Access of Hispanics to Health Care and Cuts in Services: A State-of-the-Art Overview

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Synopsis

The most current research literature on the access of Hispanics to medical care is reviewed, and data from a 1982 national survey by Louis Harris and Associates on access to health care are presented to document current levels of access to health care of the Hispanic population. Through telephone interviews, 4,800 families were contacted, yielding a total sample of 6,610 persons.

According to the survey's data, the ability of Hispanics to obtain health services is hampered by relatively low incomes, lack of health insurance coverage, and ties to a particular physician. However, Hispanics do not differ significantly from whites in their use of hospitals, physicians, or outpatient departments and emergency rooms. Hispanics are less satisfied than whites on a host of measures describing the most recent medical visit. These levels of dissatisfaction with the visit are similar to those of blacks.

The recession and public care service cutbacks did not appear to result in a substantial reduction in the volume of medical care received by Hispanics and blacks. Still, the services available to minorities are viewed by them as less effective in meeting their needs in comparison with how whites view the services they receive. Further, the 1982 survey reveals particular difficulties and barriers for Hispanics in obtaining needed medical services. More than one-fifth of the Hispanic families had one or more significant problems in obtaining needed services.

ACCESS TO MEDICAL CARE IMPROVED considerably for the poor, ethnic minorities, elderly, rural residents, and other traditionally disadvantaged groups as a result of a series of governmental programs and private initiatives implemented in the 1960s and 1970s; examples include Medicaid, Medicare, migrant health centers, community mental health centers, and rural health initiatives (*1-4*). However, with these improvements there were huge increases in national and personal medical expenditures (*3-4*). The government at the Federal, State, and local levels responded by adopting a series of policy measures geared to reducing or limiting government and personal health care expenditures, and the changes may have a potentially negative impact on access to care for traditionally disadvantaged groups (*3-4*). As a result of this shift in health policy, Hispanics and blacks as well as other minority groups are now substantially affected by Federal and State reductions during the 1980s in health and mental health, maternal and infant care, Medicaid, Medicare, and other programs. These factors, combined with financial barriers resulting from high unemployment and inflation, may undo much of the progress made by the poor and by minority groups in the last two decades, leading to further inequalities in access to and utilization of health services (*3,4*).

This paper provides empirical data on the possible impact of the economic and political changes on access to health care for Hispanics relative to blacks and whites. Through analysis of a series of potential access indicators, (for example, health insurance coverage and inconvenience of care) and utilization measurements (realized access), it will specifically examine (*a*) the current patterns of access to medical care among Hispanics

and blacks, (*b*) which ethnic groups were most affected by the economic and political climate, and (*c*) the special access problems of Hispanics relative to whites and blacks.

Sources of information include the current literature and a 1982 national survey of access to medical care in the U.S. population conducted by Louis Harris and Associates (*3*) and sponsored by the Robert Wood Johnson Foundation.

Literature on Access to Health Care

Despite improvements in levels of access to medical care among Hispanics, there is evidence that suggests this group continues to experience barriers to obtaining care. Some of the barriers cited in the literature have to do with Hispanics' socioeconomic, demographic, and cultural characteristics, while others relate to organizational aspects and structural characteristics of the health delivery system.

Education is a factor that appears to affect Hispanics' access to health care. This is partly related to the fact that low levels of education have proven to be related to traditional health beliefs and health practices, high levels of distrust of modern medicine and doctors, and informational gaps about available services—all of which are found to be linked to low levels of utilization of health services (*5–8*).

Furthermore, low levels of education were found to be related to willingness to be hospitalized (*9*), to low utilization of physicians' and dentists' services, and to low rates of preventive examinations among Hispanics in the southwestern United States (*10*).

Hispanics' occupational status is a factor that also predisposes their lower access to health care. Nearly half of the Hispanic population (47 percent) has blue-collar jobs, compared with one-third for the non-Hispanic population (*11*). They are heavily represented in low-paying factory jobs. The tendency of Hispanics to have low-paying jobs helps explain the fact that they have no or limited health insurance coverage. The jobs in which Hispanics are primarily employed have few fringe benefits (*10*).

A great deal of the literature on Hispanics' physical and mental health indicates that language is a major barrier to access and appropriate utilization of health services. Language presents a problem when the population to be served is mainly Spanish-speaking. Edgerton and Karno (*12*) wrote that the language barrier may very well be linked to other barriers also (for example, low socioeconomic status and limited health insurance). However, the 1976 National Survey on Access to Care does not provide evidence that language per se is a barrier in seeking medical care among the Hispanic population in the southwestern States (*10*). These findings were borne out in East Los Angeles as well (*13*).

The sociocultural predispositions of Hispanics toward medical care have been frequently proposed as an explanation for their low access also. A great deal of the literature on Hispanics has been devoted to exploring these factors. Early studies stressed the existence of an Hispanic health subculture that consists of a different set of health beliefs and health practices (such as the use of herbs, teas, and other home remedies and over-the-counter medications) to treat symptoms of illness as well as acute and chronic health conditions and the use of lay persons such as curanderas (faith healers) for health advice and folk treatments (*14*). However, at the present time discrepancies prevail in the literature as to the extent and frequency of these practices. For example, Andersen and associates found that 21 percent of the Hispanic population in the southwestern States of the United States use herbs and other home remedies to treat episodes of illness (*10*). This is almost twice the proportion reported by the total U.S. population (12 percent). In addition, the same study found one-third of all Hispanics believed that illness can be better treated by home remedies than by prescribed medicine, compared with 24 percent for the total U.S. population.

On the other hand, few studies have presented empirical data about numbers of folk practitioners such as curanderas and espiritistas, where they are located, their sociodemographic characteristics, and the kind of clients they serve. Some studies claim that folk practitioners have virtually disappeared (*15*), and their salience as a health resource alternative has been questioned in the work of Edgerton and Karno (*12*) in Los Angeles. In addition, the access study by Andersen and associates (*10*) did not find evidence of the use of curanderas among the Hispanic population in the southwestern United States. Others assert that use of such practitioners does not necessarily preclude Hispanics' seeking care through the regular health care system as well (*16*).

Reliance on the family has frequently been proposed as an explanation for low utilization of health services among Hispanics. Hispanic families have been frequently described as a group that is

highly integrated, with strong ties and possessing most of the attributes of the classical extended family system (*17*). The Hispanic family has been perceived as providing a source of social support to Hispanics in the United States (*18*). However, studies have found that strong family ties have a negative effect on the utilization of medical services during illness, since family members are encouraged first to seek help (curative measures) within the family except when illness is very serious (*19,20*). The effect of the family on access to medical care among Hispanics is expected to change with the increased number of households headed by single parents and females. However, the percent of female-headed households varies considerably by national origin. The greatest effect will be among Puerto Ricans, because 45 percent of all Puerto Rican families in the United States in 1982 were maintained by women with no husband present, compared with 18 percent among Mexican-Americans and 15 percent among non-Hispanic-origin families (*11*).

The cost of medical services has been frequently cited as an important barrier affecting access to medical care among Hispanics. In 1980, median family income for Hispanics was one-third lower than for non-Hispanics (*21*). With this lower income, Hispanic families have to support a larger family size, and this leaves Hispanics with less disposable income to pay out-of-pocket expenses for health care (*22*). One segment of the population affected the most are the "working poor Hispanics," who are not eligible for governmental programs and cannot afford the rising cost of medical services. Furthermore, due to the economic recession and fiscal austerity that has characterized the decade of the 1980s until now, Hispanics and blacks have experienced a high incidence of unemployment, which can be expected to affect their access to health services even more (*3,4*).

Having a regular source of medical care has been proposed as a good predictor of health services utilization because it facilitates the continuity and quality of health care (*3,4*). However, studies on Hispanic health indicate that Hispanics are less likely to have such a regular source of care. Aday and associates, in the 1976 National Survey on Access to Medical Care, found that Hispanics in the southwestern States were less likely to have a regular source of medical care than any other racial and ethnic group in the United States (*2*). Seventeen percent of Hispanics did not have a regular source of care, compared with 12 percent for the total U.S. population. The percent without a regular source of care increases among Hispanics below the poverty level (20 percent compared with 13 percent for white non-Hispanics) (*2*). Kasper and Barrish, based on the National Medical Care Expenditures Study, found similar results (*23*); 19 percent of the Hispanic population did not have a regular source of care, compared with 13 percent of the total U.S. population.

Among people who reported having a regular source of care, Hispanics were least likely to see a particular physician at their source of care. Information on the availability of services outside normal office hours at different sites of care indicated that blacks and Hispanics were more likely than whites to have a physician with regular Saturday morning hours, but least likely to have access to emergency treatment after office hours (*23*). In addition, a national health survey conducted by the National Center for Health Services Research found that minority groups (primarily Hispanics and blacks) without a regular source of care were least likely to visit the doctor, thereby diminishing treatment opportunities for these populations (*24*).

When a regular source of care is reported for these minority groups, public health facilities, hospital outpatient clinics, and emergency rooms are a common source of medical care (*23-25*). For example, Berstein and Berk (*24*) found that elderly Hispanics were as likely as elderly blacks to use the hospital outpatient clinic (22 percent) as a regular source of care, compared with 7 percent among aged whites. Furthermore, Kasper and Barrish (*23*) found that the hospital emergency room was most used by blacks and Hispanics, relative to whites.

Other studies have found, however, that Hispanics are as likely as whites to indicate preferences for private physicians (*26*). Factors affecting the choice of medical facilities are related to income, doctor's ethnic background (for example, doctor's ability to speak Spanish), and the individual's immigration status (*27*).

The lack of health insurance also presents special barriers to Hispanics entering the health care system. Andersen and associates, in their 1976 nationwide study on access to medical care in the United States, found that the Hispanic population (primarily Mexicans) in the southwest (Colorado, Texas, New Mexico, Arizona, and California) had the lowest percentage of health insurance coverage of any racial or ethnic group studied (*10*). This

proportion (65 percent) was also lower than that of the total U.S. population (88 percent). When adjustments were made for socioeconomic factors, the percentage with health insurance increased but still remained considerably lower than for other groups (*10*).

Data from the Health Interview Survey of 1976–77, sponsored by the National Center for Health Statistics (NCHS), provided relatively similar results. It found that 76 percent of the Hispanic population had some form of health insurance coverage, compared with 89 percent for the total population. In addition, the data indicated that health insurance coverage increases with income over $10,000 a year, reaching 88 percent of Hispanics nationwide. However, there were still fewer Hispanics with health insurance than the 94 percent for the total U.S. population with similar incomes (*28*). In a study on health services use and health insurance coverage, Wilensky and Walden also found that minorities (primarily Hispanics and blacks) of different income levels were most likely to be uninsured for a longer period during the year (*29*).

Welch and coworkers, in their study of health care among the Mexican-American population in four counties in Nebraska, found that only 17 percent of the sample population had health insurance (*8*). When Mexican-Americans were compared with low-income Anglos, researchers found that both groups pay for health care from their own income (64 percent and 69 percent, respectively), but that low-income Anglos were more likely to be covered by private health insurance and Medicare, while Mexican-Americans were more likely to depend on public sources for financing their medical care.

Furthermore, when Trevino and Moss (*30*) differentiated the Hispanic population on the basis of national origin (for example, Mexican-Americans and Puerto Ricans), they found that Mexican-Americans were less likely than other Hispanics to have health insurance coverage. Approximately 30 percent of the Mexican-American population was uninsured, compared with 9 percent for white non-Hispanics and 12 percent for the total U.S. population. In addition, approximately 20 percent of black non-Hispanics, Cuban-Americans, and Puerto Ricans were uninsured. When family income was examined, Hispanics in each income category reported less insurance coverage than whites and blacks. Mexican-Americans, again, were least likely to have health insurance coverage, regardless of income.

After adjusting for all other variables, 29 percent of Hispanics had waiting times of more than 30 minutes, compared with 16 percent of non-Hispanics. These differences may be due to the unavailability of Spanish-speaking health care personnel or the specialty of the types of providers contacted.

In reference to type of coverage, Puerto Ricans, followed by Mexican-Americans and blacks (non-Hispanics), were least likely to have private health insurance. Furthermore, Puerto Ricans were most likely of all racial and ethnic groups to report Medicaid coverage (32 percent), followed by blacks (20 percent), compared with 6 percent for the total U.S. population. When adjustments for income differences were made, this percentage increased substantially. Sixty-four percent of the Puerto Ricans with incomes below $7,000 a year reported Medicaid coverage only, followed by 47 percent for blacks and 30 percent for the total U.S. population in that income group.

An explanation provided by the authors was that a high percentage of Puerto Rican and black families are female-headed households, and, therefore, they are most likely to be eligible for Medicaid coverage. This same population is also most likely to live in States that provide better Medicaid benefits. The low rate of private health insurance among Mexicans was explained by Trevino and Moss as the result of their low income and employment by firms that generally do not provide health insurance coverage as a fringe benefit (*30*).

Finally, using 1978 and 1980 data from the National Health Interview Survey, Trevino and Moss (*30*) found that lack of health insurance reduces an individual's access to health care, as a high proportion of the uninsured (35 percent) had not consulted a physician in the past year when compared with the insured (22 percent). Among Hispanic subgroups, Mexican-Americans and Cubans had the highest proportions with no physician visit in the past year. People with Medicaid coverage only were most likely to report a physician visit within the year. This was partly explained by their possible high level of illness (*30*).

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Medical needs are considered the strongest predictor of health services (*2*). Data on self-perceived health status obtained from the Health Interview Survey of 1976–77 indicated that Hispanics and blacks were more likely than whites to perceive their health as poor or fair (*28*). This same study indicated that Hispanics reported fewer restricted activity days per year than whites, which may be due to the fact that some restricted activities are "prescribed" by medical care contacts occurring less often for Hispanics. In addition, the survey indicated that the number of restricted days varied by income; Hispanics with incomes of less than $10,000 a year reported 21 days a year, compared with 26 days for whites and 25 days for blacks. Hispanics with $10,000 or more of yearly income reported slightly fewer restricted days (12), compared with whites (14) and blacks (15) (*28*). Data from the 1978–80 NCHS Health Interview Survey suggested that Mexican-Americans experienced the fewest restricted activity days and Puerto Ricans the most (*31*).

Andersen and associates supported these findings (*10*). In the 1976 National Survey of Access to Medical Care they examined the Hispanic population of the southwestern States and found that Hispanics reported a slightly smaller mean number of disability days per year (7 days), compared with the total U.S. population (10 days). In addition, this same study found that fewer Hispanics overall reported at least some worry about their health (25 percent) than the total U.S. population (32 percent) (*10*). Age adjustments may well reduce these differences. However, in measuring need, in the 1976 National Survey of Access to Medical Care a panel of physicians was asked to determine the age-appropriate level of medical care for a variety of symptoms. According to this procedure, Hispanics from the Southwest saw a physician 11 percent less than what the physician panel estimated necessary (*2*).

The Hispanic health literature that addresses structural characteristics of the health delivery system states that language barriers, middle-class values and attitudes, and cultural disparities between client and providers are discouraging features of health care services and facilities (*16,32,33*). These factors have been found to have negative implications for delivery of services.

It is frequently mentioned in the literature that language and cultural barriers can be overcome by recruiting bilingual or bicultural staff. But, according to Ruiz (*34*) and Phillipus (*33*), cultural barriers in the health setting are not solved by simply recruiting bilingual personnel. There is also a need for health providers to get more involved in community affairs as a means of becoming more acquainted with the clients' community problems. Inservice training is also recommended for health providers to develop cultural awareness.

Furthermore, health and mental health centers are better utilized if Hispanics are employed as administrators or in other decisionmaking positions. To occupy a position of power facilitates changes in agency policies (that is, recruitment and services delivery policies) aimed at making services more relevant and accessible to the Hispanic population (*32*).

A concern that repeatedly emerges in the literature is the limited number of Hispanics in health and mental health professions (*16,35*). That fact has been proposed as a deterrent to Hispanics seeking care. This situation is expected to get worse, because studies indicate severe underrepresentation of Hispanics' enrollments in professional schools, particularly medicine (*36,37*).

Other discouraging characteristics of the health delivery system that affect access of Hispanics as well as other groups to care are long traveling times to one's regular source of care, long waiting times in the doctor's office for a brief visit with the physician or nurse, the assignment of different doctors to patients on different appointments, and the bias of maternal and child health clinics to treat "well babies" while turning down sick children (*10,23*).

Proof of access per se is ultimately reflected in the actual utilization of health services by the Hispanic population. National data from the Health Interview Survey of 1976–77 indicate that 69 percent of the Hispanic population reported at least one physician visit, compared with 76 percent

for whites and 74 percent for blacks (*28*). Hispanics made slightly fewer visits to a physician per year (4.2) than whites (5.0) or blacks (4.6). The number of physician visits is slightly more for persons in all three racial-ethnic groups if they earn less than $10,000 a year, and the number is slightly less for persons who earn more (*28*). More recent Health Interview Survey data from 1978–80 indicate that Mexican-Americans tended to have the lowest (age-adjusted) average number of physician visits (4.3), while Puerto Ricans had 6.1 and Cuban-Americans 5.8, compared with whites (4.8), blacks (4.8), or other Hispanics (5.1). Mexican-Americans were also least likely to have seen a physician at all in the year—33.1 percent had no contact (*31*).

The 1976–77 Health Interview Survey also found that Hispanics, as well as blacks, were least likely to report a dentist visit in the year prior to the interview. In both groups 34 percent made a dentist visit; the percentage was lower for persons earning less than $10,000 a year. In this income category, 28 percent of Hispanics reported visits, compared with 31 percent for blacks and 39 percent for whites. On the other hand, the percentage with dentist visits increased for those persons with incomes of $10,000 or more a year: 41 percent for Hispanics, 40 percent for blacks, and 59 percent for whites (*28*). In 1978–80, Mexican-Americans 4 years of age and older were least likely to have seen a dentist in the year (34.5 percent), compared with whites (55.8 percent), blacks (36.9 percent), or any other Hispanic groups—Puerto Ricans (45.6 percent), Cuban-Americans (44.5 percent), or other Hispanic (49.8 percent). The rates of never having seen a dentist were also highest for Mexican-Americans (17.4 percent), compared with only 2.5 percent for whites, for example (*31*).

Regardless of income, Hispanics reported fewer admissions to the hospital (9 per 100 persons per year, compared with 10 for blacks and 11 for whites). The number of hospital days was slightly higher for the three groups earning less than $10,000 a year (*28*). Hospital use rates are, to a considerable extent, a function of the age and severity of conditions of the individuals admitted. The most recent (1978–80) NCHS data confirm that Mexican-Americans were least likely to be hospitalized and also tended to spend fewer days in the hospital than any other Hispanic or non-Hispanic group (*31*). Hispanics' low utilization of health services was reported in earlier community studies conducted by Moustafa and Weiss (*38*) in San Antonio, TX, Galvin and Fan (*39*) in the Los Angeles metropolitan area, Roberts and Lee (*40*) in Alameda County, CA, and Andersen and associates (*10*) in the southwestern States. In addition, Andersen and associates (*10*) found that the Hispanic population in the Southwest reported substantially fewer preventive examinations in the absence of illness than the total U.S. population. These researchers concluded that the low utilization of medical services (reflected in low numbers of physician and dentist visits) was related more to socioeconomic and enabling factors than to need. The lack of insurance coverage appears to be a particularly significant barrier to the use of physicians' services.

Underutilization of health services is also reflected in the area of prenatal care and use of family planning (*41–43*) and mental health services (*28*).

Finally, the literature on Hispanics' access to medical care explores Hispanics' levels of satisfaction with the delivery of health services. Data from the 1976 access study indicate that Hispanics from the Southwest were the most dissatisfied of all racial-ethnic groups studied with the cost of medical care on their last physician visit (*10*). The percentage of dissatisfaction (39 percent) with this dimension was slightly above that for the total U.S. population (37 percent). Dissatisfaction with appointment and office waiting times ranked second, with 32 percent of Hispanics from the Southwest expressing dissatisfaction with these indicators. This percentage is substantially higher than the 16 percent dissatisfied with appointment times and 28 percent dissatisfied with office waiting times in the total U.S. population.

Dissatisfaction with the interaction with providers—as measured by the information provided by physician—(24 percent of those interviewed) and time spent with physician (23 percent) ranked third. The percentages of dissatisfaction (18 percent) were higher than those of the total U.S. population (16 percent). When adjusted for socioeconomic factors, needs, and previous experience with the health care system, the dissatisfaction of Hispanics with cost of care and time spent with physician appeared to be associated more with socioeconomic variables than with level of need and experience (*10*).

In summary, Hispanics as a minority group tended to be socioeconomically disadvantaged, as reflected in their low education, low income, and high unemployment rates, compared with the U.S. population as a whole. Their socioeconomic and

cultural factors have given rise to a series of barriers to their access to and utilization of health services, especially by the Mexican-American population.

In the past two decades, some efforts were made by the government (Federal, State, and local) to make health services more accessible, available, and appropriate to the needs of Hispanics. Despite these improvements, the literature reveals that some inequities persist. For example, Hispanics are least likely to have a regular source of care. When a regular source of care is reported, Hispanics are most likely to use public facilities, hospital outpatient clinics, and emergency rooms. They are least likely to have a regular doctor with services available to take care of emergencies after office hours.

In addition, Hispanics are least likely to have health insurance coverage. When health insurance coverage is reported, certain segments of the Hispanic population (for example, Puerto Ricans) primarily report having public coverage only (such as Medicaid).

Other factors that inhibit Hispanics from access to health care are related to the structural characteristics of the health delivery system, such as shortages of bilingual and bicultural staff, the middle class values of health providers, and a series of inconveniences in the provision of health services (for example, long waiting times to see a physician once they get to his or her office).

The result of Hispanics' difficulties in obtaining health care is likely to be lower use of health and mental health services. This situation could get worse because of cuts in basic health and human services programs. In the following sections, 1982 national survey data are presented to explore the potential further impact of these cuts on Hispanics' access to health services.

Methodology

Sample. During spring and summer of 1982, Louis Harris and Associates conducted a national telephone interview survey of the total U.S. population (*3,4*). A total of 3,000 families were interviewed. In addition, the sample design included oversampling of low-income families, which yielded an additional 1,800 families. One adult and one child under 17 years of age (if the child lived in the home) were randomly selected, yielding a total of 6,610 individual interviews. The selected adult or adult proxy, usually a parent, was interviewed for the child. Data were collected on the type, location, and availability of services of one's regular source of health care; types of health insurance coverage; health status information; utilization of health services (including hospital use and preventive care); and satisfaction with the services received. To permit assessment of the current impact of the economic and political trends, information was also collected on the special access problems of families who are most apt to be affected by the economic hard times of the past few years—those who had a serious illness in the family or experienced particular problems in obtaining care, especially for financial reasons. Individual interviews varied in length but averaged about half an hour.

The overall response rate for the survey was 60 percent. Although we would have hoped for a higher response rate, weights were applied to adjust for the nonresponse. These weights also adjust for the method of sampling individuals, the oversampling of families below poverty level, and biases that may result from households without telephones (*3*).

For the purpose of this paper, Hispanics were those who identified themselves as such in the question, "Are you of Hispanic origin or not?", regardless of their racial classification. All non-Hispanics were then assigned to the white, black, or other (oriental and other race) categories based on their response to the racial classification question, "Do you consider yourself white, black, oriental, or what?"

A total of 563 Hispanics, 688 blacks, and 5,264 whites were interviewed. No data were collected on the different Hispanic subgroups. Since this is a national sample, it is expected that the mix of Hispanics might reflect the mix in the country as a whole (58 percent Mexican-American, 16 percent Puerto Rican, 6 percent Cuban, and 20 percent other) (*28*). The questionnaire was not translated into Spanish. However, Spanish-speaking interviewers were available to do the interview in Spanish if the respondent preferred. The absence of a Spanish version of the questionnaire may have resulted in some unknown amount of misinterpretation of the questions and some misclassification of responses. We do know that respondents interviewed in Spanish tended to be older, were less apt to have a high school education, and were more likely to report their health as fair or poor.

Measures of access levels. Access implies ease of entry to the health care system. We will first

examine demographic and need characteristics that predispose people to enter the system, such as whether people have a regular source of care, how long they have to wait to see a physician, and whether they have health insurance. We will then consider enabling factors that facilitate utilization of care. Finally, we will treat outcomes (realized access) such as actual utilization of health services, levels of satisfaction with medical care received, and special problems in obtaining care.

Analysis. In the following analyses we will compare Hispanics with the white and black populations in the United States. Variation will be explored for these population groups according to predisposing, enabling, and need characteristics that predict the use of health services. In addition, differences in use of services, satisfaction with care, and perceived difficulty in obtaining necessary services will be examined. Tests of significance of means and proportions will be used to judge the significance of the differences uncovered. For selected access measures, multiple classification analysis (MCA) will be used to see if significant differences between Hispanics and the rest of the population can be accounted for by related predisposing, enabling, and need factors.

Findings

Predisposing and need characteristics. Certain predisposing and need characteristics, such as age, sex, education, family size, and health, are associated with people seeking health services. The Hispanic population is young, with a relatively small proportion 65 years of age and older (table 1). The proportion of Hispanic females is similar to that for the rest of the population.

Table 1 confirms the lower level of education of minorities. One-quarter of the Hispanics (26 percent) and one-third of blacks (32 percent) come from homes in which the main earner has not completed high school, compared with 17 percent for whites. Family size is larger for minorities (more than 4 persons per family compared with about 3½ for whites). About one-quarter of the Hispanic respondents elected to be interviewed in Spanish, providing some measure of language preference among Hispanics. Furthermore, Hispanics were most likely to have lived a shorter time in the community; 39 percent reported living in the community 5 or fewer years, compared with 28 percent for blacks and 26 percent for whites.

Turning to the need measures, table 1 reveals that Hispanics are more likely to report fair or poor health (18 percent) than whites (13 percent), but less likely to do so than blacks (24 percent). There are no significant differences among the ethnic groups in reporting of disability days, although Hispanics appear to report less disability, as our literature review has suggested.

Enabling factors. Enabling factors include financing and residential characteristics and how care is

Table 1. Characteristics of Hispanics, blacks, and whites in study of access to medical care, United States, 1982 [1]

Characteristics	Hispanics	Blacks	Whites	Total U.S. population
Total (percent)	8	11	80	100
Predisposing factors:				
Age under 6 years (percent)	10	9	8	8
Age 65 years and over (percent)	5	8	[2]12	11
Female (percent)	50	53	52	52
Family's main wage earner did not complete high school (percent)	26	32	[2]17	19
Mean family size (number of persons)	4.2	4.0	3.4	3.5
Residence 5 or fewer years in community (percent)	39	[2]28	[2]26	28
Interviewed in Spanish (percent)	26	. . .	. . .	. . .
Need factors:				
Fair or poor health (percent)[3]	18	[4]24	13	15
Mean disability days[5]	11.5	15.5	14.1	14.0

[1]Information from the questions, "Are you of Hispanic origin or not" and "Do you consider yourself white, black, oriental, or what?" Those who said "yes" to the Hispanic origin question were assigned this status, regardless of their racial classification. All non-Hispanics were assigned to the white, black, or other (oriental and other race) categories, based on their responses. Oriental and other race categories were excluded from analyses.

[2]Significantly different from Hispanics ($P < .01$).

[3]Based on respondents' rating of their general health as (1) excellent, (2) good, (3) fair, or (4) poor.

[4]Significantly different from Hispanics ($P < .05$).

[5]Refers to the number of days during which respondents had to stay in bed or cut down on their usual daily activities. Bed days exclude hospital days.

Table 2. Enabling indicators of access to medical care for Hispanics, blacks, and whites, United States, 1982 (percentages)

Enabling indicators	Hispanics	Blacks	Whites	Total U.S. population
Total	8	11	80	100
Financing:				
Below poverty level[1]	31	[2]48	[3]21	25
No health insurance[4]	16	11	[3]7	9
Family's main wage earner unemployed[5]	8	9	4	5
Family's main wage earner not in labor force[5]	12	[3]20	16	16
Organization:				
Have particular physician[6]	72	67	[3]79	77
Have regular source of care but no particular physician	17	20	11	12
Have no regular source of care	11	14	10	11
Use hospital outpatient department or emergency room as regular source of care[7]	12	[3]20	8	10
Waiting time more than 30 minutes[8]	29	23	[2]15	17
Community residence:				
Standard Metropolitan Statistical Area (SMSA)—central city	36	[2]53	[2]24	28
SMSA—other	48	[2]28	49	47
NonSMSA—nonfarm	15	14	[3]22	20
NonSMSA—farm	2	5	4	4
Community region:				
Northeast	18	17	22	21
North central	15	18	[2]29	27
South	31	[2]57	31	34
West	36	[2]8	[2]18	18

[1]The poverty level cutoffs were based on a poverty index developed by the Social Security Administration. The cutoff used here was adjusted by family size only and multiplied by 1.5 (150 percent of poverty level). See reference *3* (appendix c) for further explanation.

[2]Significantly different from Hispanics ($P < .01$).

[3]Significantly different from Hispanics ($P < .05$).

[4]Adult respondents only were asked about insurance coverage. This information was used to provide insurance coverage estimates for the U.S. adult population. Persons without any form of public or private coverage are uninsured. See reference *3* for further explanation.

[5]Respondents were asked to describe their current employment status. "Unemployed" includes those persons looking for work, those not looking for work, and those laid off or on strike. Those not in the labor force include persons who are retired or unable to work, who keep house, or who are full-time students.

[6]Persons reporting a regular source of care were asked if they usually see one particular physician or not. See reference *3* for additional information.

[7]Persons reporting a regular source of care were specifically asked if they usually go to a hospital outpatient clinic or to a hospital emergency room. See reference *3* for additional information.

[8]Persons who had visited a physician in the past year were asked in reference to their most recent visit, "How long did you have to wait to see the doctor once you got there?"

organized. Enabling factors facilitate the receipt of services. Hispanics are more likely than whites to have a family income that places them below the poverty level (31 percent versus 21 percent for whites) (table 2). In contrast, they are significantly less likely than blacks (48 percent) to be below the poverty level.

Hispanics are more likely to have no health insurance coverage (16 percent) than either blacks (11 percent) or whites (7 percent). Trevino and Moss (*30*) reported similar relationships for a national sample from 1978–80, but that data showed that the proportion of Hispanics under age 65 without insurance appears somewhat higher (26 percent versus 18 percent for blacks and 9 percent for whites). Both minority groups are more likely than whites to live in families in which the main earner is unemployed (table 2). However, Hispanics are less likely than blacks to have family main wage earners who are not in the labor force, that is, retired or unable to work (12 percent versus 20 percent).

Hispanics are less likely to name a particular physician as their regular source of care (72 percent) than whites (79 percent) (table 2). However, they are about as likely to report no regular source of care (11 percent versus 10 percent). On the other hand, more Hispanics than whites report a place they go to regularly but do not name a particular physician they normally see at that place.

Hispanics appear more likely to use an outpatient department or emergency room than whites (12 percent versus 8 percent), although the difference is not significant. However, Hispanics are significantly less likely to use an outpatient department or emergency room (12 percent) than blacks (20 percent). Among all ethnic groups, Hispanics are most likely to report waiting times to see a doctor of 30 minutes or more. Twenty-nine percent

Table 3. Utilization indicators of access to medical care: Hispanics, blacks, and whites, United States, 1982

Utilization indicators	Hispanics	Blacks	Whites	Total U.S. population
Total	8	11	80	100
Physician and hospital use:				
Percent seeing a physician in last year[1]	80	82	82	81
Mean number of medical doctor visits per person per year[2]	6.7	6.7	5.9	6.1
Percent hospitalized in a year[3]	9	9	10	10
Mean nights in hospital for those hospitalized[4]	6.5	12.3	9.8	10
Percent outpatient department-emergency room visits of total medical doctor visits[2]	16	[5]27	17	18
Preventive care—adults[6]:				
Percent with blood pressure check	73	77	78	78
Percent females with Pap smears	67	64	[7]58	60
Percent females with breast examinations	64	68	65	65
Preventive care—children[8]:				
Percent with tuberculosis skin test	80	[7]71	81	80
Percent with measles immunization	93	92	94	94
Percent with diphtheria-pertussis-tetanus (DPT) immunization	97	96	98	98
Percent with poliomyelitis immunization	96	98	97	97

[1]Information obtained from the question, "Did you see or talk to a doctor anytime during the past 12 months, that is, since ... 1981?" This response includes visits to the physician and any visit to a nurse or other medical person on the physician's staff instead of the physician.

[2]Mean number of visits to medical doctor is based on the total visits to medical doctors, osteopaths, or their nurses or technicians at the following sites: patient's home, physician's office or private clinic, company or union clinic, school clinic, neighborhood or government-sponsored clinic, hospital outpatient clinic, hospital emergency room, or other place.

[3]Information based on response to the question, "Have you been a patient overnight in a hospital during the past 12 months?"

[4]Refers to the mean number of nights that respondents stayed in a hospital during the past 12 months.

[5]Significantly different from Hispanics ($P < .01$).

[6]Persons 17 years of age or older were asked if they had a blood pressure reading within the last 12 months. Women 17 years of age and older were also asked if they had a pap smear or a breast examination by a physician.

[7]Significantly different from Hispanics ($P < .05$).

[8]Proxy respondents for children under 17 years of age were asked if the child ever had a skin test or any kind of test for tuberculosis, poliomyelitis shots, or medicine, or DPT or baby shots in the last 12 months.

of Hispanics reported waiting 30 minutes or more, compared with 15 percent of whites.

Finally, table 2 shows that generally more Hispanics live in urban areas than whites but fewer than blacks. Compared with whites, more Hispanics live in central cities of Standard Metropolitan Statistical Areas (SMSAs), and fewer live in non-SMSAs. Conversely, compared with blacks, fewer live in central cities but proportionately more live in SMSAs outside the central city. Proportionately, more Hispanics than other ethnic groups live in the West. Fewer Hispanics live in the north central States than whites, and fewer live in the South than blacks.

Realized access to medical care. Table 3 shows relatively few significant differences among Hispanics, whites, and blacks in their use of physician, hospital, and preventive services. There are no significant differences in the proportion seeing a physician or the mean number of visits for those seeing a physician. Similarly, NCHS survey data (*31*) show no differences in 1978–80 in the mean number of visits between Hispanics and non-Hispanics, but do suggest that a smaller proportion of Hispanics see the physician. There are also no significant differences in the percent hospitalized or nights spent in the hospital (table 3). Hispanic rates appear considerably lower, but the large standard errors prevent the differences from being significant. Still, the results support earlier findings showing Hispanics to be low utilizers of inpatient services. The proportion of ambulatory visits taking place in outpatient departments and emergency rooms is similar for Hispanics and whites (16 percent and 17 percent), while blacks have a considerably higher proportion of ambulatory care visits to the hospital (27 percent).

Generally, Hispanics are as likely as other groups to receive preventive services. In fact, where significant differences are found, Hispanics are more likely to receive services than the comparison groups. Female Hispanics are more likely to receive Pap smears than whites, and Hispanic children are more likely to have tuberculosis skin tests than black children.

Satisfaction. Hispanics reported being significantly more dissatisfied with their medical care than whites on several measures but similar to blacks

Table 4. Percent not completely satisfied with aspects of recent medical visit: Hispanics, blacks, and whites, United States, 1982[1]

Aspect	Hispanics	Blacks	Whites	Total U.S. population
Total	8	11	80	100
Travel time	29	22	[2]19	20
Office waiting time	37	34	31	31
Time with physician	29	23	[2]20	21
Information received	25	24	[3]17	18
Out-of-pocket cost	38	43	40	40
Quality	24	24	[3]17	18
Overall visit	28	28	[3]21	22

[1]There were seven questions asking respondent's satisfaction with different aspects of the recent medical visit. For each, the respondent had three choices: "completely satisfied," "somewhat satisfied," and "not at all satisfied."

[2]Significantly different from Hispanics ($P < .01$).

[3]Significantly different from Hispanics ($P < .05$).

Table 5. Special issues in access to medical care in 1982 for Hispanics, blacks, and whites (percentages)

Issues	Hispanics	Blacks	Whites	Total U.S. population
U.S. families who found it more difficult to get help in 1982 than earlier	10	10	[1]5	6
Families refused care for financial reasons in 1982	3	2	1	2
U.S. adults with less insurance coverage in 1982 than previously	30	32	25	26
With less insurance coverage who put off care	33	[2]14	[2]23	23
Family who needed care in 1982 but did not get it	9	8	[1]5	6
Who needed care and tried to get it	31	[2]49	[1]39	40
Family with a seriously ill family member	11	11	9	9
With seriously ill family member who was not able to obtain special service	11	[2]24	9	11
With serious illness for whom it was a financial problem	39	40	[2]18	22
Persons with medical emergency	18	16	14	15
With medical emergency who did not make a visit or had trouble getting to care	2	4	5	5
With medical emergency who were not at all satisfied with visit overall	17	[2]7	[1]11	11
U.S. families in trouble regarding access to care[3]	21	22	[2]13	14

[1]Significantly different from Hispanics ($P < .05$).

[2]Significantly different from Hispanics ($P < .01$).

[3]Families with one or more of the following problems: more difficulty in getting care than in previous years, family members refused care, family members needed but did not get medical help, had a seriously or chronically ill family member and could not find certain services, and/or had major financial problems due to illness.

(table 4). Hispanics were less likely than whites to be completely satisfied with their most recent medical visit in the measures of travel time, time with physician, information received, quality, and the overall visit. Similarly, office waiting time was viewed less satisfactorily by Hispanics but not significantly so. Only for out-of-pocket cost was the trend reversed (more Hispanics than whites were completely satisfied), but the difference was not significant.

Special access issues. Table 5 shows a number of questions about access to medical care in special situations which were asked of the national sample in the 1982 Harris study. It highlights numerous problems of special importance to Hispanics in

Table 6. Selected indicators of access to medical care for Hispanics and non-Hispanics, adjusted for predisposing, enabling, and need characteristics, United States, 1982

Group	Particular doctor as regular source of care		Office waiting time of more than 30 minutes		Not completely satisfied with quality of care	
	Percent	Adjusted F value	Percent	Adjusted F value	Percent	Adjusted F value
Hispanics	75	...	29	...	22	...
Non-Hispanics	77	.11	16	[1]4.05	18	.75

[1]Adjusted *F* value is significant at .05 level.

attaining health care. On most measures, more Hispanics have problems than whites. Hispanics found it more difficult than whites to get medical help in 1982 than earlier, were more often refused care for financial reasons in 1982, and had less insurance coverage in 1982. More Hispanics than whites put off care in 1982 because they had less insurance, more needed care in 1982 but did not get it, more had a serious illness in the family that caused a financial problem, more had medical emergencies, and more were not at all satisfied with the care received. Finally, a summary measure of proportion of families with some type of access problem (see footnote 3, table 5) showed 21 percent of the Hispanic families in trouble, compared with 13 percent of the white families.

Only one measure suggested whites had more problems than Hispanics—5 percent of whites with a medical emergency did not make a visit or had trouble getting care, compared with 2 percent of Hispanics. Generally, the differences in table 5 between Hispanics and blacks were not large. Hispanics who had less health insurance coverage in 1982 than previously were more likely to put off care than blacks, and Hispanics were more likely than blacks not to be at all satisfied with the care received for a medical emergency. Blacks, however, were more likely to have attempted to get care when they needed it, and blacks were more likely to fail to obtain special services for a seriously ill family member.

Multivariate analyses of access differences. Important access indicators that showed significant differences between Hispanics and the comparison groups included having a particular physician as a regular source, office waiting time, and general dissatisfaction with quality of care. This multivariate analysis seeks to discover what other factors might be related to these observed differences.

Multiple classification analysis (MCA) is used to adjust differences between Hispanics and non-Hispanics. Certain key predisposing and enabling variables are included in each adjustment. These include age, sex, residence, race, employment status, insurance coverage, and regular source of care (except for the particular physician analysis). In addition, other selected predisposing and need variables (time in the community, disability days, and perceived health) were included in particular adjustments if they had a zero-order correlation of .05 or higher with the access indicator.

Table 6 shows the adjusted Hispanic and non-Hispanic values for each access indicator. An adjusted *F* statistic is shown in table 7 for all of the variables entered in the model. The *F* statistic reported in the MCA procedure was adjusted to reflect the fact that the sample was weighted and clustered. For details concerning these MCA analyses and the *F* test adjustments, see the work of Aday and associates (*3*).

The difference between Hispanics and non-Hispanics in the proportion having a particular physician as a regular source of care is eliminated by the adjustment process (75 percent, Hispanic versus 77 percent, non-Hispanic). Other significant variables in the analysis included sex and time in community. Particularly noteworthy is the finding that Hispanics are much more likely to be newcomers in the community. When this is taken into account, no significant difference remains between Hispanics and others in the proportion who can name a particular physician as their regular source of care. Thus, residential mobility appears to limit Hispanic access in this instance.

Table 6 shows that adjustments have no effects on the significant differences in waiting time between Hispanics and others. After adjusting for all other variables in the model, there were still 29 percent of the Hispanics waiting more than 30 minutes, compared with 16 percent of non-

Table 7. *F* values for adjustment characteristics for selected indicators of access to medical care for Hispanics and non-Hispanics, adjusted for predisposing, enabling, and need characteristics, United States, 1982

Particular doctor as regular source of care		*Office waiting time of more than 30 minutes*		*Not completely satisfied with quality of care*	
Characteristic	*F value*	*Characteristic*	*F value*	*Characteristic*	*F value*
Under age 6	3.34				
Over age 64	1.49	Over age 64	2.51	Over age 64	3.29
Sex	[1]4.61	Sex	.09	Sex	.52
		Perceived health	3.48	Perceived health	[1]10.54
150 percent poverty level × race	.94	150 percent poverty level × race	.58	150 percent poverty level × race	.13
Main earner's employment status	.09			Main earner's employment status	.54
Time in community	[1]9.52			Time in community	[1]6.39
Residence	1.20				
		Region	1.25		
		Insurance coverage	.18	Insurance coverage	.11
		Regular source of care	1.24	Regular source of care	1.54
				Disability days	.04

[1] Adjusted *F* value is significant at .05 level.

Hispanics. These differences may be due to the unavailability of Spanish-speaking health care personnel or the specialty of the types of providers contacted.

Perceptions of quality of care differences are reduced by the adjustment process so that the proportion not completely satisfied with the most recent visit to the doctor for Hispanics (22 percent) is not significantly higher than for non-Hispanics (18 percent). Significant variables in this model include perceived health and time in the community. These findings suggest that perceptions of lower quality of care by Hispanics may be associated with poor perceived health and the discontinuities resulting from having lived for a shorter time in the community.

Summary and Implications

Hispanics in the United States have a number of predisposing characteristics that differentiate them from the rest of the U.S. population and may influence the health services they receive. They are a relatively young population. They are more likely than whites to be in families with main earners who have not completed high school. The average Hispanic family size is larger. Spanish is the preferred language in one-fourth of the interviews. Hispanics have lived in their community for a shorter period than the rest of the population. They are more likely to report fair or poor health than whites but less likely to do so than blacks.

Hispanics' ability to obtain health services is affected by a number of enabling characteristics. They are more likely to be below the income poverty level than whites, but less likely than blacks. Hispanics are less likely to have health insurance coverage than either whites or blacks.

Hispanics are less likely than whites to report a particular physician as a regular source of care, but not more likely to be without a regular source at all. They are twice as likely as whites to report a waiting time of 30 minutes or more.

Our 1982 analysis utilization of basic measures does not provide strong evidence of special problems for Hispanics. They do not differ significantly from whites in their use of hospitals, physicians, or outpatient departments and emergency rooms. Although their inpatient use appears low, large standard errors preclude statistically significant differences. Reported preventive use by Hispanics is generally as high or higher than that for both blacks and whites.

The access measures showing the greatest problems for Hispanics in 1982 are those related to satisfaction with services and reported difficulties in obtaining service. Hispanics are less satisfied than whites on a host of measures describing the most recent medical visit. These levels of dissatisfaction with the visit are similar to those of blacks. Similarly, Hispanics generally report more problems in obtaining health insurance and obtaining and financing care for serious illness and emergencies than whites. Summarizing these access prob-

lems, more than one-fifth of Hispanic families are described as "in trouble" with respect to access, compared with 13 percent of whites. Hispanics and blacks have similar levels of special access problems.

In conclusion, in 1982, Hispanics' ability to obtain health services continued to be hampered by their relatively low income and lack of health insurance. Still, they generally reported a regular source of care although they must wait longer to see the physician. The realized access picture for Hispanics is somewhat of a paradox. While Hispanics do not appear to be at a particular disadvantage in terms of volume of medical care and preventive services received, they are less satisfied with their care and report more difficulty in obtaining services they believe they need. This paradox applies to blacks as well as Hispanics. The recession and public medical care service cutbacks did not appear to result in substantial reduction in the volume of medical care received by minorities. Still, the services available to minorities are viewed by them as less effective in meeting their needs. Further, the special access question suggests particular difficulties and barriers for minorities in obtaining needed medical services.

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