

Racial and Ethnic Disparities in Adolescent Health and Access to Care

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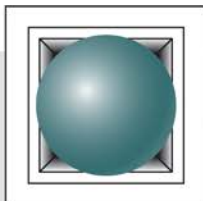
Racial and ethnic minority adolescents currently represent 39% of all adolescents in the U.S. By 2040, they will constitute the majority of the nation's adolescent population. In the nation's five largest cities -- New York, Los Angeles, Chicago, Houston, and Philadelphia -- minority adolescents already make up more than half of the adolescent population.²

Hispanic and Black adolescents are the largest minority groups. Among U.S. adolescents, 17% are Hispanic and 15% are Black. Together they represent a third of the adolescent population, with other minorities accounting for 7% of the adolescent population.³ By 2040, the percentage of Hispanic adolescents is projected to increase by almost 60%, bringing their proportion of the adolescent population to 27%, with the percentage of Black adolescents remaining essentially unchanged and the percentage of White adolescents steadily declining.⁴

Compared to Whites, Hispanic and Black adolescents face significant economic disadvantage. They are more than twice as likely as White adolescents to be living in families with incomes at or below 200% of the federal poverty level.⁵ As many as 60% of Hispanic and 57% of Black adolescents

are from such low-income families, while only 24% of White adolescents are.⁶ In addition, Black adolescents, but especially Hispanic adolescents, are more likely than Whites to be without health insurance coverage, despite the fact that a sizeable proportion would meet citizen requirements and be eligible for Medicaid or the State Children's Health Insurance Program (SCHIP) coverage. Among White adolescents, 8% are uninsured all or part of the year; among Blacks, the proportion is 11%; and among Hispanics, it is 25%. Among adolescents without insurance, 72% of Hispanics and Blacks live in families with incomes at or below 200% of poverty compared to 49% of Whites.⁷

Given the demographic trends, it is important to understand the extent to which health status and health care access disparities may exist for Black and Hispanic adolescents. Unfortunately, as Elster et al. have reported, there are few studies on health care access and use among adolescents in which race and ethnicity have been examined independent of socioeconomic factors, and these do not permit any definitive conclusions.⁸ With respect to health status, there is a body of literature that shows higher rates of overweight, low fitness, and diabetes among



Hispanic and Black adolescents compared to White adolescents,^{9,10,11,12,13,14} but little else is known about other racial and ethnic disparities that might exist. Several studies have, however, assessed the important role that family income and health insurance play in assuring health care access for adolescents.^{15,16,17} A strong association has been found between higher family income and improved access to care. The literature also shows that insured adolescents fare much better in terms of access, use, and fewer unmet needs compared to uninsured adolescents.^{18,19,20}

This fact sheet provides new national information on disparities in health status and access to care among Hispanic, Black, and White adolescents ages 12 through 17. It addresses racial and ethnic disparities for a broad set of indicators and also examines the impact of income, insurance, and mother's or household education on these indicators. A companion fact sheet provides information on racial and ethnic disparities in health status and access to care for older adolescents ages 18 through 21.²¹ This fact sheet does not address the very critical health issue of disparities in environmental and behavioral risks, which will also be addressed in a subsequent fact sheet. Understanding whether racial and ethnic disparities exist is important not only for federal and state policymakers, but also for clinicians, managed care plans, public health programs, and purchasers.

Methodology

Two national data sets were used for this analysis -- the National Health Interview Survey (NHIS) and the National Survey of Children's Health (NSCH). The NHIS is a large annual in-person household interview survey that collects information on access to care, utilization, and health status for a nationally representative sample of the U.S. civilian, non-institutionalized population.²² A pooled sample from the 2004 and 2005 surveys was used for this analysis. The NSCH is a new large household interview survey, conducted by telephone during 2003-2004, that provides a broad range of information about health and well-being for a sample of children and adolescents, birth to 18, that is

representative of the nation and individual states.²³

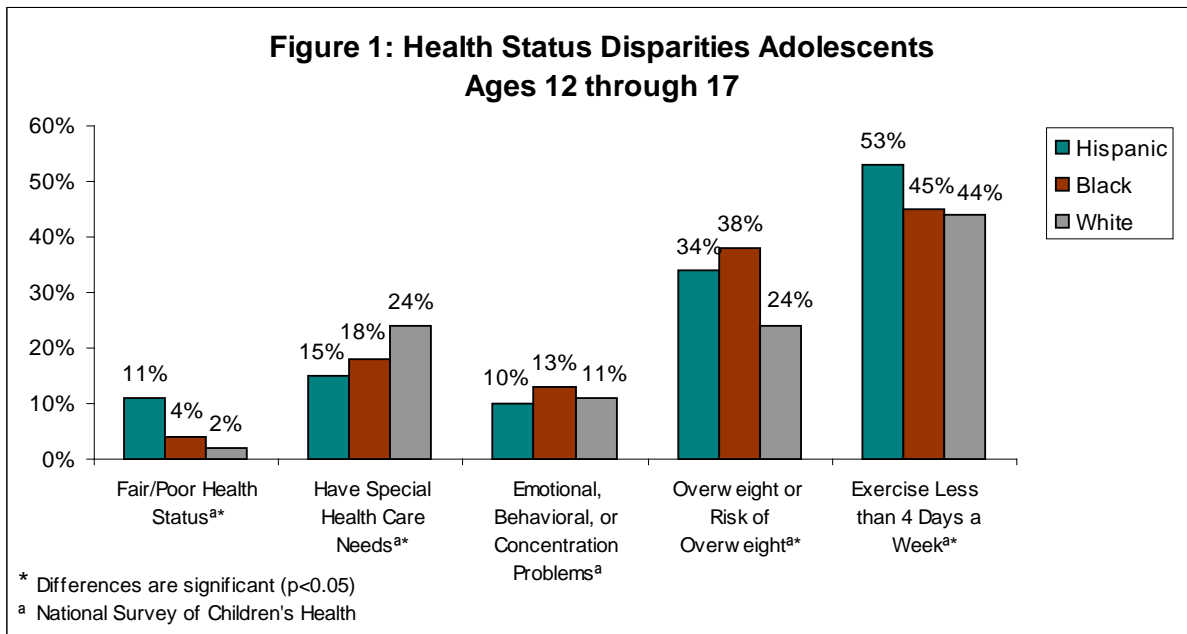
The relationship of race and ethnicity was examined for a set of 12 indicators pertaining to health and risk status, access to care, service utilization, and unmet needs.²⁴ Our study compares the results for Hispanic, non-Hispanic Black, and non-Hispanic White adolescents and includes a multivariate analysis. Copies of the full models and results of the multivariate analysis are available from The National Alliance To Advance Adolescent Health. All differences reported as significant are significant at the .05 level or higher. It is important to note that the survey findings reported are parental responses, and parents may be unaware of the health care services used or needed by their teens, since many adolescents seek care on their own.²⁵

Disparities in Health Status

Significant differences were found in general health status among Black, but especially Hispanic, adolescents compared to White adolescents. Only 2% of White adolescents are reported by their parents to be in fair or poor health, while twice as many Black adolescents and five times as many Hispanic adolescents are reported to be in fair or poor health, as shown in Figure 1.

Yet, interestingly, Hispanic and Black adolescents are less likely than White adolescents to be reported as having a special health care need, a chronic health condition -- physical, behavioral, or developmental -- that requires an amount or level of health care services above what is typically needed. Also, with respect to moderate or severe difficulties in the areas of emotion, behavior, concentration, or the ability to get along with others, responses for Black and Hispanic adolescents are not statistically different from those for Whites. The substantially higher reported prevalence of special needs among White adolescents, however, may be a reflection of differences in health care access and early detection and diagnosis of health care conditions.

Given the link between obesity and chronic conditions, such as diabetes, cardiovascular



disease, and hypertension, the fact that Hispanic and Black adolescents are far more likely than White adolescents to be reported as overweight is a significant finding. Compared to White adolescents, Hispanic adolescents are more likely to be overweight or at risk for overweight and they are less likely to engage in regular, vigorous physical activity. Black adolescents, however, are even more likely to be overweight or at risk of overweight compared to Hispanic adolescents, which is particularly significant given their reported higher levels of participation in regular, vigorous exercise.

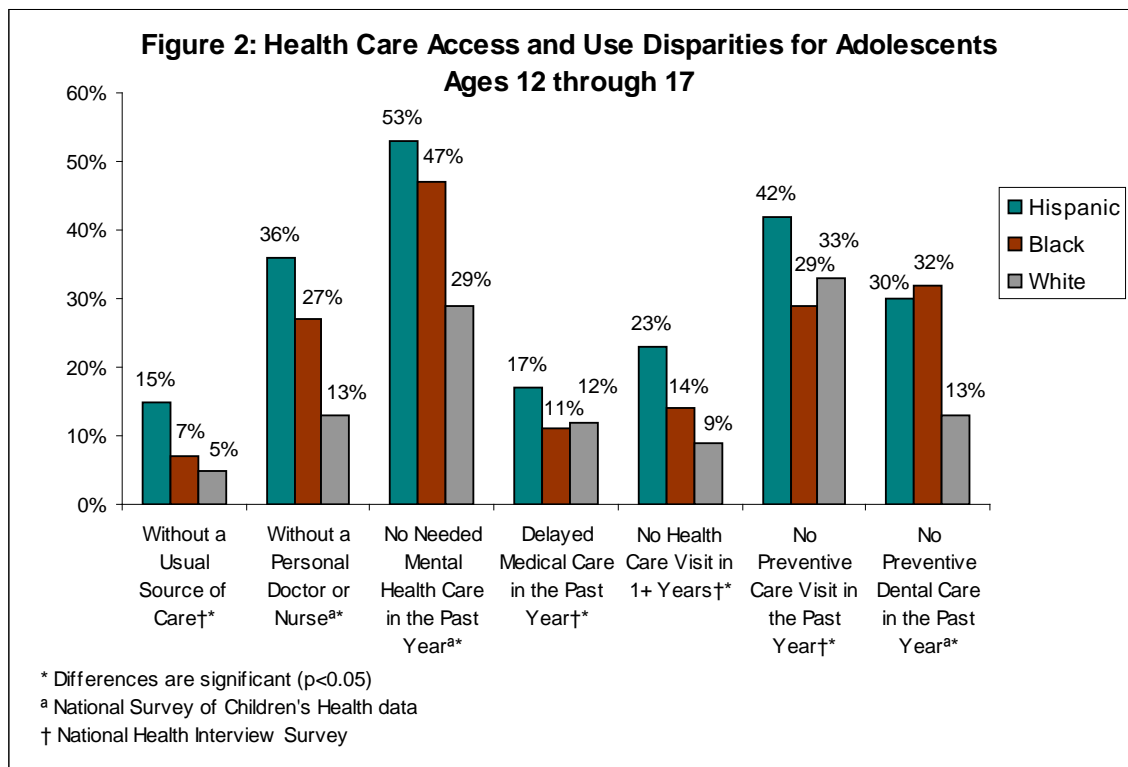
Disparities in Access and Use

On indicators of access and use, Hispanic adolescents consistently fare far worse than White adolescents, while for Black adolescents disparities are more variable, as shown in Figure 2. Hispanic youth are more than twice as likely as both White and Black adolescents to be without a usual source of care. They are also almost twice as likely as White adolescents to use clinics, including hospital outpatient departments, as their usual source of care, while for Blacks differences in usual source of care are evident but less dramatic. This greater reliance on clinics may explain why, compared to White adolescents, a substantially higher proportion of Black, and, especially Hispanic,

adolescents do not have a personal doctor or nurse, an indication that it may be more difficult for minority adolescents to establish a trusting relationship with a particular health professional who knows their history.

Hispanic adolescents are reportedly also more likely to delay seeking medical care. They are not more likely to delay care because of cost than White or Black adolescents are; rather, they are more likely to delay care because they could not get an appointment or had to wait too long to see the doctor.

Compared to White adolescents, a significantly higher proportion of both Hispanic and Black adolescents are going a year or more without a visit to a health care provider. For Hispanics, however, the disparity is greater than for Blacks. They are reportedly more than twice as likely as Whites not to have had a health care visit in at least a year. Disparities for Hispanic adolescents are almost as great for preventive care visits and even greater for preventive dental care visits. Black adolescents are actually somewhat less likely than Whites to have gone without a preventive care visit in the past year, but the disparities they face in access to preventive dental care are equal to those of Hispanics. While access to general preventive care appears to be a problem for all adolescents, access to dental care is more directly linked to race and ethnicity.



Finally, among adolescents reported to have moderate or severe emotional, behavioral or concentration problems, a remarkably large proportion of Hispanic and Black adolescents have not received any mental health treatment or counseling in the past year. About half of Hispanic and Black adolescents are not receiving needed mental health services, compared to less than a third of White adolescents. These findings, which indicate mental health access problems for all adolescents, show significant disparities for minority adolescents and are particularly disturbing given that both problems and service utilization with respect to mental health are likely to be underreported.

Explanatory Factors

To identify the extent to which other factors might provide an explanation of the racial and ethnic differences in health status and access to care among adolescents, a multivariate analysis that controlled for family income, health insurance coverage, and mother's or household education was conducted. The analysis was done for the 6 indicators that revealed the most

significant disparities for Hispanic and Black adolescents: fair or poor health status, no usual source of care, no personal doctor or nurse, more than a year without a health care visit, no preventive dental care in the past year, and no needed mental health care in the past year.

For each of the six indicators, racial and ethnic differences decrease, in some cases by as much as 50%, when family income, insurance coverage, and household education are included in the analysis, as shown in Table 1. With respect to the fair or poor health status measure, both income and insurance show significant predictive influence. With respect to the five health care access measures, income, insurance, and education have significant predictive influence for at least four measures. Being without health insurance for all or part of the year, however, is the strongest explanatory variable for three measures, with the most dramatic finding being that the odds of uninsured adolescents being without a usual source of care are 13 times greater than those for privately insured adolescents. Only for the preventive dental care measure was having a family income below 100% of poverty the most significant explanatory variable.

| Table 1. Logistic Regression Analysis for Health Indicators Showing Racial and Ethnic Disparities | | | | | | |
|---|--------------------------------------|---|---|--|---|---|
| Independent Variables | Fair/Poor Health Status ^a | Without a Usual Source of Care [†] | Without a Personal Doctor or Nurse ^a | No Needed Mental Health Care in the Past Year ^a | No Health Care Visit in 1+ Years [†] | No Preventive Dental Care in the Past Year ^a |
| Race/Ethnicity | | | | | | |
| Hispanic - Unadjusted | 6.2* | 3.2* | 4.0* | 2.8* | 1.7* | 3.7* |
| Hispanic - Adjusted | 2.9* | 1.7* | 1.9* | 2.1* | 1.5* | 1.5* |
| Black - Unadjusted | 2.4* | 1.4* | 2.6* | 2.2* | 1.3* | 3.0* |
| Black - Adjusted | 1.3 | 1.2 | 1.9* | 1.8* | 1.2* | 1.9* |
| White | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Health Insurance Coverage | | | | | | |
| Uninsured | 1.7 | 13.1* | 3.5* | 3.2* | 1.4* | 3.2* |
| Public | 2.6* | 1.5* | 1.0 | 0.8 | 1.2* | 1.1 |
| Private | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Education Level | | | | | | |
| Less than High School | 1.5 | 1.4* | 1.9* | 1.3 | 1.2* | 1.7* |
| High School | 1.7 | 1.2 | 1.5* | 1.7* | 1.0 | 1.6* |
| More than High School | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Federal Poverty Level (FPL) | | | | | | |
| 0-99% FPL | 2.7* | 1.2 | 2.6* | 1.7 | 1.3* | 4.9* |
| 100-199% FPL | 1.7 | 1.1 | 2.0* | 1.2 | 1.1 | 3.8* |
| 200-299% FPL | 1.4 | 1.5* | 1.3* | 1.2 | 1.1 | 2.1* |
| 300% FPL or greater | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |

* Differences are significant (p<0.05)

^a National Survey on Children's Health, 2003

[†] National Health Interview Survey, 2004 & 2005

Perhaps surprisingly, the impact of insurance is a function not only of being uninsured but also of having public coverage. Our analysis reveals that public health insurance is negatively associated with adolescents' fair or poor health status, being without a usual source of care, and going without a health care professional visit in the past year.

Despite the impact of family income, household education, and especially health insurance coverage on adolescents' impaired health status and lack of health care access, racial and ethnic differences still remain significant. Even adjusting for these demographic and insurance variables, the fact of being an Hispanic or Black adolescent remains significant for four indicators: being without a personal doctor or nurse, not receiving needed mental health care in the past year, not having preventive dental care in the past year, and having gone a year or more without seeing a health professional. Being Hispanic is also a significant predictive factor for not having a

usual source of care and being in fair or poor health. In fact, compared to White adolescents, the odds that Hispanic adolescents are in fair or poor health are three times greater.

With respect to the differences found for Hispanic adolescents, it was possible, at least for the measures used in the NSCH,²⁶ to probe further and investigate the impact of Spanish as the primary household language. The introduction of this additional independent variable revealed an entirely new pattern for Hispanic adolescents. According to the NSCH, 56% of Hispanic adolescents live in households in which Spanish is the primary language. They are more than twice as likely as Hispanic adolescents whose primary household language is English to be in fair or poor health (16% vs. 5%), without a personal doctor or nurse (49% vs. 20%), without needed mental health care in the past year (73% vs. 36%), and without preventive dental care in the past year (47% vs. 22%). These disparities among Hispanic adolescents remain strong and significant even

after controlling for differences in family income, health insurance coverage, and household education. Equally important is the fact that on each of these four measures, findings for Hispanic adolescents living in households with English as the primary language are either similar to or better than those for Black adolescents. Moreover, after accounting for race and ethnicity, income, insurance, and household education, living in a household with Spanish as the primary language is the strongest explanatory factor for three of the four measures. In fact, the odds that Hispanic adolescents whose primary household language is Spanish are in fair or poor health or have gone without needed mental health care in the past year are both 4.5 times greater than for Whites. For the pre-ventive dental care measure, however, family income continues to have the strongest predictive influence for all adolescents regardless of race and ethnicity or primary household language.

Conclusions

Both Hispanic and Black adolescents ages 12 through 17 face substantial disadvantages in health status and access to care compared to their White peers. Disparities are greatest, however, for Hispanics. Black adolescents fare worse than Whites on two of the five health status indicators we examined and four of the seven access indicators. Black adolescents, in fact, are twice as likely as Whites to be in fair or poor health, be without a personal doctor or nurse, and not have preventive dental care in the past year. Hispanic adolescents rank worse than Whites in three of the five health status measures and all of the seven access indicators. They are at least two to three times as likely as Whites to score poorly on the same measures that Blacks do and also at least two to three times as likely as Whites to be without a usual source of care and go a year or more without a visit to a health professional. Still, the greatest discrepancy was found among Hispanic adolescents in primarily Spanish-speaking households who by far experience the worst health status and access barriers.

For those indicators in which racial and ethnic disparities were found, multivariate analysis reveals that health insurance is a

consistently predictive factor associated with improved access to care and is the most predictive factor for three of the measures. It is only the dental care measure for which income holds the strongest predictive influence. When the household language of Hispanic adolescents is included in the multivariate analysis, primarily speaking Spanish at home is the strongest predictive factor for all but dental care. Importantly, however, race and ethnicity, being in a primarily Spanish-speaking household, insurance status, family income, and household education all independently affect some component of adolescents' health status and access to care.

Understanding these disparities is critical for tailoring effective solutions. For Hispanic adolescents from primarily Spanish-speaking households, the acculturation effect appears to play a very important role. Clearly, outreach and education efforts need to take account of their knowledge, attitudes, and beliefs, as well as those of their parents, regarding the benefit of intervention to address health problems, especially nutritional and mental health problems, and also the value of preventive care, including dental care. Also, for Black parents and adolescents, family and religious beliefs along with past experiences with the health care system are important factors to consider when designing effective outreach and health education interventions. Studies have shown that in reaching minority parents, the involvement of trusted community liaisons (such as Spanish-speaking promotoras), influential church leaders, and extended family mentors can be very effective.^{27,28,29} Similarly, to reach the adolescents themselves, many of whom are seeking care on their own,³⁰ peer health educators have been shown to successfully engage minority adolescents, encouraging their use of services and conveying important health promotion information.³¹ Linking service delivery with schools and other youth programs in minority neighborhoods also has been shown to improve health care access and use.^{32,33}

The important role that health insurance plays in mitigating access problems is clear from our data. Yet, despite state and community efforts to aggressively pursue enrollment of children and adolescents into Medicaid and SCHIP, much work still remains to enroll

potentially eligible Hispanic and Black adolescents from low-income families. Increasing insurance coverage among Hispanic adolescents is a complex issue due to language and citizenship issues. However, a great deal has been written about outreach strategies that work^{34,35} and a growing number of states are now offering state-funded insurance coverage for undocumented children and adolescents. Expanding sources of free care, especially dental care and mental health care, is another important strategy.

These findings show, however, that even when Hispanic and Black adolescents are insured they continue to encounter more

difficulties than White adolescents achieving optimal health status and accessing basic health care services. Cost is reportedly not the only reason that minority adolescents delay seeking care, and the association of public health insurance with certain negative outcomes suggests the need for improvements in health care delivery for adolescents. Establishing teen-friendly health care sites in convenient locations; extending office and clinic hours to evenings and weekends; and co-locating physical, behavioral, and dental care services could facilitate improvements in the overall health and well-being of minority adolescents.

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Endnotes

¹ Harriette Fox, Margaret McManus, and Matthew Zarit are from The National Alliance To Advance Adolescent Health in Washington, DC. Gerry Fairbrother and Amy Cassidy are from Cincinnati Children's Hospital Medical Center. Christina Bethell and Debra Read are from the Data Resource Center on Child and Adolescent Health at the Oregon Health Science University.

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The National Alliance to Advance Adolescent Health provides education, research, policy analysis, and technical assistance to achieve fundamental improvements in the way that adolescent health care is structured and delivered in the United States. Its mission is to enhance the physical and emotional well-being of adolescents, especially those who are low-income and minority, by improving the health care delivery model for adolescents and achieving the infrastructure changes needed to support it. The National Alliance seeks to promote comprehensive, interdisciplinary models of physical, mental, behavioral, and reproductive health care that incorporate a youth development philosophy and operate in collaboration with schools and other community-based programs. It also seeks to ensure that all adolescents have health insurance coverage for the services they require.

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

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