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Disparities in Public Use Data Availability for Race, Ethnic, and Immigrant Groups:

National Surveys for Healthcare Disparities Research

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Abstract

Background—Disparities in healthcare coverage and access have a prominent place on the national health policy agenda. It is, therefore, essential to understand strengths and limitations of national surveys that provide annual or periodic data for population-based healthcare disparities research and monitoring. Importantly, publicly available data on healthcare coverage and access are needed for disparities populations defined by race, ethnicity, or immigrant group (REI).

Objective—To document public use data availability for REI groups, insurance coverage, and access to care measures in selected national surveys used for healthcare disparities research.

Design—We examined public use data for general population surveys that collect information on healthcare coverage and access on an annual or periodic basis for the nation. Data sources examined include the following: Current Population Survey, Survey of Income and Program Participation, National Health Interview Survey (NHIS), National Health and Nutrition Examining Survey, National Survey of Children's Health, Behavioral Risk Factor Surveillance System, and Medical Expenditure Panel Survey-Household Component.

Results—Although each survey has strengths for healthcare disparities research, there is no single survey that has detailed REI group identifiers, comprehensive measures of coverage and access, and geographic identifiers.

Conclusions—Current Population Survey and NHIS have detailed REI identifiers. NHIS and Medical Expenditure Panel Survey-Household Component have comprehensive measures of coverage and access but are limited by smaller samples and no geography. Findings summarized in this article will assist with identifying existing data to examine healthcare coverage and access disparities and highlight areas for improvement in public use data availability.

Keywords

access to care; health disparities; health insurance; survey data; race/ethnicity

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Disparities in healthcare coverage and access have a prominent place on the national health policy agenda as evidenced by the monitoring efforts of Healthy People 2010 and the annual National Healthcare Disparities Report. Access to healthcare is 1 of 10 Leading Health

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Indicators (LHI) that is routinely monitored at the national level. Each LHI has Healthy People 2010 objectives associated with it. The objectives used to monitor access to healthcare in the United States are as follows: (1) insurance coverage, (2) having a usual source of care, and (3) prenatal care in the first trimester.¹ The National Healthcare Disparities Report is an important vehicle to monitor population-level healthcare disparities in terms of access and quality.² However, lack of data for some race, ethnicity, or immigrant (REI) groups precludes a comprehensive examination of healthcare disparities.³⁻⁵

To identify potential data sources for healthcare disparities research, we reviewed publicly available data from selected national surveys that collect information on healthcare coverage and access. Although others have recently reviewed data availability issues for assessing healthcare disparities,⁶⁻⁸ our review is unique in several ways that complement this previous work. First, we document detailed race and ethnic groups identified in the public use data and corresponding sample sizes. Second, we document the availability of public use data for immigrant groups by national origin. Third, we focus on “access to care” but go beyond the measures represented by the LHI objectives to look at a broader set of variables representing insurance coverage and access to care. Our intent is to document existing data availability and highlight potential areas for improvement in available survey data that will facilitate identifying, monitoring, and ultimately eliminating health disparities.

METHODS

We examined public use data for general population surveys that collect information on healthcare coverage and access on an annual or periodic basis for the nation. Prenatal care is not measured in any of these national surveys. Data sources that we examined included the following: the Current Population Survey (CPS), the Survey of Income and Program Participation (SIPP), the National Health Interview Survey (NHIS), the National Health and Nutrition Examining Survey (NHANES), the National Survey of Children’s Health (NSCH), the Behavioral Risk Factor Surveillance System (BRFSS), and the Medical Expenditure Panel Survey-Household Component (MEPS-HC). Table 1 provides an overview of each survey. Our review focused on the availability of public use data for 2 content areas: (1) race, ethnicity and immigrant group identifiers; and (2) health insurance coverage and access to care measures. We briefly describe the measures in the following paragraphs.

REI Group

In 1997, the Office of Management and Budget (OMB) issued a revision to OMB Directive 15, which provides recommendations for the collection and classification of race and ethnicity.⁹ The OMB guidelines were not developed to define the concepts of race or ethnicity; they were intended only to standardize data collection and publication across federal agencies.

Race—The minimum OMB standard for collecting data on race is to include the following: (1) American Indian or Alaska Native (AIAN), (2) Asian, (3) Black or African American, (4) Native Hawaiian or other Pacific Islander (NHOPI), and (5) White. All surveys conformed to the OMB minimum standards for collection of data on race. However, data collection varied across surveys.

Ethnicity—In federal surveys, ethnicity refers to Hispanic ethnicity. The minimum OMB standard for collecting data on Ethnicity includes the following options: (1) Hispanic/Latino and (2) Not Hispanic/Latino. The surveys varied in terms of group-specific detail collected from none to as many as 8 Hispanic subgroups.

Immigrant Group—We use the term immigrant to broadly represent the distinction between US born and foreign born and more specifically to identify foreign-born groups by country of origin. There are no OMB standards for the collection of data on immigrant groups. We reviewed publicly available variables for each survey to determine whether respondents could be grouped as US or foreign born, as well as for detailed information on country of origin.

Healthcare Coverage and Access

We examined public use data looking specifically for measures of healthcare coverage and access. Some surveys have other healthcare related measures, but our review focused on concepts for health insurance and access to care outlined later.

Health Insurance—We examined whether publicly available data allow researchers to distinguish types of insurance coverage. Several surveys collected detailed health insurance coverage types. Some even collected information about service providers that often act like “health insurance” like Indian Health Service and the Veterans Administration (VA). For the uninsured, we assessed whether variables allow researchers to distinguish point-in-time uninsurance from past year intermittent uninsurance or all year uninsurance. A critical review of uninsurance measures has been previously documented for several of the surveys.¹⁰⁻¹²

Access to Care—The concept of access to care is not well-defined and measures representing access are not universally agreed upon.^{13,14} A critical review of access measures is beyond the scope of this article, but previous authors have addressed how this concept has been measured in surveys.¹⁵⁻¹⁷ We examined publicly available variables related to 3 elements: usual source of care, barriers to care, and utilization of care. Source of care was assessed by variables related to the respondents’ usual provider or usual place for healthcare. Barriers to care were assessed by variables related to delayed care and foregone care in the past year. Utilization was assessed by variables related to the interval since the last doctor visit and measures indicating the numbers of past year doctor visits, dental visits, emergency room visits, or hospital overnight stays.

RESULTS

REI Group

Most surveys reviewed collected detailed race and ethnicity information, although this detail is not necessarily available in the public use files. Table 2 shows REI groups identified in the public use data and un-weighted sample sizes for each.

Race—NHANES provides a single variable combining ethnicity and race, therefore, only distinguishing non-Hispanic White, non-Hispanic Black, and non-Hispanic Other from all Hispanics. SIPP identifies 3 single race categories (White, Black, Asian) and a residual other category that includes AIAN, NHOPI, and multiple race individuals. NSCH identifies 2 single race categories (White and Black) with a residual other for all states. However, AIAN, Asian, and NHOPI can be individually identified for selected states. MEPS identifies all 5 OMB categories for single race individuals and a residual multiple race category. CPS identifies all 5 single race categories and provides detailed identifiers for many multiple race combinations. BRFSS and NHIS provide several race variables, allowing researchers to choose single race categories with a residual multiple race category or a recode that allocates multiple race individuals to a race category based on self-identified preferred race. The NHIS is the only public use data with an expanded race variable, distinguishing some Asian subgroups.

Ethnicity—Three surveys (SIPP, NSCH, BRFSS) only distinguish Hispanic from non-Hispanic, while the NHANES distinguishes Mexican from other Hispanic and non-Hispanic. The CPS, NHIS, and MEPS-HC provide additional detail on Hispanic origin so that Hispanic subgroups can be disaggregated.

Immigrant Group—Immigrant group identifiers are the most limited across the public use data files. Two surveys, BRFSS and MEPS-HC, do not identify respondents' place of birth. Two surveys (SIPP, NSCH) identify whether the respondent was born in the United States or not, whereas the NHANES distinguishes those born in the United States, Mexico, or elsewhere. The NHIS distinguishes those who are US born from those born in 10 global regions and a residual foreign-born category. The CPS provides the most detailed information, with 149 countries of origin identified for respondents in 2007.

Healthcare Coverage and Access

Health Insurance—Publicly available data for insurance coverage types and the coverage time period varied across surveys (see Table 3), primarily due to differences in the data originally collected.

Coverage Types—With 2 exceptions (BRFSS and NSCH), available data allow for the distinction between basic private (employer/union sponsored and privately purchased) and public insurance coverage (Medicare, Medicaid, State Children's Health Insurance Plan (CHIP), and other public programs) with many offering detail on types of coverage. BRFSS only distinguishes those who are covered and not covered, while NSCH identifies whether a child had coverage through Medicaid or SCHIP; there is no additional detail. Public use data for CPS, SIPP, NHANES, NHIS, and MEPS contain variables representing different types of coverage. Those covered by Medicare can be identified in all 5 surveys. Medicaid and SCHIP are distinguishable in 4 surveys (CPS, SIPP, NHANES, NHIS), while they are grouped together in MEPS. Data for those who report Military coverage are aggregated in 3 surveys (SIPP, NHANES, MEPS). In CPS and NHIS, it is possible to distinguish CHAMPUS/TRICARE, CHAMP/VA, and VA/Military. Three surveys (CPS, NHANES, NHIS) have a variable to identify those who report access to Indian Health Service.

Coverage Period—The CPS uninsurance variable represents all year uninsurance, whereas the BRFSS variable represents point-in-time uninsurance coverage. NHANES and NSCH variables represent point-in-time coverage and past year intermittent coverage. NHIS insurance variables are similar to NHANES and NSCH, but include additional specification of the number of months not covered in the past 12 months allowing estimation of all year uninsurance. Because they are panel surveys and data are collected several times, SIPP and MEPS can be used to estimate point-in-time uninsurance, past year intermittent uninsurance, the length of time someone has been uninsured, and all year uninsurance.

Access to Care—Three elements were reviewed: usual source of care, barriers to care, and utilization of care (see Table 3). Source of care: Variables varied from a single indicator of whether the respondent has a usual doctor (BRFSS) or where the respondent seeks healthcare (SIPP) to multiple questions about usual place and type of place (NHIS, NHANES, MEPS), usual provider and type of provider (MEPS), and reason for no usual place (MEPS). The NSCH has a set of variables related to whether the child has a primary care provider and access to a "medical home." Barriers to care: Three surveys had no measures of barriers to care. The 4 surveys with measures of barriers varied from a single variable indicating whether care was foregone in the past year (BRFSS) to variables representing types of delayed care (MEPS), reasons for delayed care (NHIS, MEPS), types

of foregone care (NHIS, MEPS, NSCH), and reasons for foregone care (MEPS, NSCH). Utilization: The CPS has no utilization measures, and BRFSS has a single variable indicating the amount of time since the last doctor visit. Three surveys (NHANES, NHIS, NSCH) had a measure of the interval since last doctor visit and additional measures of various types and numbers of past year healthcare visits. Both MEPS and SIPP are panel surveys that collect repeated measures of healthcare encounters.

Geographic Identifiers

Access to geographic identifiers is critical to local healthcare disparities research. Although a detailed summary is beyond the scope of this article, brief comments are warranted. Four surveys provide state identifiers, some with caveats. CPS and BRFSS include state identifiers for all respondents. The SIPP has state identifiers but was not intended to produce state-level estimates. The NSCH provides state identifiers; however, state-specific analysis is limited for children identified as AIAN (n = 7 states), Asian (n = 5 states), or NHOPI (n = 1 state). Other geographies may be available through Research Data Centers.¹⁸

DISCUSSION

The United States has rich and varied data resources to study health, healthcare access, and health disparities. We recommend CPS and NHIS as surveys with the most detailed REI identifiers. The NHIS and MEPS-HC have the most comprehensive measures of coverage and access, whereas CPS and BRFSS allow estimates at state and local levels. However, there is no single national survey that will support a comprehensive analysis of healthcare coverage and access for race, ethnicity, or immigrant groups. For example, whereas CPS has detailed REI identifiers and local geography, it is not a health survey and only includes health insurance. Although NHIS has detailed REI identifiers and comprehensive measures of healthcare coverage and access, it is limited by small REI samples and no geography.

Many decisions regarding coverage and access to care are made at state and local levels, thus good data to inform practice and policy and to evaluate the impact for local REI populations are critical. However, only 4 of the reviewed surveys provide state-level identifiers. More effort must be made to collect and release data that allow for state-level disparities analysis. The NHIS releases state-level estimates of health insurance coverage for the 20 largest states.¹⁹ However, state estimates are not available for REI groups, which minimizes the utility for healthcare disparities monitoring. The State Health Access Data Assistance Center has a data tabulator²⁰ and also documents states that regularly administer surveys on healthcare coverage.²¹ Yet, state survey data are not publicly available (except California Health Interview Survey). A new data resource, the American Community Survey, will support state and county-level estimates of health insurance coverage and include REI variables comprising detailed categories of race, tribal affiliation, and country of origin.²² The American Community Survey is an annual survey designed to replace the long-form of the Decennial Census, but it is not a health survey so there are no health or healthcare access data.

Previous authors have called for enhancing federal survey efforts or expanding state-federal partnerships to improve state-level health insurance estimates.^{10,23,24} We echo this call and further argue that efforts must also address the disparate availability of REI group-specific data. Given federal priorities²⁵ and state-level resource constraints,¹⁰ we encourage the exploration of innovative approaches including academic partnerships or privately funded initiatives.⁷ Good data are essential to developing new knowledge for all groups, including First Americans and New Americans. We hope that calling attention to the limited availability of public use data for healthcare disparities research will foster continued

dialogue on improving data availability to support the goal of eliminating health disparities for all.

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TABLE 1

Summary of Selected National Surveys Measuring Healthcare Access

Survey	Agency	Periodicity	Purpose	Target Population	Most Recent Year of Data	Total Observations
CPS	Census	Annual	Primary source of information on labor force characteristics of the US population	Civilian, non-institutionalized US population	2007	206,639
SIPP	Census	Panel	Assess effectiveness of government programs; estimate future costs and coverage for programs; measures of economic well-being in the country	Civilian, non-institutionalized US population	2004 panel	441,849
NHIS	NCHS	Annual	Monitor health and healthcare of the US population	Civilian, non-institutionalized US population	2007	75,764
NHANES	NCHS	Periodic	Health and nutrition of the US household population	Civilian, non-institutionalized US population	2005–06	10,348
NSCH	NCHS	Periodic	Children's health and well-being (physical and mental health, healthcare, social well-being)	US children < 18 yr	2003–04	102,353
BRFSS	CDC	Annual	Health risk behaviors, preventive health practices, and healthcare	US adults > 18 yr	2007	430,912
MEPS-HC	AHRQ	Panel	Health services used, frequency used, cost of services, how paid for	Civilian, non-institutionalized US population	2006 panel	34,145

TABLE 2
Unweighted Sample Size for REI Groups in Public Use Data for Selected National Surveys

Race	CPS* 2007	SIPP 2004	NHANES 2005/06	NHIS† 2007	NSCH‡ 2003/04	BRFSS 2007	MEPS 2006
White	164,839	350,093	3,928	56,827	76,403	354,481	25,625
Black	23,532	57,292	2,710	11,813	10,134	34,644	6,097
AIAN	2,793			893	1,017	6,953	300
Asian	9,208	15,400		4,730	798	6,657	1,298
Asian Indian				813			
Chinese				1,013			
Filipino				1,180			
Other Asian				1,784			
NHOPI	908				397	1,170	126
Other		19,064	514	124	4,499	14,743	
Multiple	5,359			1,377	4,407	8,074	699
Unknown			3,196		6,910	4,190	
Ethnicity							
Not Hispanic or Latino	172,456	392,472	7,152	56,976	88,996	397,547	24,745
Hispanic or Latino		49,377			13,357	31,310	
Mexican/Mexican-American	21,648		2,847				7,053
Mexican				6,596			
Mexican-American				5,843			
Puerto Rican	3,115			1,644			634
Cuban/Cuban-American	1,131			655			254
Dominican (Republic)				500			225
Central or South American	6,196			2,762			902
Other Latin American				39			133
Other Hispanic/Latino/Spanish	2,093		349	342			199
Multiple Hispanic				407			
Unknown							
Immigrant group						2055	

	CPS* 2007	SIPP 2004	NHANES 2005/06	NHIS [†] 2007	NSCH [‡] 2003/04	BRFSS 2007	MEPS 2006
US born	178,745	394,835	8,799	61,425	97,666	N/A	N/A
Foreign born		47,014			3,738		
Mexico, C. America, Caribbean	13,839			8,008			
Mexico			961				
South America	1,880			877			
Europe	2,666			968			
Russia	532			198			
Africa	834			390			
Middle East	519			191			
India	1,250			640			
Asia	2,116			863			
SE Asia	2,859			1446			
Elsewhere	1,399		588	302			
Unknown				456	949		

* CPS has 149 distinct countries of origin identified, which were recoded for table presentation following NHIS categories.

[†] Asian subgroups are also counted in the "multiple" category for NHIS.

[‡] Asian, ALAN, NHOPI groups are also counted in the "other" category for NSCH.

TABLE 3
Summary of Variable Availability for Measures of Healthcare Coverage and Access by National Survey

	Insurance Coverage Measures		Access Measures		
	Coverage Types	Reference Period	Source of Care	Barriers to Care	Utilization
CPS	Private	All year uninsurance	N/A	N/A	N/A
	Medicare, Medicaid, SCHIP, other				
	CHAMPUS/TRICARE, CHAMP/ VA, VA/Military				
SIPP	IHS				
	Private	Point-in-time	Where respondent seeks health advice (doctor's office, clinic, hospital)	N/A	Hospital stays
	Medicare, Medicaid, SCHIP	Ever during year			Doctor visits and frequency of visits
NHANES	Military	All year uninsurance			Dental visits and frequency of visits
	Private	Point-in-time	Usual source of sick care	N/A	Time since last visit
	Medicare, Medicaid, SCHIP, state sponsored, other government	Ever during year	Type of place		Number of visits
NHIS	Military				Hospital visits
	IHS				
	Private	Point-in-time	Usual source of sick care and of routine care	Barriers to care, delayed due to cost, transportation, office hours, long wait, etc.	Doctor visits
	Medicare, Medicaid, SCHIP, state sponsored, other government	Ever during year	Type of place	Foregone care due to cost: medical, dental care, mental health, prescriptions, glasses	Hospital overnights
	CHAMPUS/TRICARE, CHAMP/VA, VA/Military	All year uninsurance			ER visits
	IHS				Surgeries
NSCH	Covered/not covered	Point-in-time	Primary care provider	Time since last visit	Time since last visit
	Covered by Medicaid or SCHIP	Ever during year	Medical home	Reasons for not getting care	Number of visits
	Covered/not covered	Point-in-time	Usual doctor	Past year foregone care	Time since last visit
BRFSS	Private	Point-in-time	Usual place	Delayed care in past year	Doctor visits
	Medicaid/SCHIP	Ever during year	Type of place	Reason for delayed care	Emergency room visits
	Medicare	All year uninsurance	Particular provider	Foregone care in past year	Hospital stays
MEPS	Military		Type of provider	Reason for foregone care	Preventive care