

Research Paper

Disparities in access to health care among adults with physical disabilities: Analysis of a representative national sample for a ten-year period

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Abstract

Background: People with physical disabilities are the largest underserved subpopulation in the U.S. However, disparities in access to health care and how these have changed over time have not been fully explored.

Objective: To examine national trends in disparities in access to health care and to identify the impact of physical disability and the personal factors that are associated with unmet health care needs, defined as self-reported ability to get medical care, dental care or prescription medications, among working age adults within the United States.

Methods: Logistic regression analysis of a nationally representative sample of adults ages 25–64 ($n = 163,220$) with and without physical disabilities, using pooled data from the 2002–2011 Medical Expenditure Panel Survey.

Results: Individuals with physical disabilities have 75% ($p < 0.0001$), 57% ($p < 0.0001$), and 85% ($p < 0.000$) higher odds of having unmet medical, dental, and prescription medication needs, respectively. Sociodemographic and health factors were related to unmet needs in all three measures of access to care. In particular, being female, living at or near the poverty level, and lacking health insurance increased the odds of unmet health care needs. Predicted probabilities of unmet health care needs from 2002 to 2011 show persistent gaps between individuals with and without physical disabilities, with a growing gap in unmet dental care ($p = 0.004$).

Conclusion: Having physical disabilities increase the odds of unmet health care needs. This study has important policy and community program implications. The Affordable Care Act could significantly reduce unmet health care needs, especially among individuals with physical disabilities. © 2015 Elsevier Inc. All rights reserved.

Keywords: Disability; Access; Health care; Disparity

Since the turn of the century, reducing health care disparities has been a stated goal of U.S. public policy.^{1–4} While people with disabilities are the largest underserved

subpopulation in the U.S.,⁵ disparities in health care among people with disabilities have not been fully explored. Today, there are more than 54 million Americans living with disabilities.⁶ Individuals with disabilities are more likely to experience unemployment, have lower educational attainments, and be poor.^{2,3,7} Thus, they are more likely to develop preventable secondary conditions, undergo severe medical complications, and experience hospitalizations.⁸ The social and environmental consequences of living with disabilities have a significant impact on individuals' health and wellness as well as on the public support system.⁹

During the last decade there have been some efforts to address the health and well-being of individuals with disabilities.^{2,3,9} A recent report by the Institute on Disability at the University of New Hampshire, *Health Disparities Chart Book on Disability and Racial and Ethnic Status in the United States*,⁵ compared the health experience of people with disabilities with that of racial and ethnic minorities and showed that people with disabilities had less desirable experiences for a wide range of outcomes, including health

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status, health behaviors, obesity, diabetes, and cardiovascular diseases. Research has also shown that rates of early death, preventable chronic conditions, and oral diseases are much higher among people with disabilities.^{10–12}

Public health efforts and research have now shifted from a focus on preventing disability to one of preventing secondary conditions in individuals with disabilities.^{10,13–15} Although there has been some progress in improving access to care among people with disabilities, research suggests that they continue to be more likely to have unmet health care needs¹⁶ and use fewer preventive medical services.^{5,17–22}

A number of federal reports^{1,23} and research studies have examined racial/ethnic or gender disparities among people with disabilities.^{8,24–27} For example, Iezzoni et al investigated the role of insurance in access to health care among individuals with disabilities.²⁷ They found that uninsured individuals with disabilities are more likely to have less access to health care.²⁷ In order to make progress in reducing disparities between individuals with and without disabilities, we not only need to measure the extent of those disparities, we also have to determine and target the underlying modifiable factors associated with them (i.e. income, education, and health insurance).

This study extends the previous literature in analyzing access to care among individuals with physical disabilities. The three specific aims of this study are: 1) examine the effect of physical disability on disparities in access to health care, 2) examine the effect of other social and environmental variables on disparities in access to health care, and 3) analyze the most recent national trend in access to care between individuals with and without physical disabilities. The three measures of access to care we investigated in this study are: 1) medical needs, 2) dental needs, and 3) prescription medication needs.

More than two decades have passed since the Americans with Disabilities Act (ADA) was signed into law in 1990. In addition, under the Patient Protection and Affordable Care Act (ACA), landmark legislation signed into law in 2010, many individuals, including those with physical disabilities, will have access to affordable health coverage. In the wake of the ADA,¹⁶ and prior to analyzing the effects of the ACA on access to health care, it is important to investigate what factors have been associated with unmet health care needs and whether access to health care has changed over time for individuals with physical disabilities.

Methods

Data

Data for this study was extracted from the full-year consolidated household component (HC) data files of the Medical Expenditure Panel Survey (MEPS) as collected between the years 2002–2011. The MEPS is an ongoing, nationally

representative survey of the U.S. civilian, non-institutionalized population, conducted annually by the Agency for Healthcare Research and Quality (AHRQ).²⁸ For this study, adults between the ages of 25–64 were included, resulting in an initial sample of 166,209 individuals. Variable-specific non-response rates ranged from 1% to 2%. After eliminating cases with missing data on dependent or independent variables, and cases with non-positive weights,^{29–31} the final sample consisted of 163,220 adults. Based on MEPS questions regarding functioning, described below, 21,880 individuals reported moderate or severe physical disabilities.

Variables and descriptive statistics for the sample are reported in Table 1. We used the weights, strata, and PSUs supplied with each year's HC file. Throughout, we made adjustments for the stratified and clustered survey design of MEPS, and all estimates were weighted using the AHRQ-supplied weights.^{28,31}

Physical disability

For this study, a broad definition of physical disability was used. Specifically, we adopted the ICF definition of activity limitation or disability, operationalizing physical disability as self-reported physical limitations or limitations in activities of daily living (ADLs),³² including difficulty with *standing, walking, climbing stairs, bending, reaching, and grasping*. From the cases extracted from MEPS, questions related to limitations in physical functioning were used to categorize an individual as having a physical disability. Specifically, the following question was used to identify physical disability status in the household: “Does anyone in the family have difficulties walking, climbing stairs, grasping objects, reaching overhead, lifting, bending or stooping for long period of time?” If the answer was “Yes,” then the specific person who had difficulties was identified and coded as “Yes.” Then, for each family member, a subsequent series of questions was administered to identify the severity of the difficulty: 1) no difficulty, 2) some difficulty, 3) a lot of difficulty, 4) unable to do, 5) completely unable to do. In this study, individuals were categorized as having a physical disability if they answered, “Yes” to the above screening question and reported either “a lot of difficulty” or the inability to perform a task or specified activities.

Dependent and independent variables

We examined access to care in three areas: (1) medical care, (2) dental care, and (3) prescription drug access. Each of our three multivariate logistic regression models included need-related variables such as age, gender, and measures of health and function. Also included were sociodemographic variables such as race and ethnicity, marital status, education, income, health insurance, and geographical location.

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