Medical Expenditure Panel Survey

Agency for Healthcare Research and Quality

STATISTICAL BRIEF #383

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Preventive Health Care Utilization by Adult Residents of MSAs and non-MSAs: Differences by Race/Ethnicity, 2009

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Highlights

- In 2009, non-MSA residents were less likely to see a doctor for a check-up, have a cholesterol screening, and visit the dentist compared to MSA residents.
- Non-Hispanic blacks residing in a non-MSA were less likely to have seen the doctor for a routine preventive visit, compared to non-Hispanic blacks residing in an MSA.
- The differential between routine preventive visits among MSA and non-MSA residents was larger for non-Hispanic blacks than for non-Hispanic whites.
- Forty-one percent of non-Hispanic blacks who lived in a non-MSA had seen the dentist in the past year, compared to 56 percent of non-Hispanic blacks who live in an MSA.

Introduction

Healthy People 2020 provides national objectives aimed at improving the health of all Americans. One objective is to increase the proportion of persons who receive regular preventive services. In order to achieve health equity we must eliminate disparities that exist in the utilization of and access to preventive health care services.

Although MEPS data indicate that residents of a non-Metropolitan Statistical Area (MSA) are more likely than MSA residents to have an ambulatory care visit, research shows that rural populations have worse access to preventive health care than residents of urban areas (Larson & Correa-de-Araujo, 2006, Bennett et al, 2012). Research also suggests that racial and ethnic minority groups face barriers to obtaining preventive services as these groups are more likely to live in counties with higher poverty rates, have less education, and are more likely to be uninsured—factors which have all been shown to be associated with reduced access to health care (Probst, et al 2004).

While MSAs have a greater percentage of racial/ethnic minority groups in comparison to non-MSAs, little is known about the extent to which the urban-rural differential in preventive care utilization differs by race/ethnicity.

This Statistical Brief presents data from the Household Component of the 2009 Medical Expenditure Panel Survey (MEPS-HC) and examines differences in the utilization of preventive health care services among adults based on the Healthy People 2020 objectives, including a routine check-up in the past year, cholesterol screening in the past five years, and dental visit in the past year. The Brief describes differences in the utilization of preventive health services by residence in an MSA and how these differences vary by race/ethnicity. Only differences that are statistically significant at the 0.05 level are discussed in the text.

Findings

In 2009, non-MSA adult residents were less likely than MSA adult residents to utilize the preventive health services examined. Non-MSA residents were less likely to see a doctor for a routine check-up in the past year, have a cholesterol screening in the past five years, and visit the dentist in the past year (figure 1).

The differential in preventive routine check-ups between MSA and non-MSA residents is not, however, the same for all racial and ethnic groups. Differences between MSA and non-MSA residents are larger for non-Hispanic blacks than for non-Hispanic whites. Seventy percent of non-Hispanic blacks who reside in an MSA have seen the doctor for a routine check-up, compared to 58 percent of non-Hispanic blacks who reside in a non-MSA (figure 2). This difference is not as pronounced for other races. For example, 65 percent of non-Hispanic whites living in an MSA had a wellness exam, compared to 61 percent of those living non-MSAs.

All racial/ethnic groups living in a non-MSA were less likely to have a cholesterol screening in the past five years, in comparison to those living in an MSA. For instance, 75 percent of Hispanics living in an MSA had their cholesterol screened in the last five years, compared to 61 percent of non-MSA Hispanics (figure 3).

For all groups, fewer than 70 percent of adults had at least one dental visit during the past year. All racial/ethnic groups living in a non-MSA were less likely to have seen the dentist in the past year, compared to their counterparts living in an MSA. For example, 66 percent of non-Hispanic whites living in an MSA have seen the dentist in the past year, compared to 56 percent of non-MSA non-Hispanic whites. Fifty-six percent of non-Hispanic blacks who live in an MSA saw the dentist, compared to 41 percent of non-Hispanic blacks who live in a non-MSA (figure 4).

Data Source

Estimates for this Statistical Brief come from the MEPS-HC Full Year Consolidated Data File for 2009 (HC-129). Estimates are restricted to adults age 18 years and older.

All estimates are weighted to represent the civilian noninstitutionalized population of the United States. Standard errors for all estimates are adjusted for complex survey design using the survey (SVY) commands in Stata 12.1.

Definitions

Metropolitan statistical area (MSA)
Areas designated by the U.S. Office of Management and Budget that are composed of a large population nucleus combined with adjacent communities that have a high degree of economic and social integration with the nucleus. Each MSA has one or more central counties containing the area's main population concentration.

Race/ethnicity
Race/ethnicity is coded hierarchically as follows: non-Hispanic white single race, non-Hispanic black single race, Hispanic or Latino of any race, and non-Hispanic "other" race. "Other" race includes Asian, other single race, and multiple other races.

Preventive service utilization
For preventive service utilization, dichotomous variables record whether individuals had a routine doctor check-up within the past year (CHECK53), had a cholesterol screening within the past five years (CHOLCK53), and had one dental visit in the past year (DENTCK53). These variables are based on Healthy People 2020 objectives.

About MEPS-HC

MEPS-HC is a nationally representative longitudinal survey that collects detailed information on health care utilization and expenditures, health insurance, and health status, as well as a wide variety of social, demographic, and economic characteristics for the U.S. civilian noninstitutionalized population. It is cosponsored by the Agency for Healthcare Research and Quality and the National Center for Health Statistics.

References

For a detailed description of the MEPS-HC survey design, sample design, and methods used to minimize sources of nonsampling error, see the following publications:

Bennett, K.J., Probst, J.C., Bellinger, J.D. *Receipt of Cancer Screening Services: Surprising Results for Some Rural Minorities*. Journal of Rural Health, 2012: 28, 63–72.

Cohen, J. *Design and Methods of the Medical Expenditure Panel Survey Household Component*. MEPS Methodology Report No. 1. AHCPR Pub. No. 97-0026. Rockville, MD. Agency for Health Care Policy and Research, 1997. http://www.meps.ahrq.gov/mepsweb/data_files/publications/mr1/mr1.pdf

Cohen, S. *Sample Design of the 1996 Medical Expenditure Panel Survey Household Component*. MEPS Methodology Report No. 2. AHCPR Pub. No. 97-0027. Rockville, MD. Agency for Health Care Policy and Research, 1997. http://www.meps.ahrq.gov/mepsweb/data_files/publications/mr2/mr2.pdf

Cohen, S. Design Strategies and Innovations in the Medical Expenditure Panel Survey. *Medical Care*, July 2003: 41 (7) Supplement: III-5–III-12.

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Larson, S., & Correa-de-Araujo, R. *Preventive Health Examinations: A Comparison Along the Rural-Urban Continuum, Women's Health Issues, 2006*: 16, 80–88.

Probst, J., Moore, C., Glover, S., Samuels, M. "Person and place: the compounding effect of race/ethnicity and rurality on health." *Am J Public Health*, 2004: 94, 1695–1703.

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AHRQ welcomes questions and comments from readers of this publication who are interested in obtaining more information about access, cost, use, financing, and quality of health care in the United States. We also invite you to tell us how you are using this Statistical Brief and other MEPS data and tools and to share suggestions on how MEPS products might be enhanced to further meet your needs. Please e-mail us at MEPSProjectDirector@ahrq.hhs.gov or send a letter to the address below:

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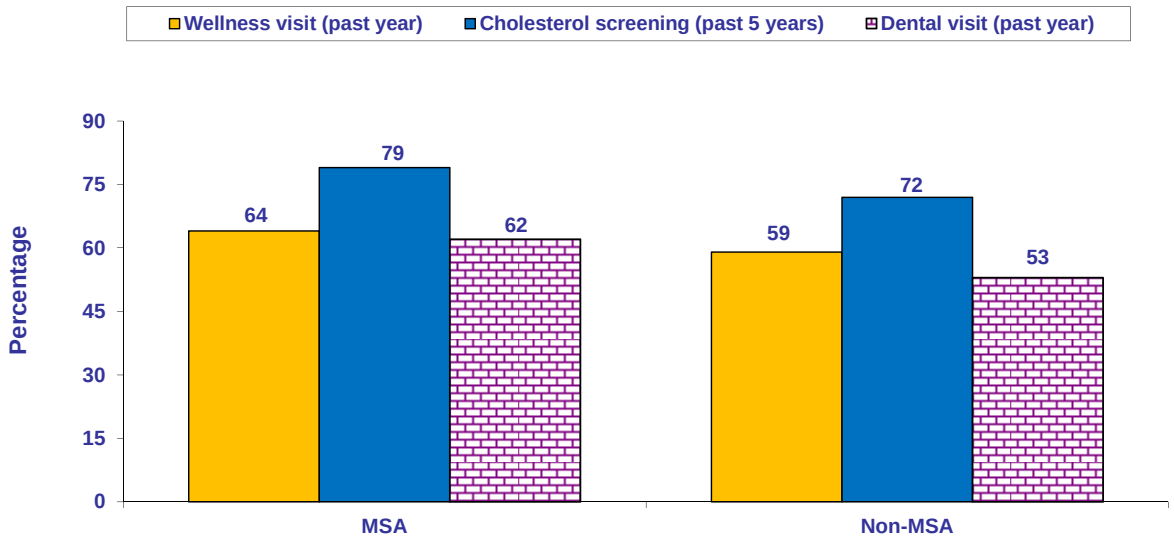
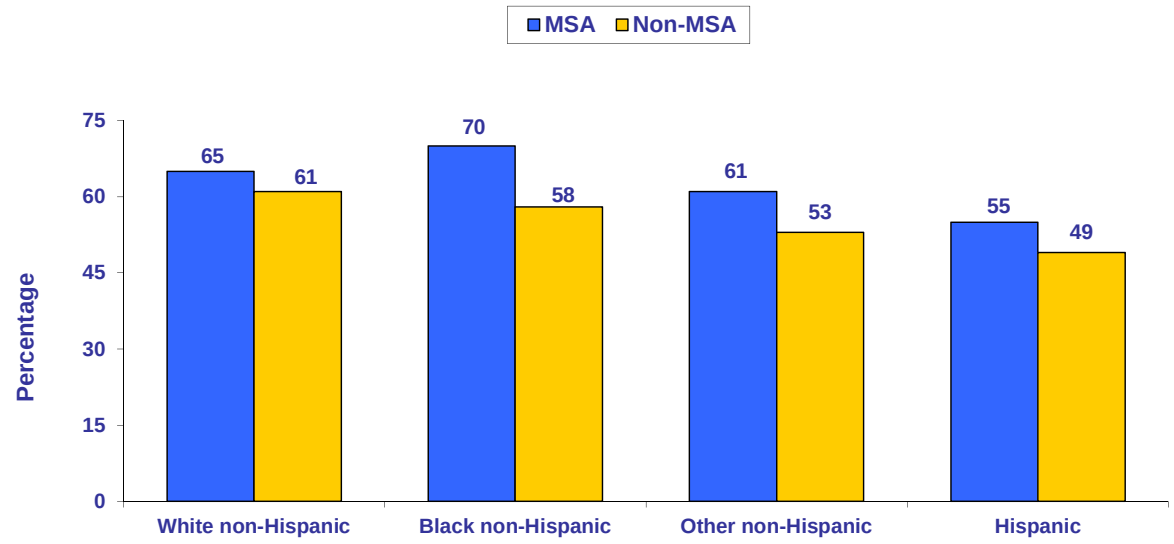
Figure 1. Preventive service use by MSA, 2009



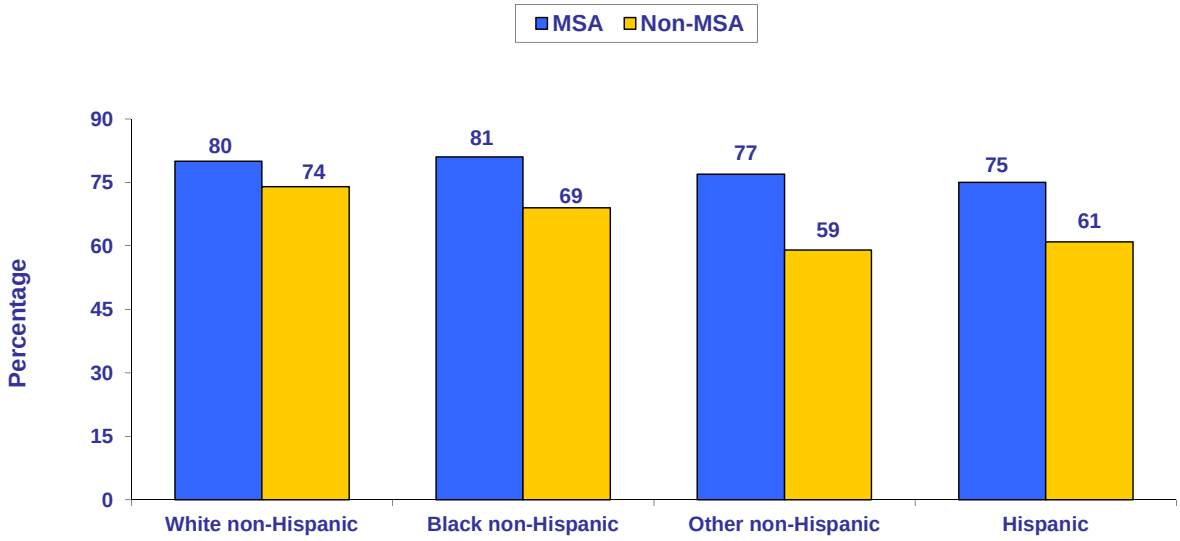
Source: Center for Financing, Access, and Cost Trends, AHRQ, HC-129 of the Medical Expenditure Panel Survey, 2009

Figure 2. Wellness visit in past year by MSA and race/ethnicity, 2009



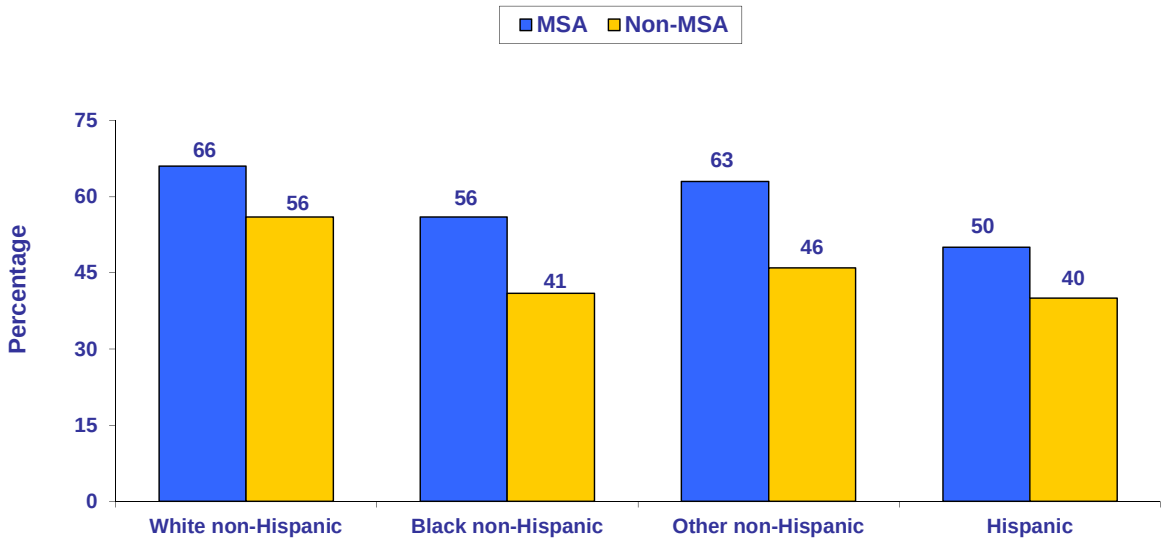
Source: Center for Financing, Access, and Cost Trends, AHRQ, HC-129 of the Medical Expenditure Panel Survey, 2009

Figure 3. Cholesterol screening in past five years by MSA and race/ethnicity, 2009



Source: Center for Financing, Access, and Cost Trends, AHRQ, HC-129 of the Medical Expenditure Panel Survey, 2009

Figure 4. Dental visit in past year by MSA and race/ethnicity, 2009



Source: Center for Financing, Access, and Cost Trends, AHRQ, HC-129 of the Medical Expenditure Panel Survey, 2009