
DataWatch

Ability To Obtain Health Care: Recent Estimates From The Robert Wood Johnson Foundation National Access To Care Survey

by Marc L. Berk, Claudia L. Schur, and Joel C. Cantor

Abstract: This DataWatch presents findings on Americans' ability to obtain health care. Data from the 1994 National Access to Care Survey sponsored by The Robert Wood Johnson Foundation suggest that earlier studies have underestimated the access problems facing Americans by not asking about supplementary services such as prescription drugs, eyeglasses, dental care, and mental health care or counseling. Using this more inclusive definition of health care needs, we estimate that 16.1 percent of Americans were unable to obtain at least one service they believed they needed. While income is highly correlated with unmet need, most persons reporting access problems are not poor.

In this DataWatch we present findings from the 1994 National Access to Care Survey sponsored by The Robert Wood Johnson Foundation (RWJF). This is the foundation's fourth major access survey; previous surveys were conducted in 1976, 1982, and 1986. We focus here on only one measure of access: Americans' perceptions about whether or not they have received all of the care they need. Results from the 1982 RWJF access survey indicated that about 6 percent of families reported that someone in the family "needed medical help but did not get it for some reason." In 1986 findings were generally based on individuals rather than families, but they too indicated that 6 percent of respondents had not received the medical care they thought they needed.

These earlier studies may have underestimated the access problems many Americans face. Estimates from the current survey similarly show that approximately 6 percent of Americans are unable to obtain the medical or surgical care they believe they need. This estimate by itself suggests neither that access to care has improved nor that it has further deteriorated. However, earlier studies missed substantial components of unmet need by failing to include specific questions about supplementary health care services such as prescription drugs, eyeglasses, dental care, and mental health care or counseling—services less likely to be covered by private insurance. Here we report on Americans' access to care, using this more inclusive

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definition of health care needs.

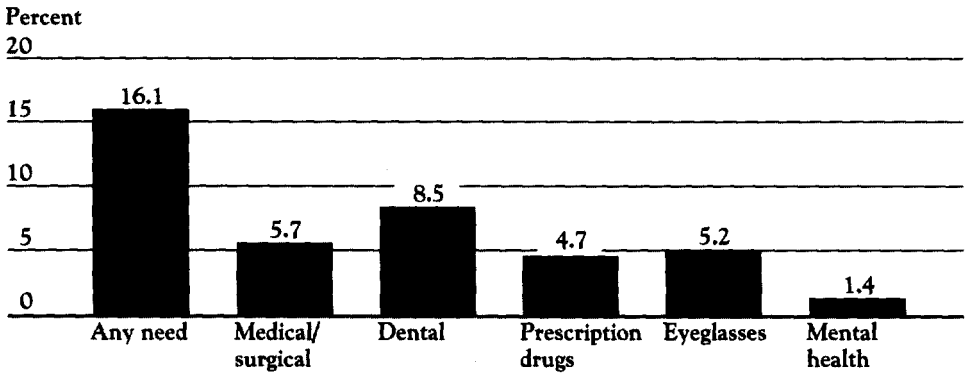
Methods. The 1994 RWJF National Access to Care Survey represents a unique public/private partnership. Under this agreement the Project HOPE Center for Health Affairs (CHA) was responsible for the design and analysis of the survey, while the National Center for Health Statistics (NCHS) received support to assist with the design and oversee the data collection efforts by the U.S. Bureau of the Census. The survey was fielded in the spring and summer of 1994 as a follow-up component to the 1993 National Health Interview Survey (NHIS). The 1993 NHIS was used to identify specific types of respondents for follow-up interviewing as part of one of three survey components: (1) a national probability sample; (2) a sample of persons reporting access barriers or who met other specific criteria suggesting low access to care; and (3) a sample of persons with one of two specific chronic conditions for which well-accepted standards of care exist.

The results reported here are from the first study component; the other components are still in the field, and findings from those components will be released beginning in spring 1996. Estimates from the first component are based on a final sample of 3,450 persons, for a response rate of 75 percent. This response rate takes into account nonresponse to the access follow-up survey as well as to the 1993 NHIS. All estimates presented here are weighted to be representative of the U.S. civilian, noninstitutionalized population. The 1994 survey was primarily a telephone survey. However, since previous studies have suggested that vulnerable populations may be undercounted when only telephone interviewing is used, persons who reported on the NHIS that they did not have a telephone were interviewed in person.¹

Findings

In addition to a question, similar to one in previous surveys, about whether or not respondents were able to obtain medical care or surgical services, the 1994 access survey included specific questions about dental care, prescription drugs, eyeglasses, and mental health care or counseling. A variable was then constructed to indicate whether or not the respondent had an unmet need for any service category (Exhibit 1). The findings show that 16.1 percent of respondents—representing more than forty-one million Americans—were unable to obtain at least one service they believed they needed. The highest reported unmet need was for dental care, with 8.5 percent of the population reporting that they were not able to obtain the dental care they needed. The proportion of the population unable to obtain medical care or surgery, prescription drugs, and eyeglasses was similar—about 6 percent for the former service and about 5 percent for each of the

Exhibit 1
Percentage Of Persons Unable To Obtain Care, 1994

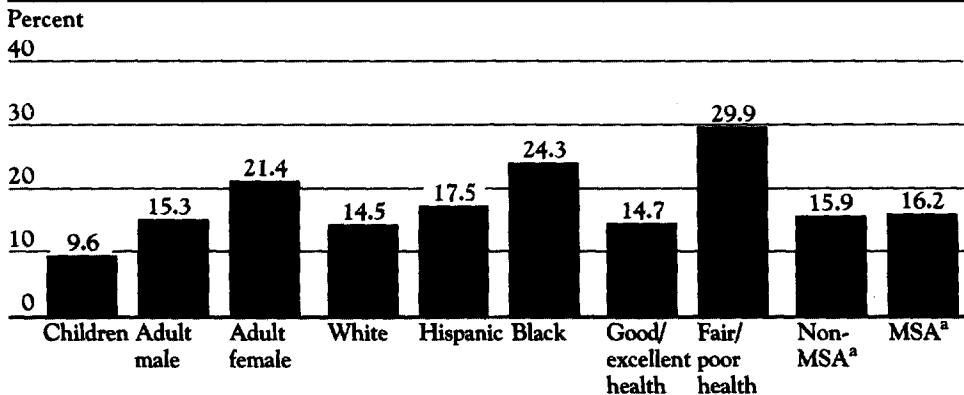


Source: 1994 Robert Wood Johnson Foundation National Access to Care Survey.

latter. Although only 1.4 percent of persons reported unmet needs for mental health services, there is empirical evidence that survey respondents are often unwilling to report stigmatizing conditions.²

Demographic characteristics. Although much of the recent health care debate focused on the needs of children, our survey findings show that both male and female adults are more likely than children to have unmet need (Exhibit 2). In fact, for each of the five services considered, the greatest unmet need was found among adult females, while the proportions for children were consistently below those for both adult females and adult males. This is likely a result of the more extensive safety net available to

Exhibit 2
Percentage Of Persons Unable To Obtain Care, By Demographic Characteristics, 1994



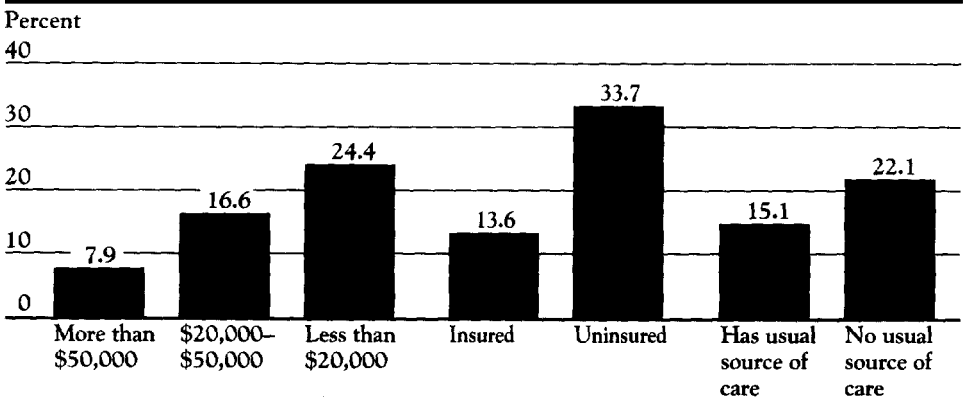
Source: 1994 Robert Wood Johnson Foundation National Access to Care Survey.
a Metropolitan Statistical Area.

children, in terms of higher rates of Medicaid eligibility as well as specific local programs directed to the young. More than 24 percent of blacks had unmet needs, compared with about 18 percent of Hispanics and 15 percent of whites. As expected, persons reporting good or excellent health were less likely than persons in fair or poor health to have unmet health care needs.

Findings from the 1986 access survey noted that “the long-standing gap in receipt of medical care between rural and urban residents appears to have been eliminated.”³ This is consistent with the present findings, which show no difference in the proportion of persons reporting an inability to get care in metropolitan versus nonmetropolitan areas. However, the apparent “disappearance” of a rurality effect could be attributable to the crudeness of the urban/rural distinction rather than to real differences in service delivery patterns. In subsequent analyses we will look at access to care in the most rural communities. Until such analyses are completed, we believe that it is premature to conclude that access differentials between rural and urban areas have been eliminated.

Income, usual source of care, and insurance status. It is clear that income, having a usual source of care, and insurance status continue to play a critical role in explaining variations in access to care (Exhibit 3). About 24 percent of persons with family incomes below \$20,000 were not able to obtain necessary services, compared with about 17 percent of persons in the middle-income range and only about 8 percent of those with incomes above \$50,000. Having a usual source of care continues to positively influence the probability that one has access to necessary services, which is consistent with earlier findings.⁴

Exhibit 3
Percentage Of Persons Unable To Obtain Care, By Income, Insurance Status, And Usual Source Of Care, 1994



Source: 1994 Robert Wood Johnson Foundation National Access to Care Survey.

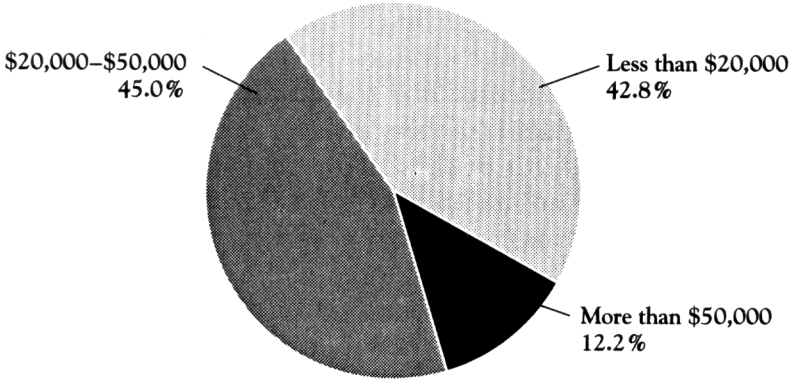
Health insurance continues to be the most important correlate of unmet need. Uninsured persons are approximately two and one-half times as likely as insured persons to have an unmet need: In the 1994 survey 34 percent of the former, compared with 14 percent of the latter, reported an inability to obtain at least one of the five services. It is interesting to note that the differential between the insured and the uninsured is large and generally comparable for all services (numbers not shown). Thus, although health insurance is a critical factor in obtaining care, large gaps in access to care between insured and uninsured persons exist even for services not likely to be covered by private insurance or covered less generously than strictly defined medical care.

Assessing the financial factor. In addition to allowing for examination of the correlates of unmet need, the survey asked respondents to identify the reasons why they did not get the care they needed. Although this information is only suggestive until data from the remaining study components are tabulated, early indications are that respondents pointed to financial reasons for their unmet need in at least half of reported cases. These recorded responses were generally along the lines of "could not afford it," "had no insurance," or "doctor did not accept Medicaid/insurance." It is interesting to note that the proportion of respondents who attributed their inability to get care to financial reasons was much higher for the supplementary services-mental health care or counseling, dental care, and eye-glasses-than for medical/surgical care or prescribed medicines.

Although it is evident that vulnerable population subgroups are disproportionately likely to experience unmet need, the inability to obtain needed care appears to transcend income categories. Exhibit 4 shows the distribution by income of the forty-one million persons who were unable to obtain care. It is important to note that while those in the lowest income group bear a somewhat disproportionate share of the problems with obtaining services, almost half of all persons with unmet need are squarely in the middle class, with family incomes between \$20,000 and \$50,000. This group represents 45 percent of the total population and accounts for the identical proportion of persons experiencing unmet need. Thus, while income is certainly correlated with access, the study indicates that most persons with access problems are not poor.

Discussion

Caution must be used in making definitive policy recommendations based on the preliminary findings presented here. Nevertheless, certain patterns are clear. Our findings are consistent with earlier investigations that have shown that the vast majority of Americans are able to obtain all

Exhibit 4**Distribution Of Persons With Anv Unmet Need, By Family Income Level, 1994**

Source: 1994 Robert Wood Johnson Foundation National Access to Care Survey.

Note: In the general population, 29.4 percent have income less than \$20,000; 45 percent have \$20,000-\$50,000; and 25.6 percent have more than \$50,000.

of the health care they believe they need. However, where a more comprehensive definition of unmet need that includes components other than medical/surgical services is used, it appears that many more Americans are not able to obtain care than has been suggested by earlier studies.

Dental care and eyeglasses. As noted above, the largest proportion of positive responses to the survey question was for persons unable to obtain dental care; in fact, two-thirds of these persons had some kind of third-party health care coverage (though not necessarily for dental services). In terms of coverage for specific services, forty-four states cover dental care for categorically needy Medicaid recipients, and thirty-three states do so for medically needy participants.⁵ In addition, 66 percent of full-time employees in medium and large firms were covered for at least some dental expenses, as of 1989.⁶ Prevalence of coverage for eyeglasses is comparable. The findings presented here suggest, however, that significant gaps in either the breadth or the depth of coverage exist among some population groups,

In the policy debate such services as dental care and provision of eyeglasses are generally relegated to a second-tier status, probably because lack of such care is not life-threatening or perhaps because such services are not deemed to pose much of a financial burden for consumers. However, policymakers should consider seriously the quality-of-life implications of going without such care.

Mental health care. Mental health care, in contrast, has received considerably more policy attention. Although the proportion of persons reporting in the 1994 survey that they were unable to obtain mental health care is relatively low (1.4 percent), it is much higher than comparable findings

from another recent survey (0.3 percent).⁷ As noted previously, survey respondents may be unwilling to provide information that they feel is embarrassing or stigmatizing. More importantly, we emphasize that this estimate should be interpreted with caution: It represents only those persons unable to get mental health services who both know and acknowledge that they need mental health care. Catchment area studies—in which psychiatric diagnoses are made of the general population using a specialized interview protocol—indicate that a much larger proportion of the population is not receiving needed mental health care.⁸ Thus, the low estimate of unmet need should not be interpreted as suggesting that the focus of policymakers on mental health care is unwarranted. Indeed, it may be that household surveys without a specific diagnostic protocol are blunt instruments for measuring unmet need for mental health services.

Two additional issues regarding the financing of mental health care deserve attention. First, the provision of mental health care and payment for those services is even more fragmented than is true for general medical care, with greater reliance on the public sector than for other types of services. The proportion of persons with mental disorders in the uninsured population has been estimated to be as high as 50 percent.⁹ Second, private coverage is generally better for less intensive or less prolonged treatments, but it may become inadequate in the most serious cases when persons need extended care or have recurring problems.¹⁰ Moreover, the past decade has seen an increase in the restrictiveness of private mental health benefits.¹¹

Vulnerable populations. Our findings also are consistent with the long history of health services research that has shown the problems of access experienced by vulnerable populations. Thus, the greatest barriers to care are experienced by minorities, the poor, the uninsured, and persons in relatively poor health. At the same time, it appears that the inability to obtain health care is not restricted to the poor and disenfranchised but affects a wider spectrum of Americans.

Health care reform. A major theme of the Clinton administration's health care reform plan was its advocacy of structural changes that would affect all Americans. One of the plan's major drawing cards was its responsiveness to middle-class fears about vulnerability to health care costs. Although the plan was rejected, it would be wrong to assume that its downfall was related to its inclusion of the middle class. In fact, it has been suggested that the plan failed because it did not fully respond to middle-class concerns. With almost nineteen million middle-class Americans reporting an inability to obtain needed health services, policymakers would be wise to keep alive consideration of structural changes in the U.S. health care system.

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NOTES

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