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Trends in Access to Care Among Working-Age Adults, 1997 – 2006

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Major shifts in the nation's economy, family incomes, and the costs of health care and health insurance have occurred in the past decade, all potentially affecting the affordability and accessibility of health care. This study examined what has happened to access to care over ten-years time, focusing on working-age adults (age 18 to 64)—the age group most likely to be uninsured or under-insured, and the least likely to qualify for public coverage. Given large differences in access to care between the insured and uninsured, the study also examined if these gaps have changed over time.

Main findings:

- Between 1997 and 2006, problems with access to care that hinged on its affordability worsened among working-age adults—even for those with private insurance.
- Taken altogether, the number of working-age adults who reported costs as a barrier to needed care grew by about one million a year between 1997 and 2006, totaling 39 million in 2006. No gains in receiving preventive care and regular professional care were made over the ten year period among working-age adults overall.
- The only improvement in access to care over the period was in the share of working-age adults reporting they had a usual source of care, and this was driven entirely by gains made by the privately insured.
- The magnitude of access problems experienced by the uninsured continued to markedly overshadow that of the insured throughout the ten year period.
- Moreover, uninsured working-aged adults experienced the most consistent erosion in their access to care over the ten years. Not only did their access to care significantly worsen across all eight access problems over the period, but the access differences between insured and uninsured adults widened in every way as well.
- Working-age Medicaid beneficiaries' access to care was similar to that of the privately insured (after controlling for socioeconomic differences); and their access to care was largely unchanged over the period with two exceptions: more had unmet needs for dental care and prescription drugs due to costs by 2006.

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Background: Shifts in the Economy and Access to Health Care

Conditions were fertile for good access to health care between 1997 and early 2001, with potential for real improvements. The nation's economy was strong and employment was stable. Growth in health insurance premiums was historically low in the mid-1990s and by 2000, the share of the population who had private insurance was gradually growing.

However, by the end of 2001 fundamental economic factors affecting access to care were changing. The economy had begun to weaken and employment was waning. While the economic downturn was brief, job recovery was slow, prolonging the impact through 2004. Household incomes fell, the poverty rate increased, and state budgets suffered large revenue shortfalls which affected their Medicaid programs. Health insurance premiums shot upward, growing annually at rates two to three times that of wages and general inflation during this time. Employer-sponsored insurance declined steadily each year. While low-income children were buffered from this loss by the Medicaid and SCHIP programs, the number of uninsured adults increased substantially each year.

By 2005, the economy had begun to improve and median household income increased each year between 2004 and 2006. State budgets stabilized and they began to repair their Medicaid programs and even consider expansions. Growth in health premiums tapered off, but still increased at rates much higher than wage growth. Even as the economy improved however, the share of the population with employer-sponsored coverage continued to decline and the number of uninsured grew, putting increasing demand on safety net providers and other sources of charity care.

In sum, in the late 1990s access to health care in the U.S. had the potential of substantially improving. However, by 2006, any possible gains might have been lost given the economic conditions starting in late 2001.

Methods

The National Health Interview Survey was used to track ten years of data (1997 – 2006). The NHIS has both large annual samples and high response rates. Eight access to care questions that have been consistently asked each year were selected. The trend analysis controlled for socio-economic and health status changes in the nonelderly adult population over time using multivariate regression methods to calculate the adjusted probabilities of having an access problem. For more methodological detail, refer to the appendix.

Eroding Access to Care, 1997 - 2006

It was primarily the costs of health care that created more access problems for working-age adults between 1997 and 2006. On all measures that hinged on the affordability of care, access to care among working-age adults had declined by 2006.

The chances of working-age adults experiencing at least one access problem due to costs (delaying care, forgoing medical care, forgoing dental care, or forgoing prescription drugs) grew from 18.2% in 1997 to 21.3% by 2006. While the size of the problem and the growth rate may seem small, combined with growth in the population, they translate into substantial numbers of people. The number of working-age adults who experienced at least one access problem due to costs grew from a total of 29.8 million in 1997 to 39.3 million by 2006.

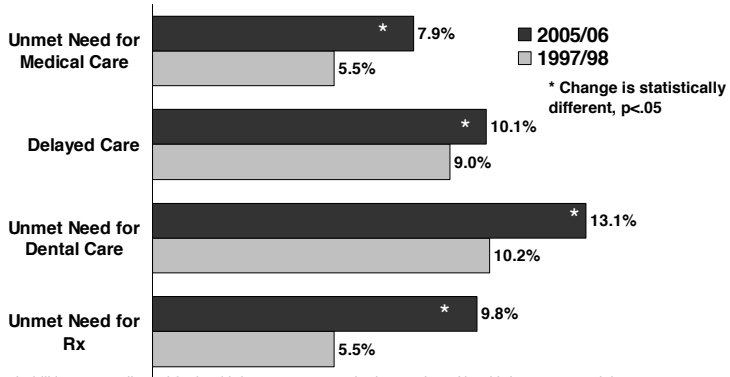
In order to test for real change in access to care between 1997 and 2006, the study controlled for the socio-economic and health status changes in the nonelderly adult population over time (see Methods appendix for more detail). The following results are based on adjusted predicted probabilities generated from a multivariate regression analysis. (Appendix tables 1 and 2 provide unadjusted rates for each of the ten years on all eight access measures as well).

Compared to 1997, more working-age adults in 2006 reported that in the past year they had:

- gone without needed medical care due to cost,
- delayed care due to cost,
- gone without needed dental care due to cost, and
- gone without prescription drugs due to cost (Figure 1).

Figure 1

Affordability:
Health Access Problems Due to Costs Among All Working-Age Adults (18-64)
2005/06 vs. 1997/98



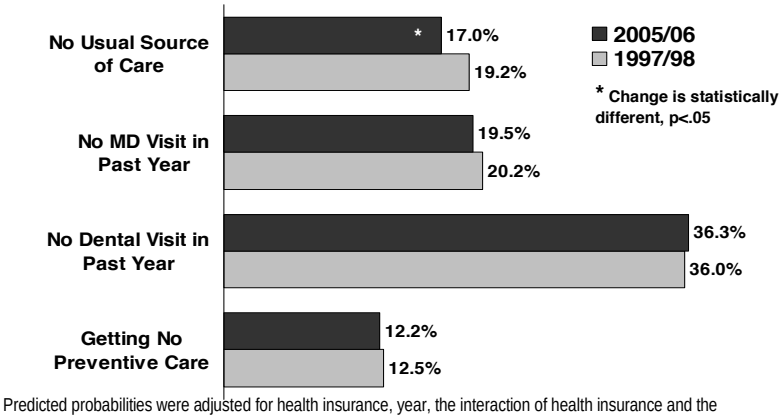
Predicted probabilities were adjusted for health insurance, year, the interaction of health insurance and the year, age, race/ethnicity, education, poverty level, sex, marital status, health status, ADL problems, IADL problems, and work limitations

The only gain in access to care over the ten years was in the share of adults who said they had a usual source for their health care. Compared to 1997, fewer reported that they did not have a usual source of care (19% vs. 17% by 2006). The share of adults who reported not seeing a physician, a dentist, or getting preventive care over the course of a year did not change over the period between 1997 and 2006 (Figure 2).

Figure 2

Barriers to Basic Primary Care Among Working-Age Adults

2005/06 vs. 1997/98



Predicted probabilities were adjusted for health insurance, year, the interaction of health insurance and the year, age, race/ethnicity, education, poverty level, sex, marital status, health status, ADL problems, IADL problems, and work limitations

Health Insurance Coverage and Trends in Access to Care

Trends in access to care among working-age adults varied considerably depending on whether or not a person had health insurance coverage.

Uninsured Lose the Most Ground. The uninsured were the hardest hit by eroding access to care among nonelderly adults. By all measures, significantly more of the uninsured were having health access problems in 2006 compared to 1997.

Rising health care costs made it harder for more of the uninsured to afford the care they believed they needed (Table 1). Significantly more of the uninsured reported by 2006 that because of what it cost, they had:

- delayed needed care (27%),
- gone without medical care (22%),
- gone without dental care (30%),
- and gone without needed prescription drugs (21% by 2006 vs. 15% in 1997).

Table 1
Affordability:
Health Access Problems Due to Cost, 1997/98 vs. 2005/06

Working-Age Adults (age 18-64)
Adjusted Predicted Probabilities

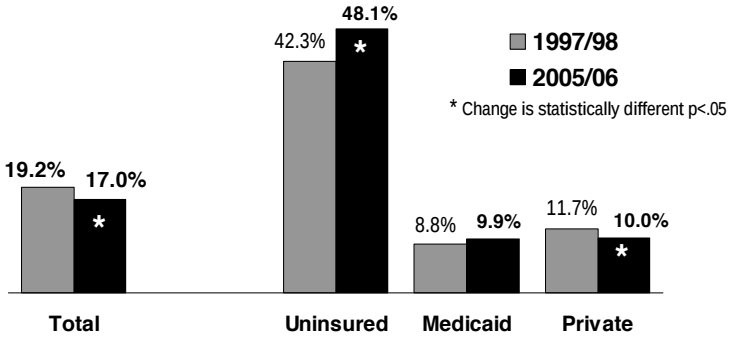
	1997-1998	2005-2006	
	* Significant Change, p<.05		
Went Without Care Due to Costs			
All	5.5%	7.9%	*
Uninsured	18.4%	22.0%	*
Private	2.0%	3.1%	*
Medicaid	2.3%	2.6%	
Delayed Care Due to Costs in Past Year			
All	9.0%	10.1%	*
Uninsured	25.6%	27.4%	*
Private	4.5%	5.1%	*
Medicaid	3.4%	4.3%	
Unmet Need for Dental Care Due to Costs in Past Year			
All	10.2%	13.1%	*
Uninsured	24.2%	29.8%	*
Private	5.4%	7.2%	*
Medicaid	6.2%	10.9%	*
Unmet Need for Prescriptions Due to Cost in Past Year			
All	5.5%	9.8%	*
Uninsured	14.8%	21.0%	*
Private	2.4%	4.8%	*
Medicaid	3.2%	5.2%	*

Unlike those with health insurance coverage, more of the uninsured experienced barriers to basic primary care as well over the ten year period. Nearly half of uninsured working-age adults did not have a usual source of health care by 2006 (48% vs. 42% in 1996; Figure 3). Substantially more of the uninsured reported they had not seen a doctor or other health professional for their medical needs in the past year (42% vs. 36% in 1997) and more had not seen a dentist in the past year either (62% vs. 56% in 1997). Over a third (37%) of uninsured adults in 2006 said that they had not gotten preventive care anywhere compared to 32% in 1997 (Table 2).

Between 1997 and 2006 the differences in access to care between the uninsured and privately insured grew. The gap widened on every health access problem, but particularly for the basic primary care measures: having a usual source of care, having at least one health professional visit a year, at least one dental visit a year, and receiving any preventive care.

Figure 3

Percent of Working-Age Adults Reporting No Usual Source of Care, 1997/98 vs. 2005/06 (adjusted)



Predicted probabilities were adjusted for age, race/ethnicity, education, poverty level, sex, marital status, health status, ADL problems, IADL problems, and work limitations.

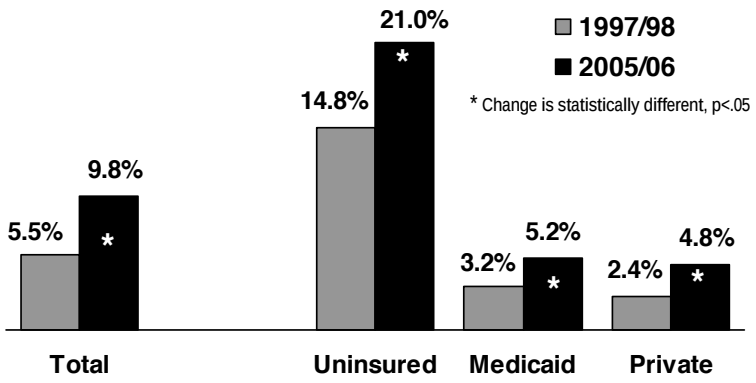
Table 2
Barriers to Basic Primary Care, 1997/98 vs. 2005/06

Working-Age Adults (age 18-64) Adjusted Predicted Probabilities	1997-1998	2005-2006	
		* Significant Change, p<.05	
No Usual Source of Care			
All	19.2%	17.0%	*
Uninsured	42.3%	48.1%	*
Private	11.7%	10.0%	*
Medicaid	8.8%	9.9%	
No Health Professional Visit in Past Year			
All	20.2%	19.5%	
Uninsured	35.6%	42.0%	*
Private	16.4%	15.7%	
Medicaid	11.9%	14.2%	
No Dentist Visit in Past Year			
All	36.0%	36.3%	
Uninsured	55.7%	61.8%	*
Private	29.8%	30.1%	
Medicaid	33.2%	34.8%	
No Preventive Care			
All	12.5%	12.2%	
Uninsured	31.5%	36.9%	*
Private	6.5%	6.2%	
Medicaid	4.8%	6.2%	

More of the Privately Insured Less Able to Afford Care. Access to care among those with private coverage is far better than that of the uninsured, however, even among the privately insured, more were cutting back on health care services because of cost by 2006. Significantly more of the privately insured reported four access problems related to the costs of care: delaying care and having unmet medical, dental, and prescription drug needs in 2006 compared to 1997 (Table 1). The share of privately insured adults reporting they went without a needed prescription doubled over the period, growing from 2.4% to 4.8% by 2006 (Figure 4).

Figure 4

Percent of Working-Age Adults Reporting Unmet Need for Rx Drugs Due to Cost in Past Year, 1997/98 vs. 2005/06 (adjusted)



Predicted probabilities were adjusted for age, race/ethnicity, education, poverty level, sex, marital status, health status, ADL problems, IADL problems, and work limitations.

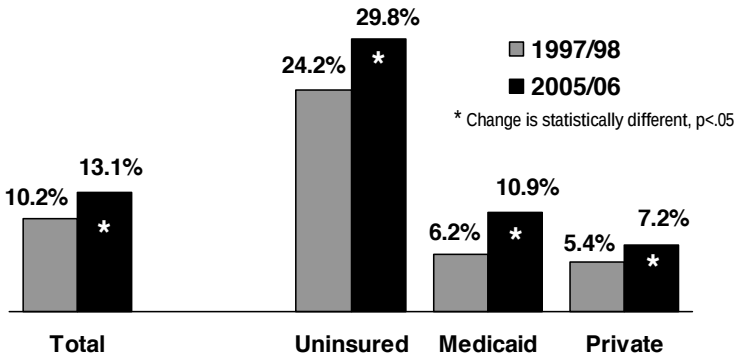
The share of privately insured adults experiencing most of the other access problems did not change over time. Throughout the period about 16% reported not having seen any medical professional in the past year, 30% not having seen a dentist, and 6% getting no preventive care. The one exception was the proportion of privately insured adults who said they did not have a usual source of care. While a problem for 12% in 1997, by the end of the period just 10% of the privately insured said they did not have a usual source of health care (Figure 3; Table 2). Given the size of this group, their improved access to a usual source of care drove the average gain for all working-age adults.

Medicaid Beneficiaries' Access to Care Least Affected by Overall Trends. Adults who qualify for Medicaid come from poor families and/or are seriously disabled, which affects their access to care considerably. However, after adjusting for these differences and others including age, gender, race, ethnicity, education, health status, and activity limitations, all known to also affect access to care—Medicaid beneficiaries' access to care was similar to that of the privately insured over the ten years.

Between 1997 and 2006 the share of nonelderly adults with Medicaid coverage who reported access problems stayed unchanged, with two important exceptions and these were again affordability-related. More adults covered by Medicaid reported having an unmet need for dental care due to costs (11% by 2006 compared to 6% in 1997; Figure 5) and more said they went without prescriptions because of costs by 2006 (5% vs. 3%, Figure 4).

Figure 5

Percent of Working-Age Adults Reporting Unmet Need for Dental Care Due to Cost in Past Year, 1997/98 vs. 2005/06 (adjusted)



Predicted probabilities were adjusted for age, race/ethnicity, education, poverty level, sex, marital status, health status, ADL problems, IADL problems, and work limitations.

Conclusion

Despite the prosperity of the late 1990s, few gains in access to health care were made during that time. Health care access began to erode for many more following the brief recession starting in 2001, in large part because health care costs continued to increase while wages idled. Unaffordable health care caused substantially more working-age adults to delay or go without needed health care altogether in 2006 than had in 1997; and significantly more were also unable to afford dental care and prescriptions drugs by 2006. In addition, no gains in access to preventive care and to regular professional care were made among working-age adults between 1997 and 2006.

Over the ten year period, the combined effect of a fluctuating economy, stagnant family incomes, and unchecked growth in health care costs put ever greater demands on family budgets, particularly in recent years. Other research has found that between 2001 and 2004, the share of those with high out-of-pocket health care costs (costs that consumed more than ten percent of their family incomes) grew from 16% to 18% of the nonelderly population, totaling over 45 million people by 2004.[1]

As health care grew less affordable over time, access to care has been jeopardized for many—but especially among the uninsured who are more likely to be poor. Uninsured adults are at least three times more likely than those with insurance to have problems getting needed medical care, dental care, and prescription drugs because they can't afford them. Roughly one quarter of uninsured adults were having problems getting the care they needed because of its cost by 2006.

Over the 1997 to 2006 time period, the growing numbers of uninsured have strained the country's safety net providers, while office-based physicians have decreased the amount of charity care they provide.[2] So on top of the affordability issues, more of the uninsured are having problems accessing basic primary care for themselves. Over half (59%) of the uninsured in 2006 said they did not have a usual source of care, 51% had not seen a health professional in the past year, 72% hadn't had a dental visit in the past year and 47% reported they had not gotten preventive care anywhere (unadjusted estimates). The consequences of such high levels of poor access to care compound into preventable health conditions and co-morbidities, avoidable hospitalizations and suffering—all of which generate significantly greater costs, both in terms of unnecessary health care spending, as well as the indirect expenses of work-loss days and disability.

While the economy stabilized in 2005 and 2006, the effect was not enough to make health care affordable for more working-age adults. Given the prolonged effect on access to care the brief 2001 recession appears to have had, even greater barriers to health care can be reasonably expected as the nation moves into perhaps a longer economic downturn, tied as it is to the housing market and job losses for families. The nation's unemployment level was as low as 4.4% in December 2006 but has been gradually growing ever since.[3] Recent research predicts that for every percentage point increase in the unemployment rate, the proportion of adults who will have employer-sponsored health insurance falls by about one percentage point.[4] This loss is buffered only modestly by public coverage because of eligibility restrictions for adults—resulting in an increase in the percent of adults who are uninsured. For example, Holahan and Cook have estimated that the 1.5 percentage point increase in the unemployment rate alone between 2007 (June; 4.6 %) and 2008 (August; 6.1%) may have increased the number of uninsured adults by two million. If the erosion in access to care is to be checked or even reversed, the rising costs of health care for families as well as the growing number of uninsured will need to be addressed.

Health insurance reform is being widely discussed in the course of the presidential campaign, providing some hope that the downward trend in access to care will not be ignored. While expanding health insurance coverage to more Americans will not remove all the barriers to good access to health care services, it could go a long way towards the goal of equitable health financing, as evidenced in the persistently large and growing insurance disparities in access to care found in this study. Both in the near and long term, the ability to control the growth of families' health care costs will be essential for all.

Methods

Survey. National Health Interview Survey (NHIS) data were used to track ten years of data (1997-2006).[5] The NHIS samples about 100,000 people each year (sample size decreased to 75,000 in 2006) and data on each of those individuals are included in the person-level file. Response rates for the NHIS for these years ranged from 86.1% to 90.3%. The sample adult file includes data on one randomly selected adult in each family. The sample size of the Sample Adult Core dataset was about 32,000 each year from 1997 to 2005 and was about 24,000 in 2006. Our analysis included only working-age adults, age 18-64. Response rates for the Sample Adult Core for these years ranged from 69.0% to 80.4%. The files that were used to calculate adjusted probabilities included 100,228 working-age adults (pooled samples for 1997, 1998, 2005, 2006).

Access Measures. Adults are asked an additional series of detailed questions including questions on access to care. The questions about delaying and not receiving care due to cost are on the person-level file. All other access and affordability questions that were analyzed are on the adult file. Basic access to care measures that could be reliably trended over this period included:

- Having no usual source of care (or the emergency room was their usual source of care),
- Having no physician or health professional visit in the past year,
- Having no dental visit in the past year, and
- Not receiving preventive care from anywhere.

Affordability and access measures included:

- Needing medical care but not getting it because person couldn't afford it in the past year,
- Delaying care due to cost worries,
- Needing prescription drugs but not getting them because person couldn't afford them in the past year, and
- Needing dental care (including check-ups) but did not get it because person couldn't afford it in the past year.

Health Insurance Categories. To clearly differentiate health insurance experience, three insurance categories were constructed: privately insured (including employer-sponsored and non-group insurance), Medicaid (including any adults with SCHIP), and the uninsured. Medicare beneficiaries were excluded. The privately insured and Medicaid groups included only the nonelderly who had health insurance throughout the past 12 months. The uninsured group included only those who said they had been uninsured throughout the past 12 months.

Analysis. Unadjusted trends were estimated for the total nonelderly adult population and each of the three insurance groups in our access measures over the entire ten year period. In order to test the change in health access disparities over time however, the study adjusted for important confounding factors and compared the endpoints, using pooled years 1997/1998 and 2005/2006. Our logistic regression models controlled for health insurance category, year endpoints, and their interaction—in addition to controlling for age, sex, race/ethnicity, education, poverty level, marital status, health status, and functional and work limitations. For simplicity, when discussing the results of the analysis the brief refers to 1997 when discussing 1997/1998 and 2006 when discussing 2005/2006.

From the logistic regression model, adjusted predicted probabilities of having an access problem depending on whether a person was privately insured, had Medicaid, or was uninsured in each of the two endpoint periods are provided. To directly test for significant changes between the two time periods for each insurance group separate logistic regressions on each access measure for each insurance group were run—with the p-value of the coefficient derived for the year variable (2005/2006 vs. 1997/1998) indicating whether there was a statistically different change over time.

All data were analyzed using Stata 9 survey commands to account for the complex survey design. More information about the data and methods are available from the authors.

Endnotes

[1] J.S. Banthin, P. Cunningham, and D.M. Bernard, "Financial Burden of Health Care, 2001-2004," *Health Affairs* 27, no. 1 (2008): 188-195.

[2] P.J. Cunningham and J.H. May, Center for Studying Health System Change "A Growing Hole in the Safety Net: Physician Charity Care Declines Again," Tracking Report No. 13, (Washington: HSC, 2006). R. Hurley R, L. Felland, J. Lauer, Center for Studying Health System Change, "Community Health Centers Tackle Rising Demands and Expectations," Issue Brief No. 116, (Washington: HSC, 2007).

[3] Bureau of Labor Statistics, extracted on October 5, 2008. Unemployment Rates. http://data.bls.gov/PDQ/servlet/SurveyOutputServlet?data_tool=latest_numbers&series_id=LNS14000000

[4] Dorn, S, B Garrett, J Holahan, and A Williams. 2008. "Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses." Kaiser Commission on Medicaid and the Uninsured (April Issue Brief #7770).

[5] More information about the NHIS is available at: http://www.cdc.gov/nchs/about/major/nhis/quest_data_related_1997_forward.htm

Appendix Table 1
Affordability: Health Access Problems Due to Cost, 1997-2006

Unadjusted Estimates

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Went Without Care Due to Cost in Past Year										
All Adults	**6.0%**	**5.5%**	**5.5%**	**5.7%**	**6.1%**	**6.2%**	**7.0%**	**7.3%**	**7.1%**	**7.8%**
Uninsured	21.4%	20.8%	20.6%	20.7%	21.2%	21.7%	22.8%	23.9%	23.4%	24.5%
Private	1.8%	1.5%	1.6%	1.6%	1.9%	1.9%	2.2%	2.3%	2.2%	2.6%
Medicaid	4.9%	4.8%	4.6%	6.0%	5.9%	4.7%	6.3%	4.9%	4.8%	5.2%
Delayed Care Due to Cost in Past Year										
All Adults	**9.5%**	**8.3%**	**8.1%**	**8.0%**	**8.4%**	**8.5%**	**9.2%**	**10.1%**	**9.7%**	**10.2%**
Uninsured	26.7%	25.7%	24.7%	24.4%	24.1%	25.8%	25.7%	27.8%	26.8%	27.3%
Private	4.4%	3.7%	3.5%	3.4%	3.6%	3.7%	4.1%	4.6%	4.3%	4.5%
Medicaid	5.8%	5.5%	6.0%	7.3%	6.6%	5.1%	6.8%	5.6%	5.9%	6.9%
Unmet Need for Dental Care Due to Cost in Past Year										
All Adults	**10.6%**	**9.2%**	**9.3%**	**9.7%**	**10.4%**	**10.4%**	**11.5%**	**13.2%**	**13.0%**	**13.6%**
Uninsured	28.0%	26.3%	24.4%	26.4%	28.0%	29.8%	29.4%	34.2%	32.1%	32.0%
Private	5.2%	4.5%	4.3%	4.5%	5.0%	4.6%	5.2%	6.4%	5.7%	6.5%
Medicaid	10.8%	10.5%	12.2%	12.2%	12.4%	13.6%	13.3%	16.5%	17.0%	16.9%
Unmet Need for Prescriptions Due to Cost in Past Year										
All Adults	**6.3%**	**5.4%**	**5.6%**	**6.6%**	**7.0%**	**7.6%**	**8.1%**	**9.2%**	**9.4%**	**9.3%**
Uninsured	18.9%	16.9%	16.6%	18.7%	21.1%	21.4%	21.9%	23.7%	24.5%	23.1%
Private	2.1%	1.8%	2.0%	2.5%	2.6%	3.0%	2.8%	4.0%	3.8%	3.5%
Medicaid	7.8%	7.4%	7.3%	8.4%	7.6%	9.0%	9.4%	9.4%	10.4%	10.9%

Analysis of National Health Interview Survey data for all years

Appendix Table 2
Barriers to Basic Primary Care, 1997-2006

Unadjusted Estimates

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
No Usual Source of Care										
All Adults	**18.4%**	**17.0%**	**18.3%**	**17.1%**	**15.9%**	**16.4%**	**16.5%**	**18.1%**	**17.9%**	**18.9%**
Uninsured	51.6%	51.1%	54.8%	54.4%	52.9%	55.1%	52.4%	57.6%	57.3%	58.7%
Private	11.4%	10.2%	11.4%	9.5%	8.4%	8.4%	8.6%	9.2%	8.6%	9.2%
Medicaid	10.3%	7.9%	9.8%	9.4%	9.7%	9.8%	7.3%	11.1%	10.6%	10.5%
No Health Professional Visit in Past Year										
All Adults	**19.6%**	**19.1%**	**20.2%**	**19.4%**	**19.8%**	**19.0%**	**18.5%**	**19.9%**	**19.5%**	**21.3%**
Uninsured	42.6%	42.3%	46.4%	46.3%	47.2%	47.0%	47.3%	48.9%	49.7%	51.2%
Private	16.3%	15.6%	16.7%	14.9%	15.5%	14.6%	13.4%	14.6%	14.0%	16.0%
Medicaid	8.5%	10.1%	9.4%	10.4%	10.3%	9.9%	8.4%	13.4%	11.8%	12.0%
No Dentist Visit in Past Year										
All Adults	**35.9%**	**34.5%**	**35.4%**	**34.7%**	**35.4%**	**37.2%**	**35.2%**	**36.0%**	**36.5%**	**37.6%**
Uninsured	66.7%	65.2%	67.7%	68.3%	68.2%	71.7%	69.5%	70.6%	71.0%	71.8%
Private	27.3%	26.1%	27.1%	25.8%	26.4%	27.5%	24.7%	25.6%	25.3%	26.7%
Medicaid	46.3%	45.7%	49.1%	42.9%	46.0%	52.5%	47.8%	49.0%	46.8%	46.4%
No Preventive Care										
All Adults	**11.2%**	**11.7%**	**12.3%**	**11.2%**	**10.9%**	**11.9%**	**11.9%**	**13.1%**	**13.0%**	**13.4%**
Uninsured	38.0%	40.4%	41.2%	40.4%	40.1%	43.2%	39.7%	44.6%	45.3%	46.5%
Private	5.9%	6.2%	7.2%	5.5%	5.3%	5.8%	5.8%	6.1%	5.6%	5.7%
Medicaid	5.0%	4.7%	6.2%	4.3%	6.6%	6.3%	5.1%	7.5%	6.3%	6.4%

Analysis of National Health Interview Survey data for all years

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.