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The Impact of Race/Ethnicity and Language on Access and Experience of Care Among California's Commercially Insured Adults

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Having health insurance has been associated with improved access to medical care, as well as with better quality of care and higher enrollee satisfaction. However, studies of uninsured populations have demonstrated the existence of racial/ethnic disparities in access to, and experience of, care, which may also be found among those who are insured. As California becomes more diverse, absorbing greater numbers of immigrants, race/ethnicity may intertwine in complex ways with English language proficiency to affect health care access and experience. These complexities must be examined and understood in order to address health care disparities.

There is little information on the existence of racial/ethnic- or language-associated disparities among Californians enrolled in commercially insured plans. The state's health plans are not required to collect information on the race, ethnicity, or primary language of their enrollees. A recent national survey determined that health plans vary in their willingness and ability to collect such data, making the determination of health care disparities more difficult.

Methods

We examined the following:

- the role of race/ethnicity and language in access to and experience of care among adult Californians enrolled in the state's seven major health plans,
- whether race/ethnicity- and language-related disparities in access to and experience of care exist, and, if so,
- whether they differ between health plans, and
- whether differences in equity exist between a given plan's Medi-Cal and commercial-only lines of business.

To answer these questions, we obtained data from the 2003 California Health Interview Survey (CHIS). CHIS is a geographically stratified, random-digit dial (RDD) telephone survey of 42,000 households drawn from nearly every county in California. The CHIS sample is representative of California's non-institutionalized population and includes all major ethnic groups and several ethnic subgroups. The 2003 survey was conducted in English, Spanish, Chinese (Mandarin and Cantonese), Vietnamese, and Korean.

Nearly 19 million Californians (56% of the population) are enrolled in the seven largest health plans: Kaiser Permanente, Blue Cross of California, Blue Shield of California, Health Net, PacifiCare of California, Aetna Health of California, and CIGNA Health Care of California. In the 2003 CHIS, 18,698 respondents between the ages of 18 and 64 identified one of the seven major health plans as their main insurer and were included in our analysis. Respondents were stratified by self-identified race/ethnicity and self-reported English language proficiency. Respondents who reported that they spoke English "well" or "very well" were considered English-proficient. Those who reported speaking English "not well" or "not at all" were identified as limited English-proficient.

We identified problems with access to ambulatory care services by evaluating responses to survey questions regarding (1) not having a usual source of care, (2) problems obtaining care, tests, or treatment the respondent or physician believed necessary, (3) problems with health insurance-related delays in getting care, and (4) problems in getting to see a specialist. We determined the respondents' experience of health care by their responses to questions on (1) problems finding a physician they are happy with, (2) problems understanding the physician, and (3) within the past five years, believing that they would have received better care had they been of a different race/ethnicity.

We report unadjusted results below. Adjusting results for sociodemographic and clinical factors did not substantially alter the findings.

Findings

- Among California adults insured by the

major health plans, differences in access to care among racial/ethnic groups were small. African Americans were equally likely as their white counterparts to report having no usual source of care (4.5% vs. 6.5%), problems getting care (15.1% vs. 15.8%), delays in getting care (14.5% vs. 15.4%), and problems in getting to see a specialist (20.4% vs. 19.6%). Latinos were slightly more likely than whites to report delays in care (18.2% vs. 15.4%), and Asians were slightly more likely than whites to report problems in getting to see a specialist (23.1% vs. 19.6%).

- Racial/ethnic disparities in the experience of health care persist despite limited evidence of disparities in access. African Americans, Asians, and Latinos were all more likely than whites to report believing that they would have received better care had they been of a different race/ethnicity: African Americans 10.3%, Asians 6.0%, Latinos 8.1% vs. whites 1.5%). Other measures of experience evoked a more variable response, and the response varied by plan. In two of the seven health care plans, Asians reported more difficulty than whites in finding a doctor they were happy with. Latinos (in four plans) and Asians (in two) were also more likely than whites to report problems understanding their physician.
- Limited English-proficient (LEP) Californians were much more likely than English-proficient (EP) Californians to report problems in obtaining access to care. LEP respondents were more likely to report having no usual source of care (9.9% vs. 6.2%), problems getting care (19.1% vs. 15.5%), delays in getting care (22.8% vs. 15.3%), and problems in getting to see a specialist (27.5% vs. 20.0%).
- Reports of language-associated problems with access were common and affect large numbers of people. More than one in five LEP respondents (23.2%), representing approximately 177,000 Californians, reported delays in getting care, and more than one in four LEP respondents, representing approximately 213,000 Californians, reported problems in getting to see a specialist.
- Californians with limited English proficiency frequently reported problems related to their experience of care. LEP enrollees were more likely than EP enrollees to report (1) problems finding a physician with whom they were happy (24.0% vs. 17.9%), (2) problems understanding their physician (11.2% vs. 2.6%), and (3) believing they would have received better care had they been of a different race/ethnicity (14.0% vs. 3.2%).
- Language-associated disparities in health care access and experience were reported by enrollees of every health plan. Kaiser Permanente enrollees were the least likely to report such disparities. None of the other six health plans were consistently associated with greater or fewer reports of language-associated differences.
- Across the private insurance and public insurance sides of all the plans, LEP Californians had more problems than EP Californians with access to and experience of care, and the disparities were of similar magnitudes on both the private and public sides. In the two cases where the size of the LEP-EP disparity differed between an insurer's private and public plan, the disparity was smaller on the Medi-Cal side. While overall the magnitude of problems reported was higher on the Medi-Cal side, the disparity was smaller in these two cases because English-proficient individuals with Medi-Cal insurance also reported high rates of problems.

Policy Implications and Recommendations

These findings suggest that while racial/ethnic disparities among the commercially insured adult population in California are small, language barriers present LEP Californians with major problems in access to health care. Negative experiences with health care are reported by large numbers of LEP Californians relative to EP Californians, and, to a lesser degree, by greater proportions of African Americans, Latinos, and Asians than by their white counterparts.

California's major insurance plans can play an important role in helping to improve access to and quality of care for their diverse enrollees through the following recommendations.

- Collect systematic and consistent data on enrollees' race/ethnicity, primary language, and English proficiency.
- Monitor enrollees' experiences of their health care by race/ethnicity and language status.
- Report quality-of-care measures by race/ethnicity and language.

Regulators should encourage the adoption by health plans of best practices:

- Provide language services—interpreters and translated materials—at all points of contact.
- Develop literacy-appropriate, easily understandable materials on navigating health provider systems and obtaining health care services.
- Increase the racial/ethnic and linguistic diversity of network health care providers.
- Provide cultural competency training for providers and other contact staff.

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