

Racial and Ethnic Disparities in Health and Access to Care Among Older Adolescents

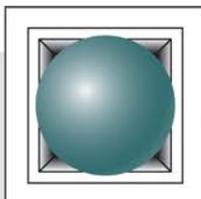
By Harriette B. Fox, Margaret A. McManus, Matthew Zarit, Amy E. Cassidy, and Gerry Fairbrother¹

There are more than 15 million older adolescents ages 18 through 21 in the United States. This number is projected to increase to 20 million by 2040, with the largest growth occurring among Hispanics and in Western states where most Hispanics reside.² Currently, Hispanics ages 18 through 21 comprise 16% of this age group and Blacks comprise 15%. While the proportion of Blacks is not expected to increase by 2040, the proportion of Hispanics is expected to rise to 27%.³ Importantly, more than half of all Hispanic and Black older adolescents, compared to almost a third of all Whites, have incomes at or below 200% of poverty.⁴

Uninsurance rates among all 18 through 21 year olds are high -- as high as 27% compared to 16% for Americans overall -- yet among minorities in this age group uninsurance rates are significantly higher.⁵ A staggering 55% of Hispanics and 32% of Blacks are without health insurance for all or part of the year, compared to 25% of Whites. Although rates of uninsurance increase with each year for older adolescents, age 19 is the biggest insurance "cliff." There are several reasons for this, most of which disproportionately affect minorities. One of the most important is loss of eligibility for public health

insurance coverage. Medicaid and the State Children's Health Insurance Programs (SCHIP) typically terminate coverage for children at age 19. At the same time, employers of low-wage workers frequently provide no health insurance benefits. Among older adolescents who are employed and have incomes at or below 200% of poverty, 45% are uninsured.⁶ Moreover, those who previously had insurance as dependents through their parents' employers are likely to be dropped from coverage, since most employers no longer insure adolescents unless they are full-time students. Even assuming their parents' employers provided dependent coverage, only 32% of Blacks and 25% of Hispanics attend college.⁷

Studies rarely address minority issues in health status and access to care for adolescents in the 18 through 21 age group. Rather, a number of studies examine insurance status^{8,9,10,11,12} and health care access and use^{13,14,15,16} for young adults ages 18 or 19 through 23 or 24. We found one study that examined rates of having a usual source of care among minorities ages 18 through 23 and reported rates of only 59% for Blacks and 50% for Hispanics compared to 71% for Whites, but the inclusion of the over-21 age group may have



led to findings that do not apply to older adolescents alone,¹⁷ given the consistent documentation of higher rates of uninsurance among young adults.¹⁸

This fact sheet presents new national information on disparities and health status and access to care among Hispanic, Black, and White adolescents ages 18 through 21. A set of 5 widely used indicators was selected to assess whether income, insurance, and mother's education explain racial and ethnic differences. A companion fact sheet is available for adolescents ages 12 through 17.¹⁹ A subsequent fact sheet will address disparities in environmental and behavioral risks affecting high school students.

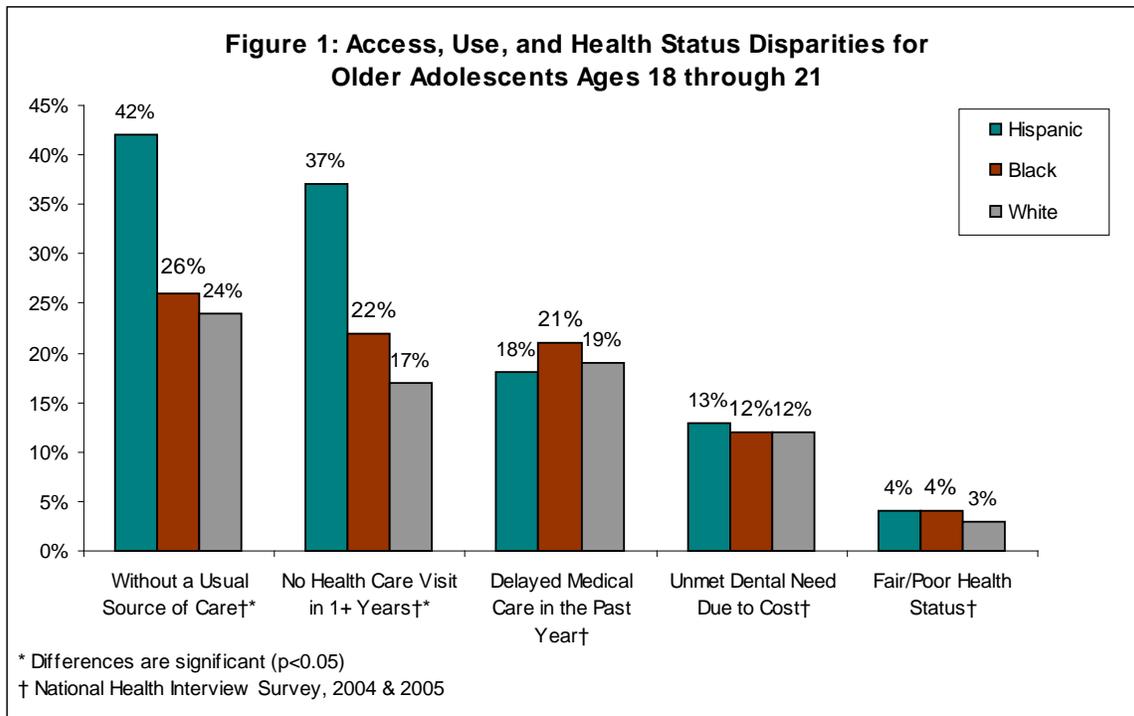
Methodology

A pooled sample from the 2004 and 2005 National Health Interview Survey (NHIS) was used for this analysis. The NHIS is an annual in-person household survey that collects nationally representative information for the US civilian, non-institutionalized population on access to care, utilization, and health status.²⁰ Older adolescents, unlike those ages 12 through 17, respond to survey questions for themselves.

The relationship of race and ethnicity was analyzed for a set of five measures -- without a usual source of care, no health visit in one or more years, delayed medical care in the past year, unmet dental care needs due to costs, and fair or poor health. For the purpose of this fact sheet, race and ethnicity was restricted to Hispanic, non-Hispanic Black, and non-Hispanic White older adolescents. Multivariate analyses were conducted to adjust for contributing factors pertaining to income, insurance status, and mother's education. Copies of the complete equations are available from Incenter Strategies. The fact sheet also includes a comparison of findings for adolescents 12 through 17 and older adolescents ages 18 through 21. The reader should bear in mind, however, that respondents for adolescents ages 12 through 17 were parents who may be unaware of the health care services used or needed by their teens. All differences reported as significant are significant at the .05 level or higher.

Disparities in Access to Care, Utilization, and Health Status

Having a usual source of care is considered a basic element of primary care. Unfortunately, a large segment of all older adolescents, but



especially Hispanic adolescents, are without a usual source of care, as shown in Figure 1. Almost half of all Hispanics ages 18 through 21 report having no usual source of care compared to about a quarter of Blacks and Whites. Among those who do have a usual source of care, physician offices are the main site of care, although both Hispanics and Blacks are more likely than Whites to rely on clinics.

Hispanic adolescents ages 18 through 21 are also more likely to have gone at least a year without seeing a health professional -- in fact, more than twice as likely as Whites. Black adolescents, too, are more likely than Whites to have gone at least a year without seeing a health professional, but while the differences are noteworthy, they are less dramatic than for Hispanics.

Surprisingly, despite significant racial and ethnic disparities in usual source of care and going one or more years without a health professional contact, older Hispanic adolescents are no more likely than Whites or Blacks to report delaying medical care in the past year. Similarly, there are no significant differences by race and ethnicity for unmet dental needs due to cost, which may suggest a lack of awareness about recommended medical and dental care requirements and also a lack of perceived need.

Moreover, no significant differences among older adolescents were found in general health status as reported by Hispanics, Blacks, and Whites, which may be more a reflection of the absence of acute illness than an accurate characterization of older adolescents' well-being.

Comparison to Adolescents Ages 12 Through 17

For 2 of the 5 measures -- no usual source of care and going a year or longer without seeing a health professional -- we were able to compare findings for older adolescents ages 18 through 21 to those of adolescents ages 12 through 17. Patterns of racial and ethnic disparities are similar: for both age groups, Hispanics are far less likely to have a usual source of care, while Blacks, but especially Hispanics, are more likely to have gone a year or longer without seeing a health professional, as shown in Table 1. On both access measures, rates are worse for older adolescents irrespective of race and ethnicity. Rate changes for being without a usual source of care are greater, however, and are most dramatic for Whites.

Explanatory Factors

To determine what factors might explain the racial and ethnic disparities we found for usual source of care and not seeing a health professional, we examined the independent role of health insurance coverage, income, and mother's education through a multivariate analysis. For the usual source of care measure, we found that being Hispanic remains significant but that being Black does not. Yet, being without insurance is the strongest predictive influence, as shown in Table 2. For the health professional visit measure, being either Black or Hispanic remains significant, although the odds ratios for Hispanics are

| Table 1. Access Indicators Showing Racial and Ethnic Disparities for Adolescents Ages 12 through 17 and Older Adolescents 18 through 21 | | | | |
|--|--------------------------------|-------|----------------------------------|-------|
| Race/Ethnicity | Without a Usual Source of Care | | No Health Care Visit in 1+ Years | |
| | 12-17 | 18-21 | 12-17 | 18-21 |
| Hispanic | 14% | 42% | 23% | 37% |
| Black | 7% | 26% | 14% | 22% |
| White | 5% | 24% | 9% | 17% |

National Health Interview Survey, 2004 & 2005

| Table 2. Logistic Regression Analysis for Access Indicators Showing Racial and Ethnic Disparities for Older Adolescents 18 Through 21 | | |
|---|--------------------------------|----------------------------------|
| Independent Variables | Without a Usual Source of Care | No Health Care Visit in 1+ Years |
| Race/Ethnicity | | |
| Hispanic Unadjusted | 2.3* | 2.7* |
| Hispanic Adjusted | 1.6* | 2.1* |
| Black Unadjusted | 1.3 | 1.4* |
| Black Adjusted | 1.1 | 1.4* |
| White | 1.0 | 1.0 |
| Health Insurance Coverage | | |
| Uninsured | 5.4* | 2.6* |
| Public | 1.0 | 0.5* |
| Private | 1.0 | 1.0 |
| Highest Education Level | | |
| Less than High School | 1.4 | 1.7* |
| High School | 1.0 | 0.9 |
| More than High School | 1.0 | 1.0 |
| Federal Poverty Level (FPL) | | |
| 0-99% FPL | 1.1 | 1.2 |
| 100-199% FPL | 1.0 | 1.0 |
| 200-299% FPL | 1.0 | 1.0 |
| 300% FPL or greater | 1.0 | 1.0 |

* Differences are significant (p<0.05)

National Health Interview Survey, 2004 & 2005

greater. Again, however, insurance holds the most predictive significance. Having a mother with less than a high school education shows significance as well, while having public insurance is a protective factor.

Looking at all of the indicators, including those for which racial and ethnic differences were not found, the strong predictive influence of insurance is revealed. Health insurance coverage, more than any demographic factor, is associated with negative findings for health status and access to care. Importantly also, for some measures -- unmet dental needs due to cost, delayed medical care for a year or longer, and self-reported fair or poor health -- having public insurance is also a strong explanatory factor for negative findings. For others -- not seeing a health professional, unmet dental needs due to cost, and self-reported fair or poor health -- having a mother with less than a high school education also shows some predictive influence.

Conclusion

Although our findings showed fewer racial and ethnic differences among older adolescents than expected for the health status and access to care indicators examined, we did find significant disparities for being without a usual source of care and going a year or longer without seeing a health professional. Compared to Whites, older Hispanic adolescents are at significantly greater risk for having no usual source of care and also having no contact with a health professional in the past year. However, older adolescents, regardless of their racial and ethnic backgrounds, fare much worse on both of these access measures than younger adolescents.

Our multivariate analysis revealed that being without health insurance is the strongest explanatory factor for these disparities. In fact, uninsurance holds the strongest predictive

influence for negative findings for each of the five measures. When insurance status is taken into account, disparities decrease. Given that over half of older Black and Hispanic adolescents without health insurance are in families with incomes below 200% of poverty, expanding Medicaid and SCHIP would be the most effective means of providing them coverage, but would require Congressional action. Currently, SCHIP coverage is limited by federal statute to children up to age 19 and, while the Medicaid statute permits states to cover children up to age 20 or 21 who meet the 1996 financial eligibility standards for AFDC, only 16 have chosen to do so.²¹ Efforts to increase the availability of employer-sponsored dependent coverage, regardless of student status, would likely require federal tax incentives, as well as state mandates for insurers, if they are to affect self-insured employers, but would ultimately have less impact on uninsurance among Blacks and Hispanics. Minority adults have higher rates of uninsurance than Whites and are more likely to work in jobs without benefits.²² Older minority adolescents would only benefit from a public-private health insurance strategy if it were broad enough to cover their parents. Of course, initiatives to ensure that all college students are insured through their academic institutions could also have some impact on uninsurance if subsidies were available to those on financial scholarships.

However, our results suggest that more than insurance is needed. Almost all older adolescents perceive that they are healthy. We found only a small percentage who characterize themselves as in fair or poor health, despite their high rates of unintended pregnancy, sexually transmitted infections, substance abuse, injuries, and chronic physical

and mental health conditions.^{23,24} We found also through the multivariate analysis that being Hispanic or Black appears to be associated with lower rates of delayed medical care and unmet dental care needs, suggesting a lack of knowledge about appropriate medical and dental care. Creative strategies are needed to encourage older adolescents, especially Hispanics and Blacks, to seek care both for preventive and acute care needs.

Moreover, the fact that negative findings on most of the health care access measures were to some extent associated with having public insurance also suggests that improving insurance is not enough. Older adolescents need a medical home that meets their needs and concerns, which at this age are primarily behavioral risk reduction and health promotion and less medical. Unfortunately, as our findings reveal, one out of two Hispanics and one out of four Blacks and Whites ages 18 through 21 have no usual site of care. Most have aged out of pediatric care but have not found a teen- or young adult-friendly site of care that focuses on wellness and risk reduction, that offers behavioral and reproductive services, is inviting to males as well as to females, and that respects cultural norms and confidentiality.²⁵

The transition to adulthood is a complex process for all youth, but especially for racial and ethnic minorities. New attention is needed at the federal, state, and community levels to correct the disconnectedness of health services and financing experienced by this vulnerable population. Adolescents, families, primary care providers, managed care plans, and insurers need to plan in advance to ensure an orderly transition into health care and coverage that adequately meets their unique needs.

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Endnotes

- ¹ Margaret McManus, Harriette Fox, and Matthew Zarit are from Incenter Strategies in Washington, DC. Amy Cassedy and Gerry Fairbrother are from Cincinnati Children's Hospital Medical Center.
- ² U.S. Census Bureau, Population Division, Population Projection Branch. Question and Answer Center. Last Revised: January 7, 2004. Available at www.census.gov/population/www/projections/natdet-D1A.html. Accessed December 2006.
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- ⁶ Ibid.
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- ¹⁹ Fox HB, McManus MA, Zarit M, Fairbrother G, Bethell C. *Racial and Ethnic Disparities in Adolescent Health and Access to Care*. Washington, DC: Incenter Strategies, 2007.
- ²⁰ This pooled sample included 10,160 older adolescents ages 18 through 21.
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The National Alliance to Advance Adolescent Health provides education, research, policy analysis, and technical assistance to achieve fundamental improvements in the way that adolescent health care is structured and delivered in the United States. Its mission is to enhance the physical and emotional well-being of adolescents, especially those who are low-income and minority, by improving the health care delivery model for adolescents and achieving the infrastructure changes needed to support it. The National Alliance seeks to promote comprehensive, interdisciplinary models of physical, mental, behavioral, and reproductive health care that incorporate a youth development philosophy and operate in collaboration with schools and other community-based programs. It also seeks to ensure that all adolescents have health insurance coverage for the services they require.

For more information about our work and available publications, contact Corinne Dreskin at The National Alliance to Advance Adolescent Health: cdreskin@TheNationalAlliance.org. Also visit our website: www.TheNationalAlliance.org.

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