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Research Paper

# Prevalence and reasons for delaying and foregoing necessary care by the presence and type of disability among working-age adults

Amanda Reichard, Ph.D.*, Michelle Stransky, Ph.D., Kimberly Phillips, M.S., Monica McClain, Ph.D., and Charles Drum, J.D., Ph.D.

*Institute on Disability, University of New Hampshire, 10 West Edge Dr., Suite 101, Durham, NH 03824, USA*

## Abstract

**Background:** While it is commonly accepted that disparities in unmet need for care vary by age, race/ethnicity, income, education, and access to care, literature documenting unmet needs experienced by adults with different types of disabilities is developing.

**Objective:** The main objective was to determine whether subgroups of people with disabilities are more likely than people without disabilities to delay/forgo necessary care, in general and among the insured.

**Methods:** We used pooled Medical Expenditure Panel Survey data (2004–2010) to examine delaying or forgoing medical, dental, and pharmacy care among five disability subgroups (physical, cognitive, visual, hearing, multiple) and the non-disabled population. Logistic regression was conducted to examine delayed/forgone care, controlling for sociodemographic, health, and health care factors.

**Results:** Over 13% of all working-age adults delayed/forwent necessary care; lack of insurance was the strongest predictor of unmet needs. Among the insured, disability subgroups were greater than two times more likely to report delayed/forgone care than adults without disabilities. Insured working-age adults with multiple chronic conditions and those with ADL/IADL assistance needs had higher odds of delayed or forgone care than their peers without these characteristics. Reasons related to affordability were most often listed as leading to unmet needs, regardless of disability.

**Conclusion:** Although insurance status most strongly predicted unmet needs for care, many people with insurance delayed/forewent necessary care. Even among the insured, all disability subgroups had significantly greater likelihood of having to delay/forgo care than those without disabilities. Differences also existed between the disability subgroups. Cost was most frequently cited reason for unmet needs. Published by Elsevier Inc.

*Keywords:* Disability subpopulations; Access to care; Health insurance

In the US, it is well-known that unmet health care needs vary by age, race/ethnicity, type of health insurance, income, and education.[1–4] Far less research documents unmet needs experienced by people with disabilities, who are at risk for major complications resulting from untreated health problems as a result of the "thinner margin of health," or increased risk for comorbidities and secondary conditions.[5–,9] The literature that does exist[10,11] reveals that people with disabilities have higher levels of health care utilization and cost[12,13] and are more likely than the general population to have unmet health care needs.[14–17] The continual growth of the population of people with disabilities as well as the 2002 and 2005 Calls to Action to improve the health and wellness of people with disabilities from the Surgeon General[18,19] substantiate the pressing need to increase and improve research on the causes of and solutions for such high prevalence of unmet health care needs.[20]

Although a lack of health insurance is associated with unmet needs for people with disabilities,[21,22] only a small proportion of this group remains fully uninsured[23]; and, with the implementation of Affordable Care Act (ACA) this proportion has shrunk.[24] For people without insurance, access to care can be improved, and unmet needs for care decreased, by providing health insurance.[25] At the same time, it is important to understand the nature of the unmet health care needs that *insured* working-age adults, especially those from vulnerable populations, still experience.[16,26]

Complicating the research on the multiple risk factors that contribute to the problem of unmet health care needs

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* Corresponding author. Fax: +1 603 862 0555.

E-mail address: Amanda.Reichard@unh.edu (A. Reichard).

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is the fact that the health needs of people with disabilities are heterogeneous and often specific to the type of limitation. Recent studies have found that access to care and health outcomes differ significantly between disability subgroups.[12,17,27,28] These studies highlight the need to conduct research that uncovers the unique experiences of disability subgroups, and how they differ from people without disabilities.

In this study, we use a nationally-representative sample of people with and without disabilities to test the following hypotheses:

1. Subgroups of people with disabilities are more likely than people without disabilities to have to delay/forgo necessary care, in general and among the insured;
2. Delaying/forgoing necessary care is more frequently a "big problem" among disability subgroups than for people without disabilities; and
3. Reasons for delaying/forgoing necessary care differ within disability subgroups and from people without disabilities.

## Methods

The Medical Expenditure Panel Survey (MEPS) is a nationally-representative survey of US community-dwelling people of all ages. It uses a complex sampling methodology to provide information on health service use and costs, health conditions, and insurance coverage.[29] We pooled data from 2004 to 2010 to create an unweighted sample of 236,240 people. Combining this number of years was necessary to achieve a sufficiently large sample to examine multiple characteristics across disability subgroups, especially the smallest groups (i.e., cognitive limitations, hearing loss, visual impairments). Our analytic sample includes 134,693 working-age adults (18–64) with information on all measures of interest. A subsample of working-age adults with health insurance was also examined ($n$ = 103,169) as well as insured working-age adults who reported ever delaying or forgoing necessary health care ($n$ = 12,080). Proxy response was provided for approximately 40% of the sample of working-age adults.

Applying methods used in previous research on disability subgroups,[6,20] we classified people into one of six mutually exclusive groups: cognitive limitations, physical limitations, deaf and hard of hearing, blind and visually impaired, multiple impairments, and no disability. A person was considered to have a cognitive limitation if they reported "experiencing confusion or memory loss, having problems making decisions, or requiring supervision for their own safety" twice during the calendar year (29: p. C-40). Physical limitations were defined by affirmative answer to "difficulties walking, climbing stairs, grasping objects, reaching overhead, lifting, bending or stooping, or standing for long periods of time" at least once during the calendar year (29: p. C-38). Those who indicated being visually "impaired near, but not far" or "impaired both near and far," when wearing glasses or corrective lenses (if used), or were "blind," were considered to have a visual impairment. Those who reported having a "moderate hearing impairment," a "major hearing impairment," when wearing a hearing aid (if used), or being deaf, were considered deaf or hard of hearing. Persons who reported at least two of the above limitations or impairments were considered to have multiple impairments; notably, 99% of people with multiple impairments had a physical limitation. Individuals reporting none of the above limitations were considered to have "no disability."

The primary outcome of interest was receipt of necessary medical, dental, or pharmacy care, without delay. This variable represents whether the "person was unable to receive treatment" or if the person was "delayed in receiving treatment" within the past 12 months.[29] Any person who reported forgoing or delaying needed medical, dental, or pharmacy care was considered to have delayed or not received necessary care.

The secondary outcomes included the extent to which delaying or forgoing care was a "big problem" and the reason for delaying or not receiving care.[29] These questions were only asked of people who reported delaying or forgoing each type of needed service. We summarized the responses for each of the follow-up questions. People who reported any delayed or forgone care was a "big problem" were categorized as such; all others were coded as "less than a big problem." Respondents who reported that they delayed or forwent care because they could not afford care, had problems getting to the doctor's office, or were refused services, that the insurance company would not cover, or that the doctor refused family insurance were coded as experiencing that barrier. All other barriers including language and child care difficulties, could not get time off from work, did not know where to get care, did not have time to get care, and other were categorized as "other." These barriers were aggregated across all types of care.

Demographic factors included age, race/ethnicity, gender, marital status, region of residence, and residence in a metropolitan statistical area (MSA). Socioeconomic factors included educational attainment, employment during the calendar year, and poverty status. Poverty status was defined as family-size adjusted income below or near federal poverty line (FPL): poor (<100% FPL), low income (100–199% FPL), middle income (200–399% FPL), and high income (>=400% FPL). Insurance status was measured using MEPS generated categories of none, any private, and public only health insurance.

Health care factors included having a usual source of care, and health insurance coverage. Health characteristics were measured as assistance needs and multiple chronic conditions (MCC). Following the approach used by Gulley, Rasch, and Chan,[12] we created a dichotomous (yes/no)