



# The Intersection of Structural Risk Factors and Insurance-based Discrimination on Healthcare Access Inequities

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# Intersectionality

“Intersectionality is a theoretical framework for understanding how multiple social identities such as race, gender, sexual orientation, SES, and disability intersect at the micro level of individual experience to reflect interlocking systems of privilege and oppression (i.e., racism, sexism, heterosexism, classism) at the macro social/structural level.”

(Bowleg. AJPH, 2012, p. 1267)

# Insurance-based discrimination

Unfair treatment that patients receive from health care providers because of the type of insurance they have or because they do not have insurance.

# Summary of prior research

- Insurance-based discrimination (IBD) is higher among those who have public insurance or who lack health insurance
- Experiences of IBD are higher among racial and ethnic minorities
- Experiences of IBD constrain access to healthcare

# Our goals

1. Describe experiences of IBD across a range of structural risk factors (gender, race and ethnicity, income) - independently and combined
2. Examine the effects of IBD and structural risk factors on access to healthcare services –independently and synergistically.

# 2015 Minnesota Health Access Survey

- Biennial statewide telephone survey
- Stratified sample:
  - Dual frame telephone (75% cell; 25% landline)
  - Knowledgeable adult answers for household
- Participants:
  - Over 11,000 completed interviews
- Field period:
  - August-November 2015
- Response rate:
  - 35% (29% cell, 41% landline)
- **Restricted analysis sample:**
  - **Non-elderly adult respondents -- answering for themselves**
  - **Approximately 3,800**

# Analysis strategy

- Descriptive analysis comparing experiences of IBD across structural factors
- Separate logistic regressions (contrasting those who do and do not report IBD) to understand the synergistic effects of structural risk factors and IBD on access to healthcare services
- All analyses weighted and accounted for complex survey design

# Insurance based discrimination (classism)

If insured:

“How often do health care providers treat you unfairly because of the type of health insurance you have?”

If uninsured:

“How often do health care providers treat you unfairly because you don’t have health insurance?”

**CODING: sometimes, usually, always (1) and never (0)**

# Other structural risk factors

## Gender (proxy for sexism)

- “What is your gender?”

**CODING: Male, female**

other (omitted due to small sample size)

## Race/ethnicity (proxy for racism)

- “Are you Mexican, Puerto Rican, Cuban or another Hispanic or Latino group?”
- “Which of the following race or races do you consider yourself to be?”

**CODING: Latinx, non-Latinx American Indian, Asian or Pacific Islander, Black/African American, White, some other race**

## Income as % of FPG (proxy for classism)

- “Approximately what was your household’s income from all sources in 2014, before taxes?”

**CODING: <138% FPG, 138-400% FPG, >400% FPG**

# Access Measures

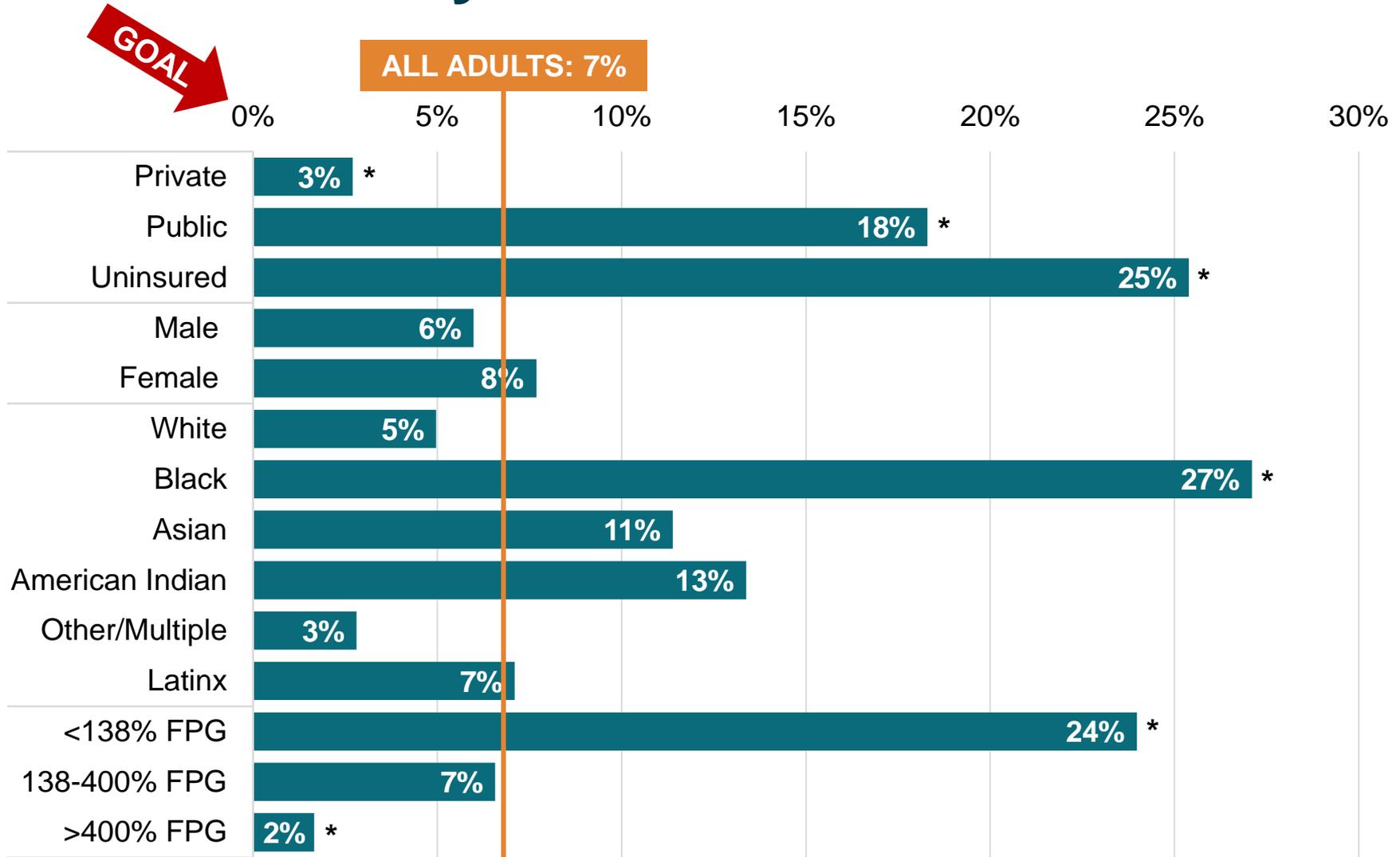
- Usual source of care
  - “Is there a regular place that you go for medical care?”  
**CODING: “Yes” and place of care NOT emergency room**
- Confidence getting needed care
  - “How confident are you that you can get the health care you need?  
Are you...”  
**CODING: Very, somewhat confident (1) a little or not confident at all (0)**

# RESULTS

## Goal 1

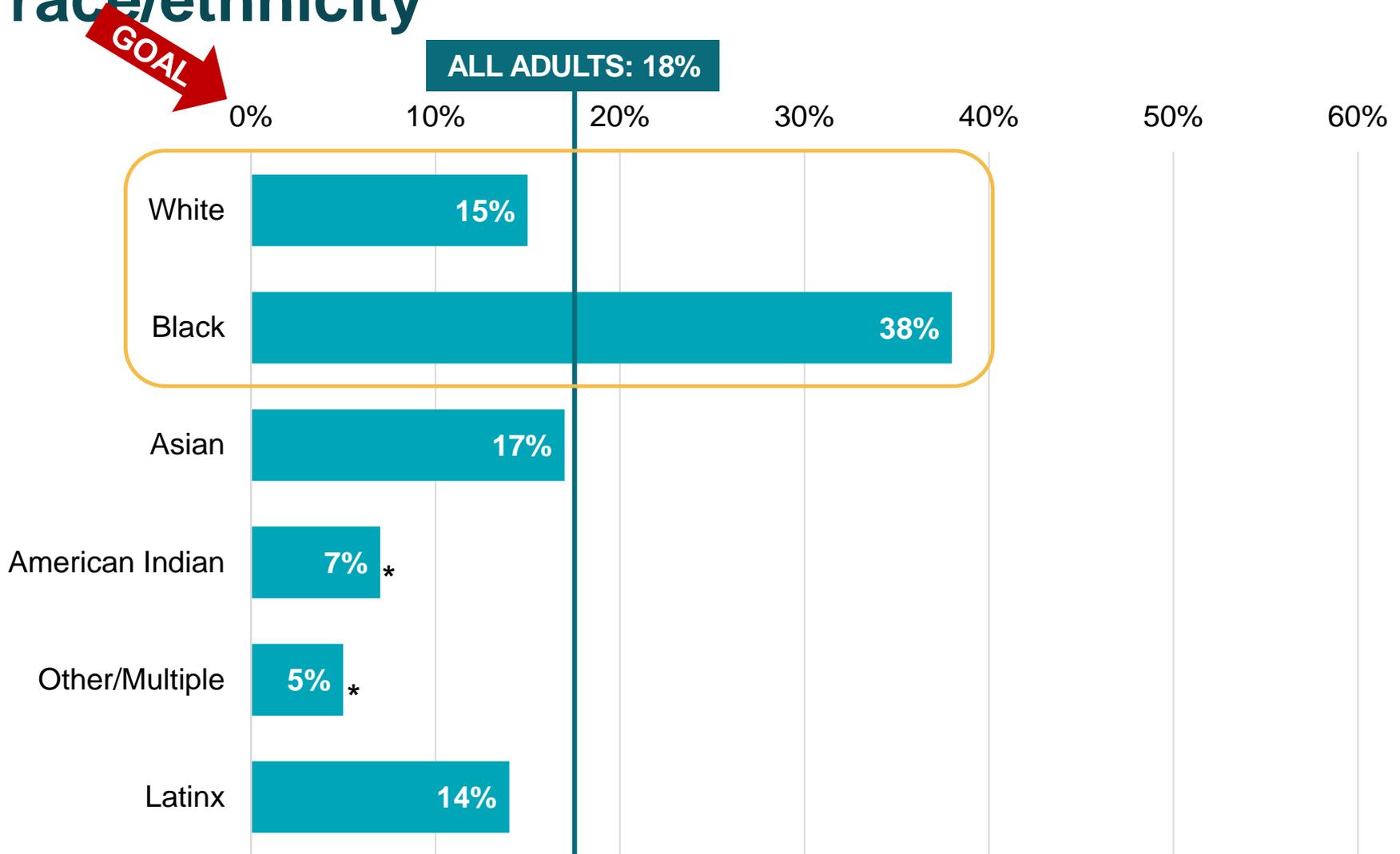
Describe experiences of IBD across a range of structural risk factors - independently and combined

# IBD varies by structural risk factors



\* Indicates significant difference in IBD compared to all adults at  $p < .05$

# Among public insured IBD varies by race/ethnicity



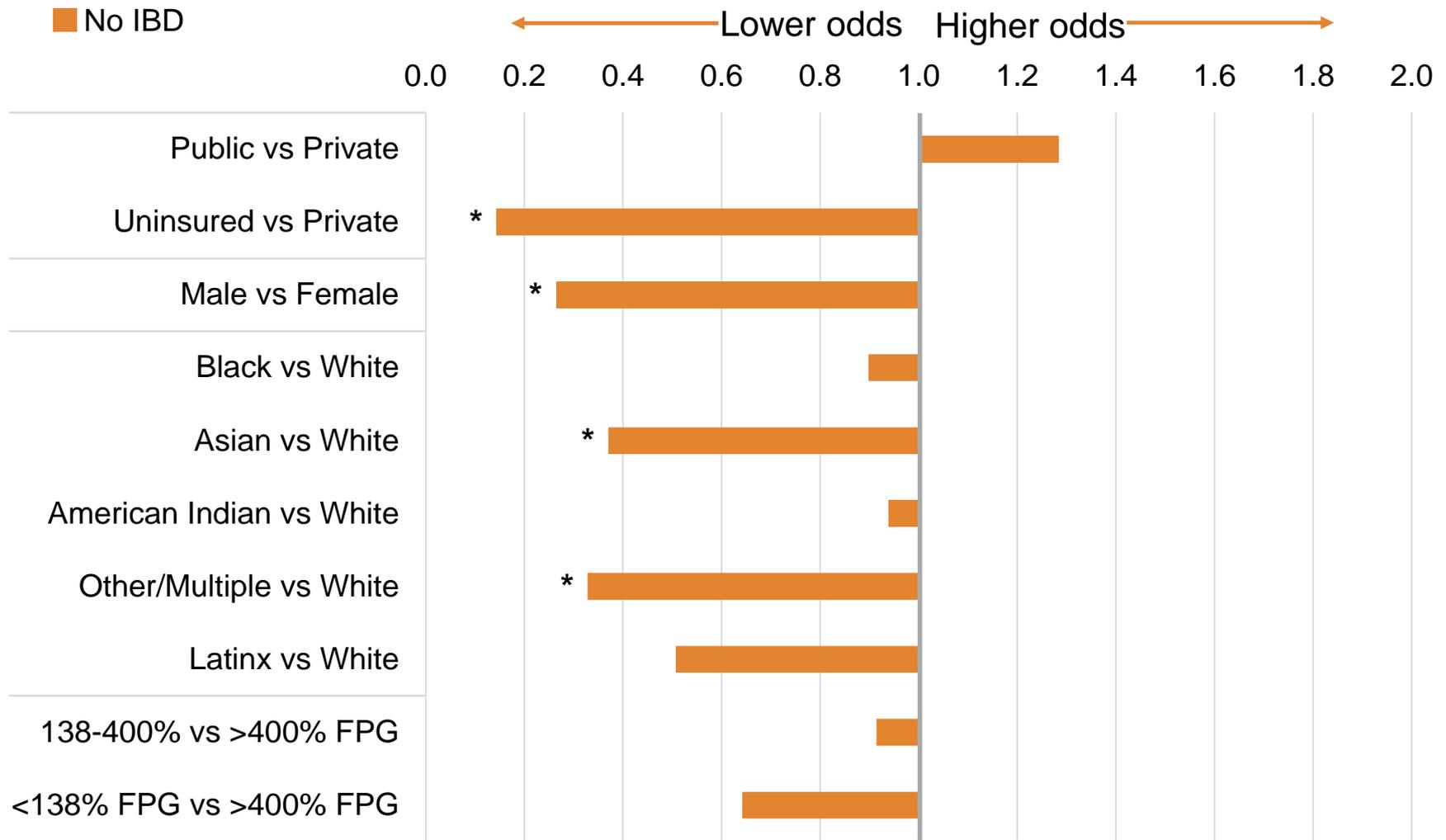
\* Indicates significant difference in IBD compared to all adults at  $p < .05$

# RESULTS

## Goal 2

Describe synergistic effects of structural risk factors and IBD on access to healthcare services

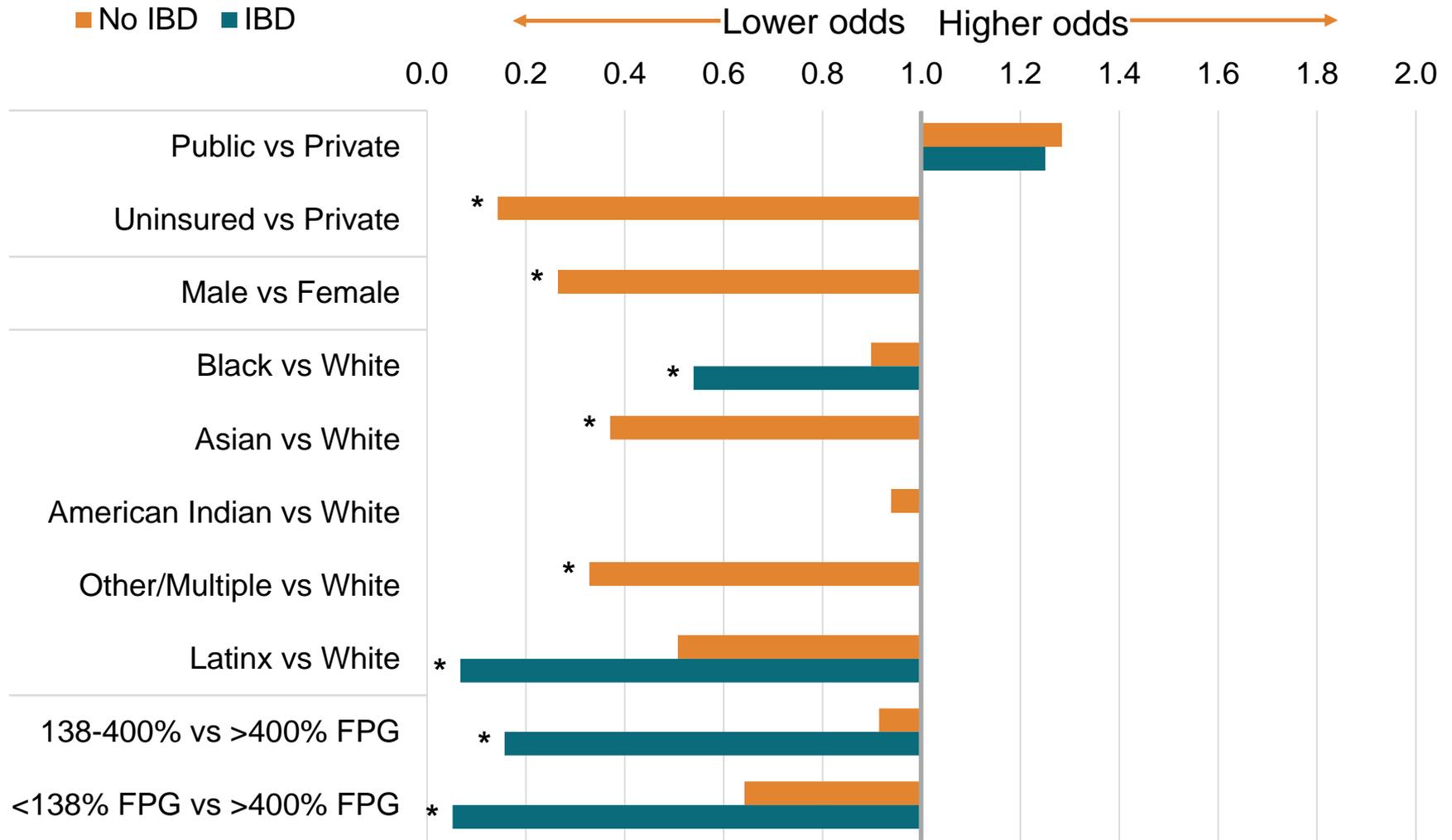
# Structural risk factors, IBD, and likelihood of access to a usual source of care



Regressions adjust for US born, age, education, marital status, urban residence and health status.

\* Indicates significant odds ratio at  $p < .05$

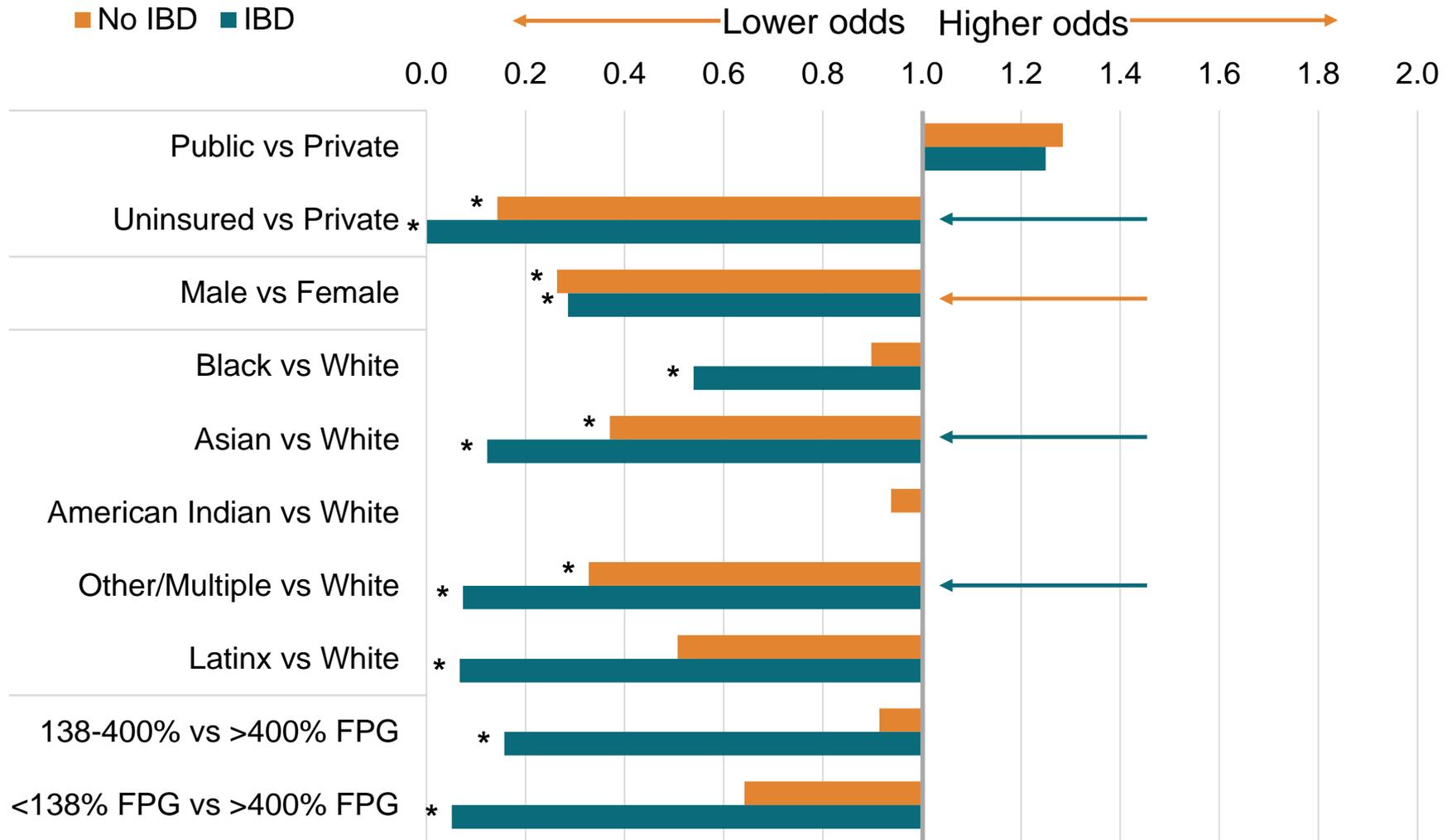
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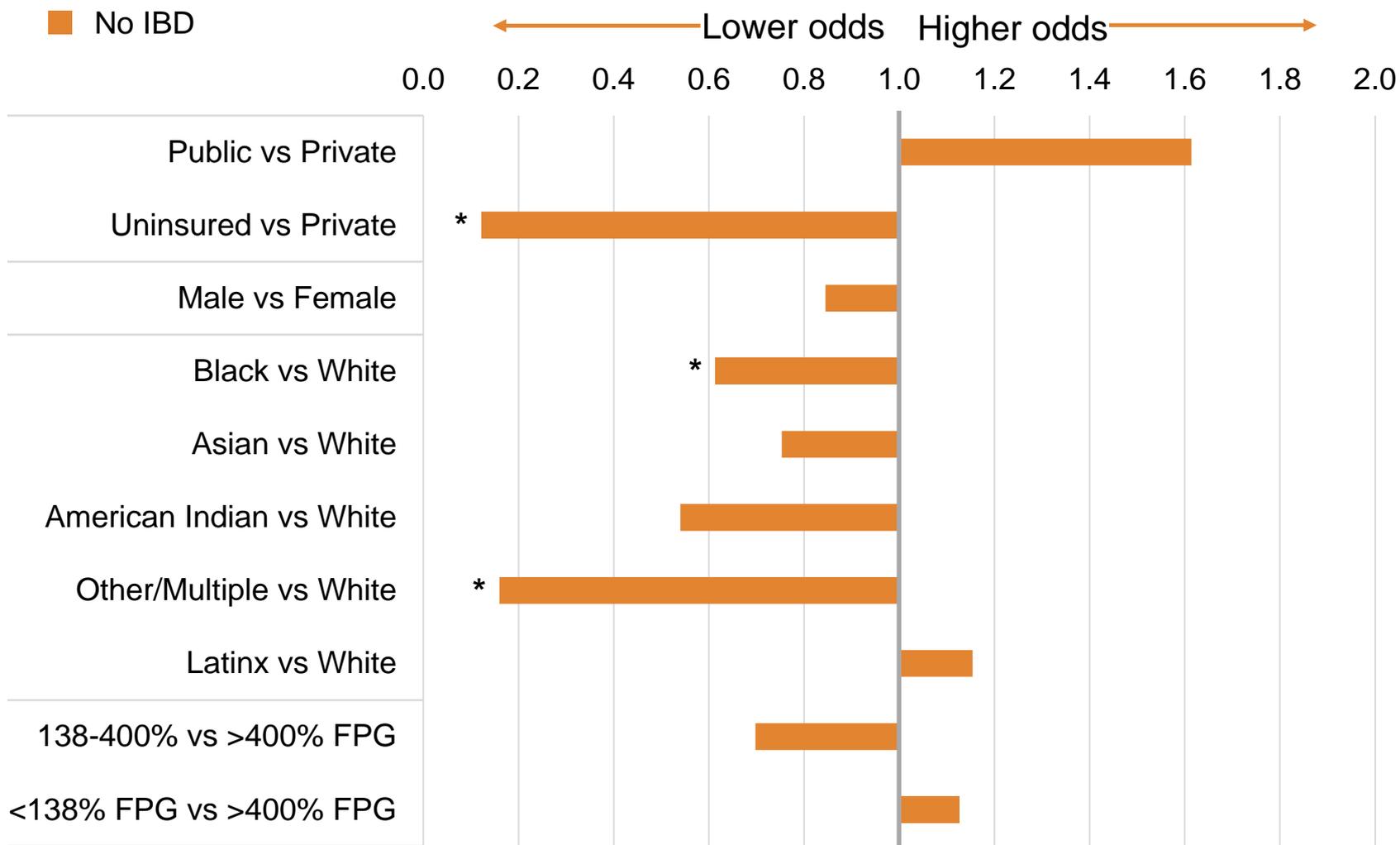
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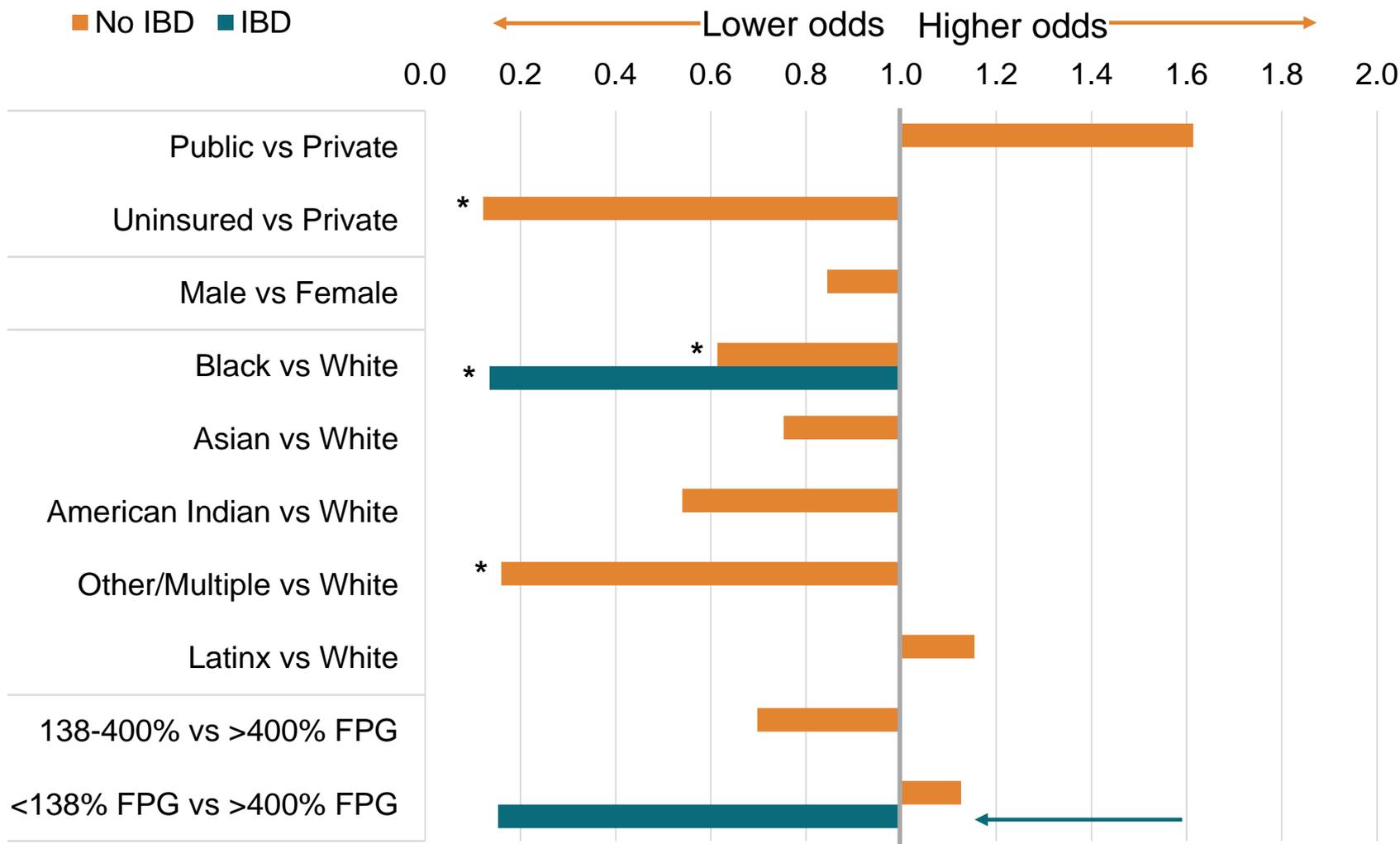
# Structural risk factors, IBD, and likelihood of confidence in getting needed care



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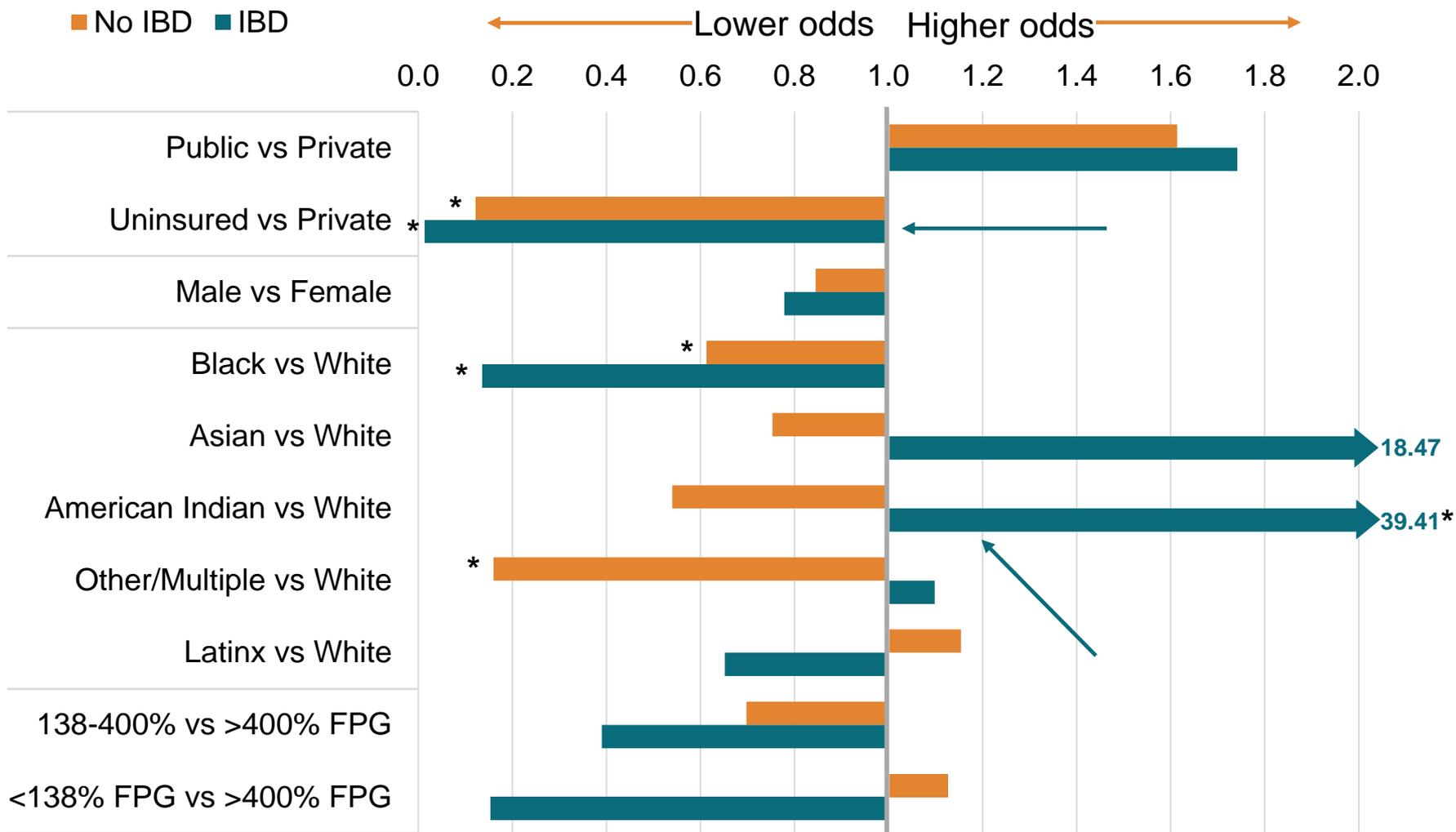
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# Limitations and challenges

- Cross-sectional data
- Unfair treatment does not specify time referent
- Only one measure of structural discrimination is experience based – specifically IBD; remaining are proxies.
- Methods for exploring intersectionality are not well developed
  - Quantitative analysis alone may be antithetical to understanding intersectionality
  - Challenging to analyze, display and interpret intersectional influences

# Summary of results

Some structural risk factors are associated with higher IBD

- Uninsured and public insured
- Blacks
- Low income
- Structural risk factors combine to create a greater sense of IBD
  - Blacks with public insurance
- Structural risk factors and IBD combine to create barrier to access which in turn, may exacerbate health inequities
  - Especially true for usual source of care
    - Black, LatinX, lower income people who also report IBD have likelihood of having a USC
    - Reports of IBD amplify lower likelihood of USC for those who are uninsured, Asian, other or multiple races
  - Less so for confidence in getting needed care
    - Black adults reporting IBD are much less confident than those reporting NO IBD

# Implications

- Reducing inequities in healthcare access requires attention to the convergence of structural risk factors
- Best to intervene at multiple levels
  - Policy:
    - Incentivize patient-centered or whole person care; reduce financial disincentive to provide care to uninsured, public insured; promote culture of health – reduce structural barriers; broaden primary care workforce; diversify policymaking and healthcare workforce/leadership; monitor IBD as quality measure
  - Clinical/provider:
    - Adopt, enforce CLAS standards; promote structural competency training, continue implicit bias training; diversify workforce/leadership; include CHWs on care team
  - Individual:
    - Patient bill of rights, patient advocates, CHWs
  - Research:
    - Grapple with methodological approaches to intersectionality research
    - Measure and monitor IBD
- **OTHER IDEAS ARE WELCOME!**

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