Previous research documents large and persistent racial and ethnic disparities in healthcare access and use. Despite many attempts to understand these disparities, they remain largely unexplained. Even after controlling for a number of characteristics including socioeconomic status and health insurance coverage, differences in healthcare access and use across racial and ethnic groups remain. To more fully explain racial and ethnic disparities in healthcare, researcher may need to look beyond differences in health insurance coverage and healthcare affordability across racial and ethnic groups. For example, systematic difference in attitudes toward health insurance and the healthcare system may exist. In addition, because the US is highly segregated by race and ethnicity, differences in the neighborhood environments in which minority groups live may explain some of the disparities in access and use. Little research exists, however, about the extent to which attitudinal differences and neighborhood characteristics explain racial and ethnic differences in access to and use of health care services.

In this study, we contribute to research on racial disparities in healthcare using new data from the 2000 and 2001 Medical Expenditure Panel Survey (MEPS). The MEPS survey includes a self-administered questionnaire (SAQ) that provides information about perceptions of and attitudes about health insurance and the healthcare system. Further, it is now possible to "geocode" MEPS households, allowing us to link MEPS data to block group-level information from the 2000 Decennial Census. We can thus investigate the extent to which differences in the communities in which people live coincide with racial and ethnic disparities in healthcare access and use. We use a regression-based approach to decompose differences across racial and ethnic groups into components due to differences in insurance coverage, sociodemographic factors,

attitudinal factors, and community-level factors.

DATA AND METHODS

Sources of Data

Data for this study come from four sources. Individual-level data come from the 2000 and 2001 Medical Expenditure Panel Surveys (MEPS). MEPS is a series of longitudinal surveys based on clustered and stratified samples of households that provide nationally representative estimates of healthcare use, insurance coverage, and socio-demographic characteristics for the U.S. non-institutionalized population. We link individuals in the MEPS to information regarding the supply of health care providers and facilities from two sources: the Area Resource File published by the Bureau of Health Professionals and the Primary Care Service Area (PCSA) files available from the Health Resources and Services Administration. Finally, to obtain community-level characteristics, we attached longitude and latitude figures to addresses in the MEPS sample (often referred to as 'geocoding'), which enabled us to link individuals to information from the 2000 Decennial Census regarding the block groups in which they live. Block groups are the smallest geographic area for which social statistics are available. They generally contain between 600 and 3000 people (U.S. Census Bureau 2000).

Our main dependent variable indicates whether individuals have a usual source of care. For our preliminary analysis, we use this single measure of access but we intend to incorporate a more robust set of indicators for our final paper. We use five sets of explanatory variables to explain observed racial and ethnic disparities in the proportion of

people who do not have a USC: 1) Sociodemographic variables (age, marital status, income, and education), 2) whether one has private, public or no health insurance, 3) employment characteristics (employer size, industry, and occupation), 4) attitudes about health insurance and health (e.g. Do you agree with the following statement: "I do not need health insurance because…"), and 5) residential characteristics (prevalence of poverty, high school completion rate, and racial and ethnic composition).

Analytic approach

We begin our analysis by describing differences in several measures of healthcare use and access across several racial and ethnic groups. At a minimum, we will describe differences across non-Hispanic Whites, non-Hispanic Blacks, Mexicans, Puerto Ricans, Cubans, and other Hispanics. We then use a regression-based decomposition approach based on the work of Oaxaca (1973) and Blinder (1973) to decompose differences across racial and ethnic groups into components due to differences in observed characteristics. This method allows us to determine the amounts of the total differences that are associated with differences in the five sets of independent variables described previously.

PRELIMINARY RESULTS

Figure 1 is a bar chart showing the proportion of individuals who do not have a usual source of care. Compared to all other racial and ethnic groups, Non-Hispanic Whites are more likely to have a usual source of care. In general, the biggest difference is between Hispanics and Whites, rather than Blacks and whites. There is, however, substantial variability within the Hispanic population. Specifically, Puerto Ricans are

only slightly more likely to be without a usual source of care than are Whites, while Mexicans and Other Hispanics are more than twice as likely to be without a USC than Whites.

While Figure 1 clearly shows differences across racial and ethnic groups, what factors explain these differences? The bar chart in Figures 2 sheds some light on this question. In Figure 2, each bar represents the difference between Whites and another racial/ethnic group in the proportion of people who do not have a usual source of care. Each bar is broken down into five parts, each representing that part of the difference that is due to differences in one of the five sets of independent variables (plus an "unexplained" category). For example, Figure 1 shows that Blacks are about 5 percentage points more likely to be without a usual source of care than Whites, and about two percentage points of this difference is due to differences in health insurance coverage between the two groups.

Not surprisingly, Figure 2 indicates that insurance status is an important factor in disparities between racial and ethnic groups, as are sociodemographic differences across groups. However, community-level characteristics also contribute to observed differences in the dependent variable across the racial and ethnic groups. In fact, for Non-Hispanic Blacks and Cubans, the community-level variables account for as much or more of the difference in the proportion of people who do not have a usual source of care than insurance status. This suggests that research on racial and ethnic disparities in healthcare should investigate explanations at the community-level. Note that the community-level component of our decomposition could simply be a relection of unmeasured individual characteristics. This too is a possibility that future research

should investigate.

Attitudes about the healthcare system and health insurance explain little of the observed disparities in the proportion of individuals who do not have a usual source of care. In fact, Figure 2 suggests that if such attitudes were the same across all racial and ethnic groups, differences in the proportion of individuals without a usual source of care across racial and ethnic groups would actually be *greater* than observed, not less.

SUMMARY OF PRELIMINARY FINDINGS AND FUTURE DIRECTIONS

Thus far, several findings emerge from this study. First, there are substantial racial and ethnic differences in the proportion of people who do not have a usual source of medical care. In general, Hispanics are most likely to be without a usual source of care, but this varies greatly by Hispanic subgroup. Specifically, among Hispanics, Mexicans and "other Hispanics" are most likely to be without a usual source of care, while Puerto Ricans are least likely. This indicates that when investigating racial and ethnic disparities in healthcare, considering Hispanics as a single ethnic group may be problematic. Second, while insurance coverage, income, and other individual-level factors are important factors in explaining racial and ethnic disparities in access to care, community-level factors may be important too. Residential characteristics such as the prevalence of poverty in a block group and the racial and ethnic composition of block groups explain a sizable amount of the racial/ethnic differences in our dependent variable. Finally, we find little evidence that systematic differences in attitudes about insurance and healthcare explain any of the racial and ethnic disparities in access.

We plan three main enhancements to the analysis of this study before the 2004

annual meeting of the Population Association of American. First, we will include several other measures of access to healthcare, rather than relying exclusively on whether one has a usual source of care. We are currently investigating several subjective measures of access to healthcare, as well as measures constructed from actual healthcare use. Second, we will expand our sample to include Asians and, if possible, Asian subgroups. Finally, we will calculate confidence intervals around each component of our decomposition using a Balanced Repeated Replications (BRR) approach.

Figure 1. Proportion of people who do not have a usual source of care by race and ethnicity

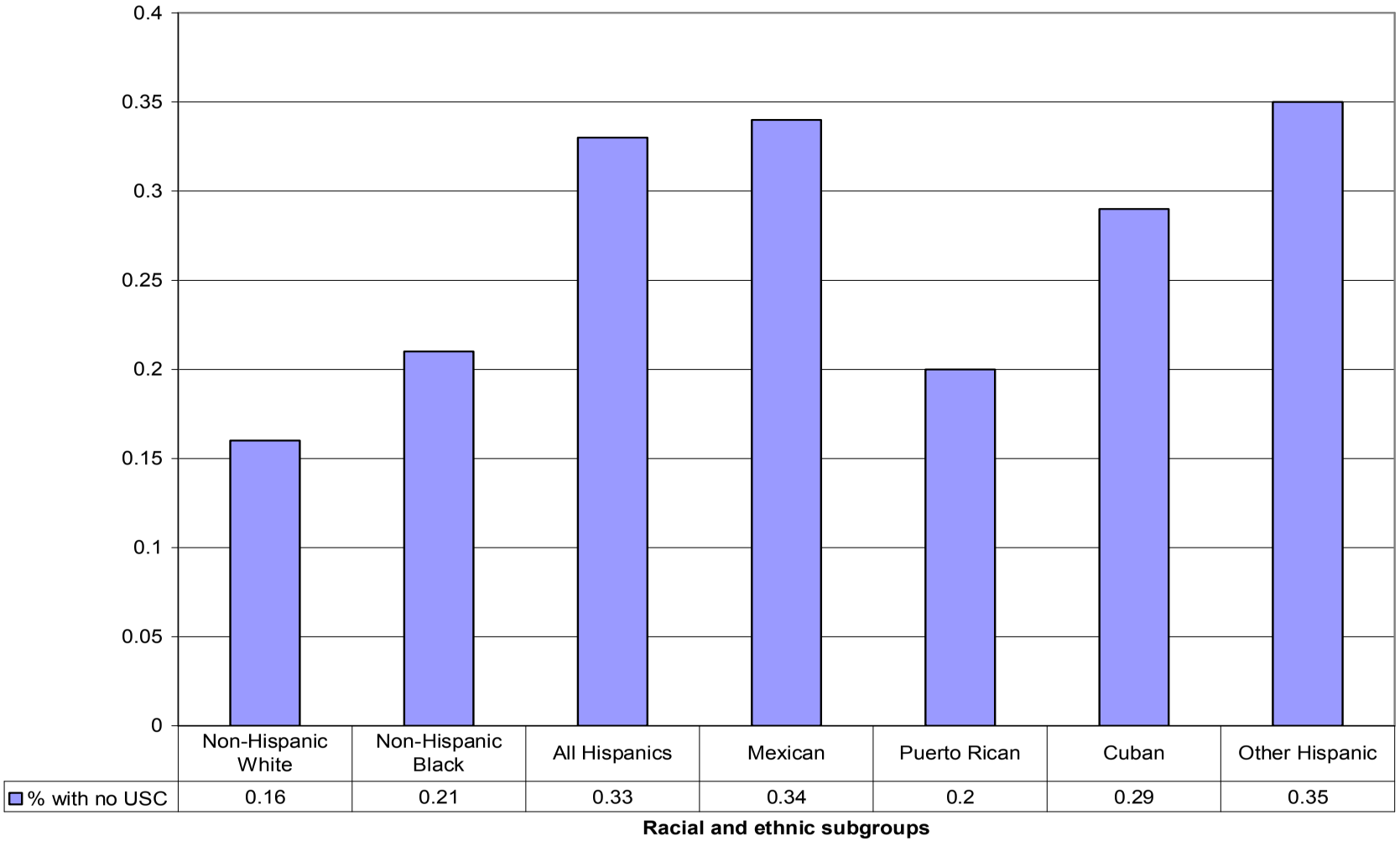
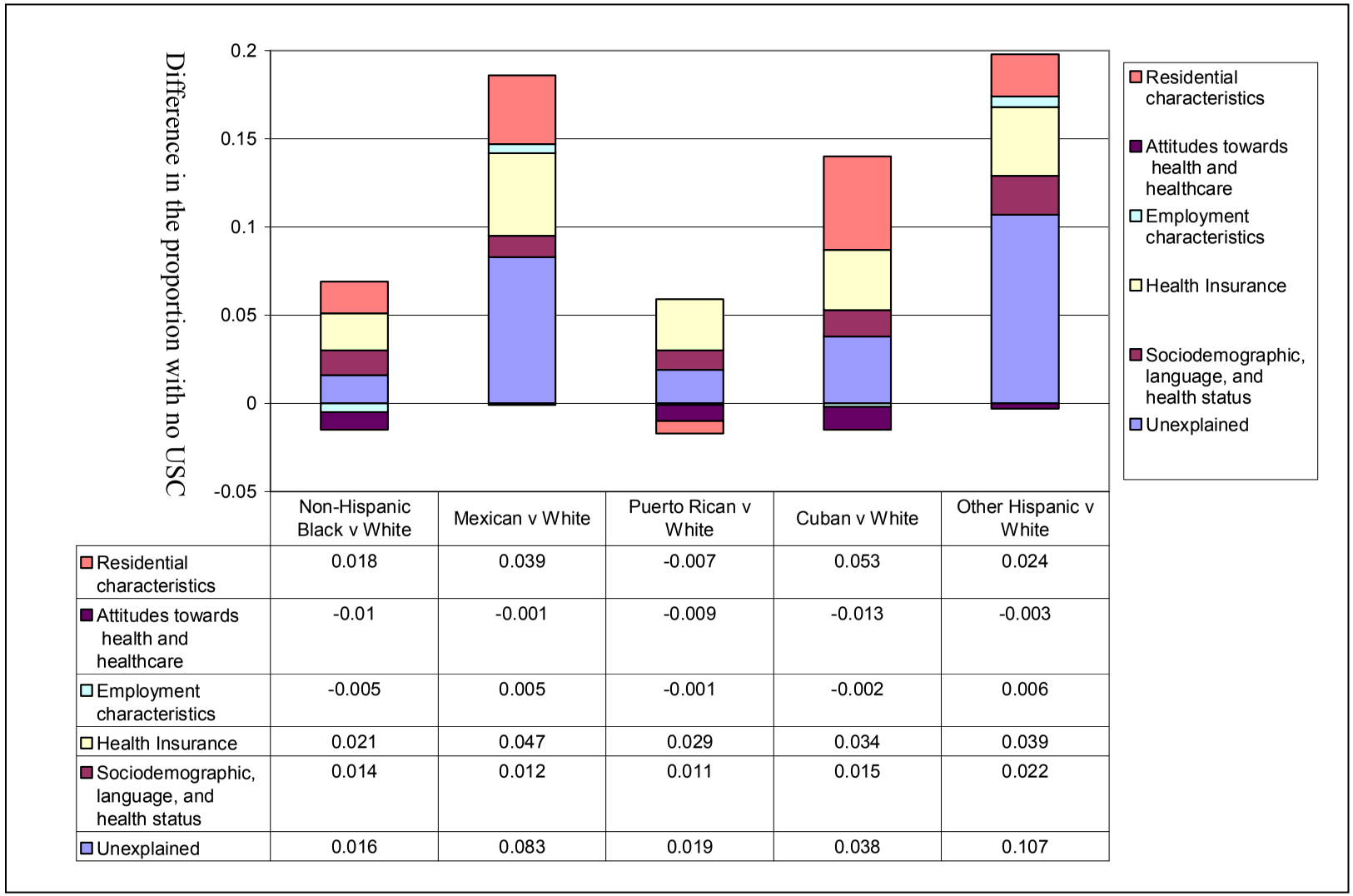


Figure 2. Decomposition of the differences between whites and other racial/ethnic groups in the proportion of people who do not have a usual source



	Non-Hispanic Black v White	Mexican v White	Puerto Rican v White	Cuban v White	Other Hispanic v White
Residential characteristics	0.018	0.039	-0.007	0.053	0.024
Attitudes towards health and healthcare	-0.01	-0.001	-0.009	-0.013	-0.003
Employment characteristics	-0.005	0.005	-0.001	-0.002	0.006
Health Insurance	0.021	0.047	0.029	0.034	0.039
Sociodemographic, language, and health status	0.014	0.012	0.011	0.015	0.022
Unexplained	0.016	0.083	0.019	0.038	0.107

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