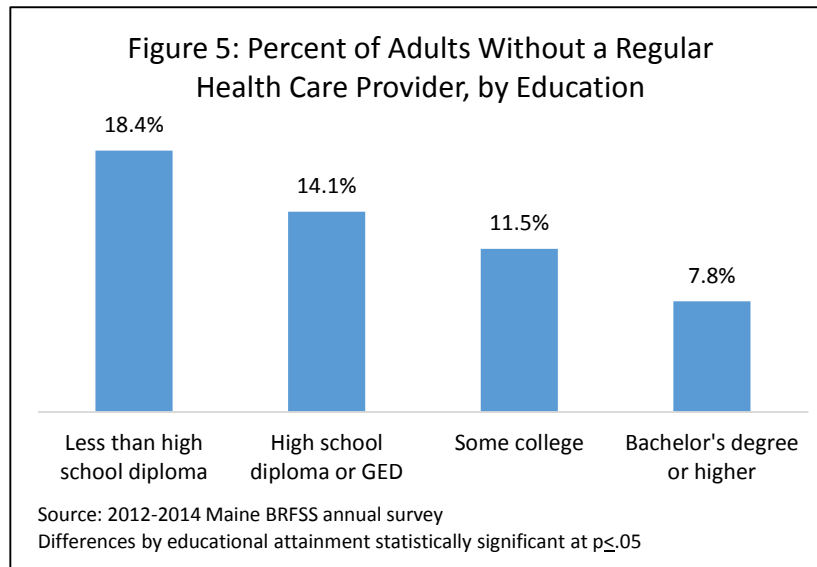


Figure 6: Percent of Adults With Delays in Obtaining Health Care and Uninsured Rate, by Education

	Family Income			
	Less than high school	High school/ GED	Some college	College graduate or more
Delayed needed care because of cost*	14.2% (11.7-16.7)	12.2% (11.2-13.1)	11.4% (10.5-12.4)	6.5% (5.9-7.1)
Delayed needed care for a non-cost reason*^	23.2% (16.3-30.1)	17.0% (14.5%-19.5%)	17.0% (14.3-19.7)	11.5% (9.8-13.2)
Uninsured in 2013-2014*	22.8% (18.3-27.3)	16.2% (14.6-17.8)	11.1% (9.6-12.6)	4.7% (3.9-5.5)

Source: 2012-2014 Maine BRFSS
* Statistically significant education differences at $p \leq .01$
^ Available in 2014 only

high school diploma to only 5% among those with at least a college education. Yet, as with other populations, lower education is associated with non-financial barriers to care as well, such as problems getting appointments at available times or in getting transportation to the provider (see Methods Note for more detail on this measure).

Younger Adults are More Likely to Lack a Usual Source of Care and to Report Cost Problems than Those at Older Ages

Younger adults are more likely to lack routine care or to report that they have delayed care because of costs (Figure 7). Nearly one-quarter

of adults aged 18-24 and 25-34 do not have a regular health care provider (24% and 23%, respectively), a rate nearly two to three times greater than for other non-elderly adults, and more than six times higher than for the elderly (ages 65 and up). Reflecting this, they are also less likely to have had a checkup within the past year. Only 62% of adults aged 18-24 and 57% of those 25-34 had a checkup, compared to higher rates among older adults, with 89% of adults aged 65 and over reporting getting a check up.

Seventeen percent of adults aged 25-34 reported that they had delayed needed health care services within the past year due to costs. Statistical tests indicate this rate does not differ

Figure 7: Percent of Adults and Access to Care, by Age

	Age Group					
	18-24	25-34	35-44	45-54	55-64	65 & Over
No regular health care provider*	24.3% (21.5-27.0)	23.3% (21.0-25.5)	13.8% (12.2-15.4)	10.4% (9.2-11.5)	7.9% (7.0-8.7)	3.5% (2.9-3.0)
Had a checkup in the past year*	61.6% (58.4-64.7)	56.9% (54.3-59.3)	61.5% (59.3-63.6)	70.1 (68.5-71.8)	78.4% (77.2-79.7)	87.8% (87.0-89.0)
Delayed needed care because of cost*	12.9% (11.0-15.1)	16.7% (14.7-18.7)	13.9% (12.3-15.5)	13.4% (12.1-14.6)	9.7% (8.8-10.7)	2.3% (1.9-2.7)

Source: 2012-2014 Maine BRFSS

* Statistically significant age group differences at $p \leq .01$

statistically from that of 18-24 year olds or 35-44 year olds, but is higher than that of 45-54 year olds (13%), 55-64 year olds (10%) and the over 65 group (2%). As with other groups at risk of access problems, this is likely related to health insurance coverage for younger adults. For example, 22% of adults 25-34 are uninsured compared to rates that range from 12% to 14% for adults aged 35-64 (data not shown).

METHODS NOTE

This brief is based on data from the 2012-2014 Behavioral Risk Factor Surveillance System (BRFSS). In 2012, 2013 and 2014, the full BRFSS samples for Maine were 9,876, 8,097 and 9,137 respectively for a total of 27,110 respondents that completed interviews over the combined three years. Because BRFSS questions vary across years, some measures are presented for a single year or pair of years (for example, certain access questions were asked only in 2014). For other measures, particularly when comparing different sociodemographic groups, multiple years are pooled to ensure sufficient sample for these sub-analyses.

Some questions used in these analyses appear in the BRFSS Core, which is standard across states and administered to all respondents. Other questions appear in optional modules, such as the health care access and coverage module that includes a series of questions related to problems or delays in obtaining needed care.

One of these questions focuses specifically on the cost of health care services, while another asks about reasons other than costs. Response options for the latter include being unable to reach the provider by phone, being unable to get an appointment soon enough, having to wait too long in the office, provider office hours, and transportation problems. Because of small sample sizes, in this brief these options have been collapsed into a single measure that indicates whether the individual had any non-cost related delay in care.

Because the BRFSS uses a complex sampling strategy, all analyses for this brief use sample weights to correct for stratification. The statistical testing and confidence intervals produced by these analyses account for the BRFSS' complex design. All reported differences reported are statistically significant at the $p \leq .05$ level unless otherwise noted. In some cases, a difference may be statistically significant across the full range of a category but not between certain groups within that category. In these cases, 95% confidence intervals are presented for each group and the text clarifies whether significant differences exist between subgroups. Statistical significance p-values appear below figures with an * and 95% confidence intervals for some estimates are presented in parentheses ().