

New Mexico Health Care Coverage and Access Study 2002

A Study Prepared by UNM Institute for Public Policy
For the New Mexico Health Policy Commission



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July 25, 2003

The New Mexico Health Policy Commission has released the "New Mexico Statewide Health Care Coverage and Access Household Survey of 2002". Administered by the UNM Institute for Public Policy, the study was conducted in English and Spanish through a random-digit dialing telephone interview sample of 3,474 NM households *with working telephones* between April and October 2002.

Study issues included health care coverage status, health care needs and access to needed services for New Mexico adults and children in 2001. Also included were questions regarding the respondents' attitudes and preferences regarding our health care system.

While the study confirms that 82% of New Mexicans had some type of health care coverage throughout 2001, it also verifies that a significant number of New Mexicans, 18% of respondents, were fully or partially without health care coverage. In 3% of these households with children, some children were covered, and in 8%, no children were covered.

For identified services such as preventive care, prescription drugs and dental care, between 5 and 20% of respondents did not always or never obtained needed health services. *Of children with no coverage, 34% received no health services in 2001.*

Economic factors are repeatedly identified as the underlying cause of these unmet needs: the lack of regular employment which provides access to health coverage; the inability to afford coverage, even if offered through an employer; if insured, the inability to afford copays or the full costs of uncovered services.

66% of respondents regard programs for meeting the basic health care needs of New Mexicans as "extremely important", and 43% believe our health care system requires major changes. The Health Policy Commission is available to provide the further information and to assist as needed to join other New Mexicans in seeking solutions to this and other health care issues.

Sincerely,

A handwritten signature in black ink, appearing to read "Patricio Larragoite".

Patricio Larragoite, D.D.S
Director

NEW MEXICO STATEWIDE HEALTH CARE COVERAGE AND ACCESS HOUSEHOLD SURVEY 2002

SUMMARY OF RESULTS

The New Mexico Statewide Health Care Coverage And Access Household Survey 2002 was administered by the UNM Institute for Public Policy for the NM Health Policy Commission. The study was conducted in English and Spanish through a random-digit dialing telephone interview sample of 3,474 NM households *with working telephones* between April and October 2002.

Health Care Coverage Among NM Adults

- **Status and Duration of Coverage**

In 2001, 82% of the survey sample had some type of health care coverage throughout the year. 6.4% were covered for part of the year, and the mean lapse in coverage was 5.1 months. 60% of those insured have held continuous coverage for longer than five years.

11.7%, predominantly younger, less educated, respondents with lower household incomes were uninsured throughout 2001. US Census data for 2001 identifies **20.7 %** of New Mexicans as uninsured. *(As households without telephones, a probable indicator of lower economic status and a corresponding lack of health coverage, were not included in the survey sample, these uninsured survey respondents must be viewed as a subset of New Mexico's total uninsured population.)*

- **Reasons For Lack Of Coverage**

Of those without coverage for part or all of 2001

- 42.3% could not afford coverage
- 15.3% lost or changed jobs
- 13.6% were not offered employer-related coverage
- 8% could not obtain coverage

The largest factor affecting the uninsured respondents' decision to obtain coverage was "cost": 64% would obtain coverage "if they could afford it." An additional 16% would obtain insurance "if it were available."

- **Employment Correlates and Health Coverage Status**

82% of respondents who were employed full-time and 75% of part-time workers had full year coverage in 2001.

Only 62% of multiple job holders and 53% of sequential job holders maintained full year coverage.

Of employed respondents who did not enroll in employer-offered coverage, **22.6%** could not afford coverage.

NEW MEXICO STATEWIDE HEALTH CARE COVERAGE AND ACCESS HOUSEHOLD SURVEY 2002

- **Types of Coverage and Out-of-Pocket Expenses**

58% of insured respondents obtained coverage through their or a family member's employer. Medicaid covered 5.3% of respondents, and Medicare 15.6%.

45% participated in an HMO and 29% in a PPO. Only 2% had indemnity plans.

The insured's out-of-pocket expenses in 2001 averaged \$1,066 (median of \$400).

Adult Access to Health Care Services

- **Respondents' Usual Sources for Health Care**

16.5% of respondents have no usual place, or rely on an emergency room, to obtain health care. Of those without coverage for part or all of 2001, 68% have no usual source of health care. Only 12% of insured have no usual source.

- **Health Care Requirements and Service Acquisition**

Services most needed in 2001 were prescription drugs, 70%; routine preventative care, 66%; and dental care, 62%. Needed services were not always or never obtained for 7% of those needing prescription drugs; 13% of those needing routine preventative care; 15% of those needing dental services and 22% of those needing counseling.

For those unable to obtain needed services, scheduling and availability were obstacles for 41% of those needing routine preventative care. Inability to pay was the primary barrier for those needing prescription drugs and dental care.

Coverage and Access Issues Among NM Children

- **Types of Coverage**

In 89% of households with children (under 19 years), all residing children had coverage. In 3% of these households, some children were covered, and in 8%, no children were covered.

Of covered children, 63% were insured through their parent's insurance, and 25% were covered through Medicaid.

- **Access to Services**

More than half of children accessed services for primary care, dental care and prescription drugs. Nearly half received preventative care. Less than 20% received other health services. *Of children with no coverage, 34% received no health services in 2001.*

Attitudes Towards Health Care Programs for New Mexicans

66% of respondents regard programs for meeting the basic health care needs of New Mexicans as "extremely important", and 43% believe our health care system requires major changes.

New Mexico Health
Care Coverage and
Access Study
2002:
Final Report

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The New Mexico Health Policy Commission

Without the support of the Health Policy Commission under contract to the UNM Institute for Public Policy this follow-on to the 1999 study would not have occurred.

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We would also like to recognize the thousands of respondents whose participation was central to this study.

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Introduction

This report summarizes the results from a statewide random household survey assessing health care coverage issues affecting over 3000 New Mexicans in 2001, which was conducted between April and October 2002.¹ The University of New Mexico Institute for Public Policy (IPP) conducted the study in collaboration with the New Mexico Health Policy Commission (HPC). This study is a follow-on to the 1999 health care coverage and access study conducted in 1999 in that it examines many of the same issues. However, it is important to note that the results of both studies are not directly comparable because of the different sampling methodologies employed. The 1999 study examined health care coverage and access issues among random households in each of the New Mexico's 13 PUMA regions and the 2002 study focused on random households statewide and at the county-level. Specifically, the focus of these studies was to provide information about the status of health care coverage and access to health care services among not only the adult non-institutionalized population in New Mexico, but also among children and immigrants residing in New Mexico.

Volume I of this report has five sections. The first section introduces the study and describes the sampling methodology. Section II presents information pertaining to the status and duration of health care coverage among respondents, including analyses about who has coverage and who does not; the types of health care coverage utilized by New Mexicans; how much New Mexicans pay for coverage; and barriers to the acquisition of coverage. Section III provides an assessment of access to various types of health care services, including what factors affect access and how respondents pay for these services. Section IV provides a snapshot of health care coverage and access information for children and the recent immigrant population throughout New Mexico. Finally, Section V provides a summary and conclusions, and also provides a discussion of areas for further research.

Methodology and the Representativeness of the Sample²

The survey sampling method employed produces a random-digit dialing (RDD) sampling frame that provides an equal probability of selection to all New Mexico households with working telephones. The IPP extends this random sampling process to also randomize the selection of respondents within households by selecting from among adult residents (i.e., those 19 years old and older³) the individual who had the most recent birthday.

The IPP maintains a nineteen-station survey laboratory that uses a computer-assisted telephone interviewing (CATI) system for telephone-based data collection. Trained interviewers employed by the IPP Survey Research Center (SRC) conduct surveys under full-time supervision using a protocol that includes 10 call attempts per RDD number, respondent appointment tracking and follow-up, and reluctant respondent persuasion where necessary. This protocol helps the SRC achieve high survey response rate and assures the consistency with which the surveys are conducted for maximum data validity and reliability.

The IPP conducted 3474 survey interviews statewide between April and October 2002; the survey response rate was 56.8% and included 3406 English and 68 Spanish language interviews. Considering the representative nature of the statewide sample, the final proportions of respondents

¹ The Health Policy Commission contracted with the Institute for Public Policy to conduct a dual design study to include interviews with 3000 New Mexicans statewide and with 100 respondents from each of the 33 counties throughout New Mexico. The county-level sample is not examined at the same level of detail since it was based on a quota sample and the margin of error for a sample of this size is $\pm 10\%$. Thus, detailed analyses would yield little, if any, meaningful results. Nevertheless, for baseline information about the county-level sample see "Section V. County-level Frequencies," *Volume II: New Mexico Health Care Coverage and Access Study 2002: Technical Report*.

² For a detailed discussion of the methodology and overall characteristics of the statewide sample, see "Section I. Introduction," *Volume II: New Mexico Health Care Coverage and Access Study 2002: Technical Report*.

³ Normally the IPP includes as eligible all residents 18 years old or older. For this survey, the lower age limit was set at 19 years old because 18 year olds are considered minors with respect to insurance coverage.

obtained for each county in the sample showed little deviation from the proportions indicated in the 2000 U.S. Census (within $\pm 1.8\%$ for the entire sample).⁴ Thus, the statewide sample was sufficiently representative of the regional population at the county-level.

Despite the fact that the statewide sample was proportional at the county-level, the sample did deviate slightly in terms of race and ethnicity. The reasons for this are complicated. A low incidence of telephone coverage in some counties, as well as the fact that low-income and/or non-White households tend to have less access to consistent telephone service than others over time also plays a big role.

What are the implications of the lack of continuity in the representative nature of the data vis-à-vis the 2000 U.S. Census? Analytically, failing to weight the data to account for inconsistencies can be problematic if the data present an erroneous picture of the health care coverage and access needs of New Mexicans. It is for this reason that the IPP conducted a variety of tests to assess the efficacy of the data. Overall, while the weights do change the nature of the findings, it is not in a manner that affects them in a negative manner. On the contrary, weighting the data strengthens the relationships identified in the analyses, thereby making them even more meaningful. Consequently, for ease of reporting and to facilitate comparison with the aggregate results presented in *Volume II: New Mexico Health Care Coverage and Access Study 2002: Technical Report*, the results presented herein do not utilize weights.

Health Care Coverage among New Mexico Adults

To profile access to health care coverage needs or the acquisition of such services among New Mexicans, respondents were asked a variety of questions, including whether

- Whether they had any type of health care coverage in 2001, including coverage through Medicaid, the Indian Health Service, and conventional types of coverage such as that offered through private insurers or employers;
- How long such coverage was in place during 2001;
- What types of coverage respondents utilized;
- What factors affect the acquisition of health care coverage, including various employment issues; and
- What respondents paid out-of-pocket for health care coverage in 2001?

Assessing the Status and Duration of Health Care Coverage

Table 2.1 not only summarizes the extent of coverage among adult respondents, but also provides information on the continuity of coverage. Nearly nine-out-of-ten respondents indicated that they had health care coverage for at least part of the year compared to less than 12% who said they had no coverage at all. Among those covered for the entire year, more than four out of five respondents (81%) had the same coverage for two or more years and three out of five (60%) had the same coverage for more than five years. In contrast, fewer than 5% had their coverage less than one year.

⁴ The margin of error reflects the confidence interval for the sample and can generally be interpreted as $1/\sqrt{n}$ (with n reflecting the sample size).

Table 2.1 Assessing the Status and Duration of Health Care Coverage Among Adult New Mexicans in 2001

Status of Coverage		
	Count	Percent
No coverage	399	11.7
Covered Part of Year	218	6.4
Covered Year Round	2793	81.9
Total	3410	100.0

Duration of Coverage Among Those Covered		
	Count	Percent
Less than one year	125	4.5
One to two years	395	14.2
Between two to five years	586	21.1
Longer than five years	1670	60.2
Total	2776	100.0

However, the picture presented in Table 2.1 might be somewhat misleading when considering that those over the age of 65 generally have access to coverage due to Medicare eligibility. Consequently, Table 2.2 examines the difference in the status of health care coverage when only considering working-age respondents. Overall, when disaggregating the data to remove those likely covered under Medicare, there is a slight increase in the percentage of respondents not covered at all (14% compared to 12% among the entire sample) and a commensurate decrease in the percentage covered for part or all of the year (86% compared to 88% among the entire sample).

Table 2.2 Assessing the Status of Health Care Coverage Among Working-age New Mexicans

	Working Age (19 to 64)		Entire Sample	
	Count	Percent	Count	Percent
No coverage	386	14.2	399	11.7
Covered Part of Year	207	7.6	218	6.4
Covered Year Round	2132	78.2	2793	81.9
Total	2725	100.0	3410	100.0

The following discussion focuses on the degree to which demographic and geographic differences may affect the status and continuity of health care coverage among New Mexicans. First, the affects of demographic characteristics, such as gender, educational attainment, age, race/ethnicity, and household income are considered. Table 2.3a shows that there is no apparent difference in the status of health care coverage among females and males statewide, or in their continuity of coverage. Overall, more than four-out-of-five female and male respondents indicated they were covered throughout the year. In contrast, the Table shows that there is a positive relationship between health care coverage and educational attainment, with the percentage of adult respondents without coverage declining as educational attainment increases. While over one-third of respondents with less than a high school education stated that they lacked health care coverage for at least part of 2001, only about 11% of college-educated respondents lacked coverage for any part of 2001. Nevertheless, two-thirds of those with less than a high school education indicated that they had health care coverage for the entire year, with this percentage increasing to almost 90% among those with a college education. Examining the status of health care coverage by other demographic subgroups yields little new information concerning the relationship between demographic characteristics and health care coverage. Generally, respondents who are younger had a greater propensity to be without coverage for at least some part of the year in 2001 compared to older respondents. Finally, more than three-out-of-four respondents, regardless of their race or ethnicity, indicated that they had coverage for the entire year in 2001. Despite this, a majority of respondents still indicated they had health care coverage for the entire year. Table 2.3b shows that

household income does affect the continuity of coverage: households with lower aggregate incomes tended to exhibit a greater propensity toward a lapse in coverage. Nevertheless, a majority of households in all income levels had coverage year round (ranging from 52% to 96%).

**Table 2.3a Assessing the Status of Health Care Coverage in 2001
by Individual-level Demographic Characteristics**

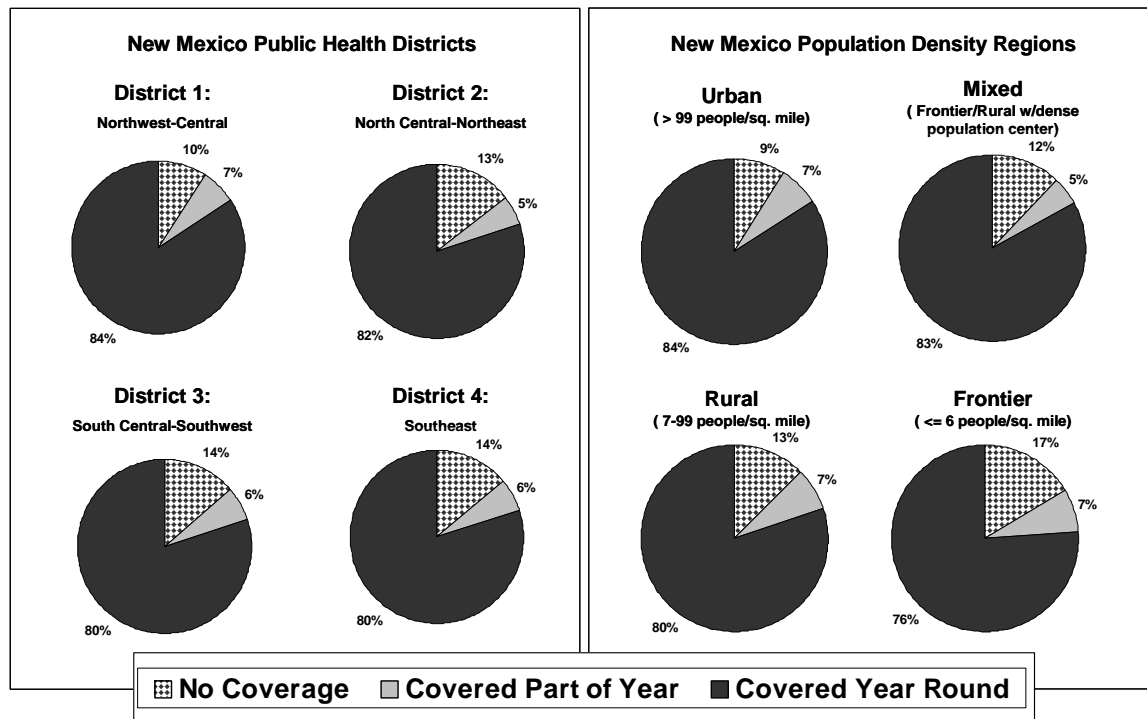
	<i>Subgroup Column Totals</i>		Health Care Coverage In 2001		
	<i>Count</i>	<i>Percent</i>	No Coverage	Part of Year	Year Round
			Row Percents (sum to 100.0% across cells)		
Total Sample	3410	100.0	11.8	6.2	82.0
Gender	3409	100.0			
Female	2026	59.4	11.8	7.0	81.1
Male	1383	40.6	11.7	5.1	83.2
Educational Attainment	3398	100.0			
Less than High School	234	6.9	27.8	6.0	66.2
High School/GED	783	23.0	16.5	6.6	76.9
Some College/Vo-Tech/AA Degree	1119	32.9	12.1	7.4	80.5
College Graduate	1262	37.1	5.6	5.1	89.3
Age Groups	3256	100.0			
19 to 24	259	8.0	21.2	14.3	64.5
25 to 34	454	13.9	20.0	11.2	68.7
35 to 49	1000	30.7	13.0	7.6	79.4
50 to 64	907	27.9	10.9	3.5	85.6
65 and older	636	19.5	1.1	1.4	97.5
Race/Ethnicity	3105	100.0			
White, non-Hispanic	1968	63.4	9.8	5.3	84.9
Hispanic	808	26.0	15.7	7.3	77.0
Native American	112	3.6	12.5	8.0	79.5
Other	217	7.0	10.1	7.4	82.5

**Table 2.3b Assessing the Status of Health Care Coverage in 2001
by Household Income**

	<i>Subgroup Column Totals</i>		Health Care Coverage In 2001		
	<i>Count</i>	<i>Percent</i>	No Coverage	Part of Year	Year Round
			Row Percents (sum to 100.0% across cells)		
Total Sample	3410	100.0	11.8	6.2	82.0
Household Income	2743	100.0			
\$10,000 or less	179	6.5	35.8	11.7	52.5
\$10 to \$20,000	369	13.5	25.2	10.0	64.8
\$20 to \$30,000	384	14.0	18.2	10.2	71.6
\$30 to \$40,000	425	15.5	8.7	8.5	82.8
\$40 to \$50,000	370	13.5	5.4	5.9	88.6
\$50 to \$60,000	245	8.9	6.1	4.1	89.8
\$60 to \$70,000	197	7.2	3.0	4.6	92.4
\$70 to \$80,000	150	5.5	3.3	1.3	95.3
\$80 to \$90,000	94	3.4	7.4	2.1	90.4
\$90 to \$100,000	74	2.7	4.1	0.0	95.9
More than \$100,000	256	9.3	2.0	2.0	96.1

Even when considering the status of respondents' health care coverage from different geographic perspectives, there is little deviation to reflect differential coverage among respondents for 2001 at the regional-level. This finding holds regardless of whether disaggregating the sample by Public Health Districts⁵ or by population density regions.⁶ Generally, Figure 2.1 shows that nearly four-out-of-five respondents within both types of regions had health care coverage for all of 2001, with the only exception the least populated frontier region. Nevertheless, even in the frontier region three-out-of-four respondents had continuous coverage. The map shown in Figure 2.2 provides a spatial representation of the Public Health Districts and population density regions in New Mexico.

Figure 2.1 Assessing the Status of Health Care Coverage in 2001 by Geographic Characteristics⁷

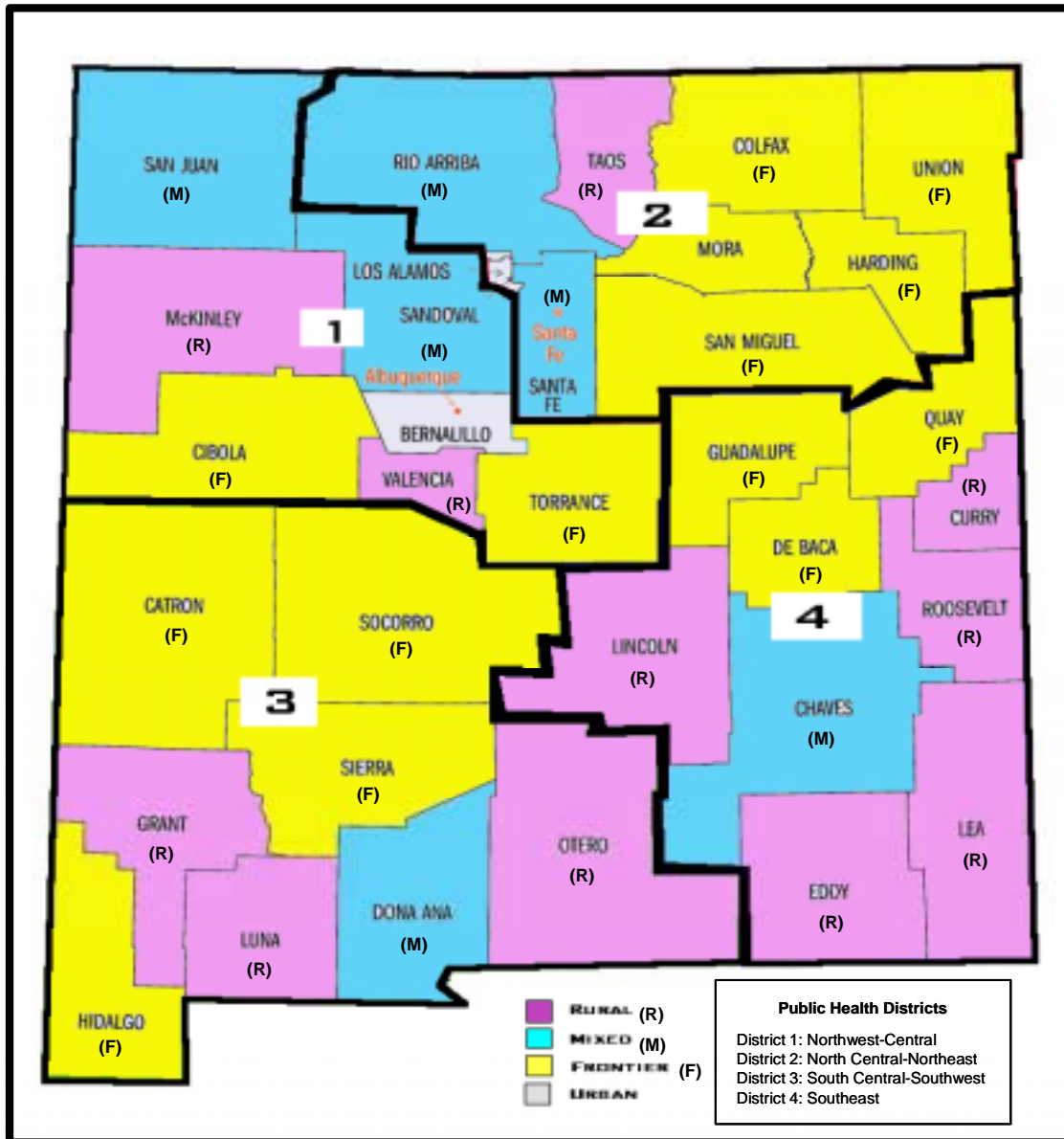


⁵ The Public Health Districts were formed by aggregating the counties throughout New Mexico in the following manner: Northwest-Central (Bernalillo, Cibola, McKinley, Sandoval, San Juan, Torrance, and Valencia counties); North Central-Northeast (Colfax, Harding, Los Alamos, Mora, Rio Arriba, San Miguel, Santa Fe, Taos, and Union counties); South Central-Southwest (Catron, Dona Ana, Grant, Hidalgo, Luna, Otero, Sierra, and Socorro counties); and Southeast (Chaves, Curry, De Baca, Eddy, Guadalupe, Lea, Lincoln, Quay, and Roosevelt counties).

⁶ The Population Density Regions were formed by aggregating the counties throughout New Mexico in the following manner: Urban (Bernalillo); Mixed (Chaves, Dona Ana, Los Alamos, Rio Arriba, San Juan, Sandoval, Santa Fe counties); Rural (Curry, Eddy, Grant, Lea, Lincoln, Luna, McKinley, Otero, Roosevelt, Taos, and Valencia counties); and Frontier (Catron, Cibola, Colfax, De Baca, Guadalupe, Harding, Hidalgo, Mora, Quay, San Miguel, Sierra, Socorro, Torrance, and Union counties).

⁷ While two geographically based representations are considered throughout this report, each of the geographic populations should only be considered on their own merits since neither is directly comparable to the other.

Figure 2.2 Spatial Representation of the Public Health Districts and Population Density Regions in New Mexico



Note: While Los Alamos County is generally characterized by the nature of its “urban” center, the county is “mixed” in terms of population density for the purposes of this analysis.

Source: New Mexico Health Policy Commission

Table 2.4 provides the output of a logistic regression testing whether there is a relationship between demographics and the status of respondents' health care coverage in 2001 at both the statewide level and across the New Mexico Public Health Districts. As is evident in the Table, age, educational attainment, gender, being Native American, and household income prove to be good predictors of disparities in coverage among respondents statewide in 2001. Age and household income are also strong predictors across all of the Public Health Districts, although educational attainment is only statistically significant in Public Health Districts 3 and 4, and gender in Public Health District 1.

Table 2.4 Logistic Regression Model Assessing the Affects of Demographic Characteristics on the Status of Health Care Coverage in New Mexico and in Public Health Districts⁸

Assessing Coverage	State	PHD-1	PHD-2	PHD-3	PHD-4
Count	2353	1167	397	409	358
Chi-square	342.7	151.8	104.5	49.7	50.4
Model P-value	<.0001	<.0001	<.0001	<.0001	<.0001
Constant					
Coef/SE	-7.0	-3.9	-4.2	10.5	-2.6
Chi-square	49.3	15.5	18.0	0.0012	7.0
P-value	<.0001	<.0001	<.0001	-0.2000	0.0082
Age					
Coef/SE	9.3	6.5	3.4	4.2	3.7
Chi-square	85.9	42.2	11.7	17.7	13.6
P-value	<.0001	<.0001	0.0007	<.0001	0.0002
Education					
Coef/SE	3.9	1.2	1.7	2.4	3.2
Chi-square	15.0	1.4	2.9	5.9	10.1
P-value	0.0001	0.2359	0.0866	0.0149	0.0015
Gender					
Coef/SE	-2.1	-2.2	-0.2	-0.1	-0.6
Chi-square	4.2	5.0	0.0	0.0	0.4
P-value	0.0403	0.0258	0.8792	0.9579	0.5353
Hispanic					
Coef/SE	0.5	0.8	0.6	1.0	-0.8
Chi-square	0.2	0.6	0.4	1.0	0.7
P-value	0.6507	0.4346	0.5527	0.3123	0.3998
Native American					
Coef/SE	2.0	1.5	1.6	0.1	0.2
Chi-square	4.1	2.3	2.4	0.0	0.0
P-value	0.0417	0.1270	0.1177	0.8869	0.8655
Household Income					
Coef/SE	11.1	7.5	6.3	3.7	3.0
Chi-square	122.2	56.7	3935	13.7	8.9
P-value	<.0001	<.0001	<.0001	0.0002	0.0029

Assessing Lapses in Health Care Coverage

While the foregoing discussion is helpful in characterizing the status of health care coverage among the adult population throughout New Mexico in terms of demographic and geographic relationships, it fails to provide adequate information about that segment of the population that had a lapse in health care coverage in 2001. Table 2.5 characterizes the average lapse in duration of coverage across demographic subgroups and Table 2.6 characterizes the average lapse across regional subgroups.

Overall, the average lapse in coverage lasted about five months, although slight deviations from this pattern are evident across demographic subgroups. For instance, Table 2.5a shows that college graduates, respondents 65 and older, as well as Native Americans and Hispanics tended to

⁸ The Public Health Districts were used in this analysis because they are more useful than Population Density Regions. Specifically, from a policy perspective, it is easier to assess unmet needs and provide for the delivery of services if such assessments rely on a framework already in use by the State of New Mexico. Also note that bold values are statistically significant at the 95% level of confidence or better, meaning that we would only expect to see the described relationships by chance in 5-out-of-100 times.

have the shortest duration lapse in coverage compared to their counterparts. There was no difference between females and males, with both averaging about 5 months. The caveat is that the relatively small sample size in this analysis (n=213 in aggregate) limits the ability to assess whether the differences depicted are truly reflected in the population as a whole or are due to random chance and, thus, not statistically significant in terms of making meaningful inferences to the New Mexico population. Table 2.5b shows that households with higher aggregate incomes tended to have the shortest duration lapse in coverage compared to their counterparts.

**Table 2.5a Average Lapse in Months of Coverage for Respondents
“Covered for part of year” by Individual-level Demographic Characteristics**

	Mean	Std. Dev.	N
Total Sample	5.1	2.8	213
Gender			
Female	5.1	2.9	141
Male	5.1	2.5	72
Educational Attainment			
Less than High School	4.8	2.5	14
High School/GED	5.4	2.8	53
Vo-Tech/AA Degree	5.3	2.9	83
College Graduate	4.7	2.5	63
Age Groups			
19 to 24	5.0	2.7	39
25 to 34	5.0	2.7	50
35 to 49	5.1	2.6	77
50 to 64	5.0	3.1	31
65 and older	3.4	2.1	8
Race/Ethnicity			
White, non-Hispanic	5.4	2.9	104
Hispanic	5.0	2.6	60
Native American	5.0	3.0	11
Other	5.5	1.8	15

**Table 2.5b Average Lapse in Months of Coverage for Respondents
“Covered for part of year” by Household Income**

	Mean	Std. Dev.	N
Total Sample	5.1	2.8	213
Household Income			
\$10,000 or less	6.3	3.4	21
\$10 to \$20,000	6.5	2.2	37
\$20 to \$30,000	5.0	3.2	42
\$30 to \$40,000	4.6	2.5	37
\$40 to \$50,000	4.2	1.7	22
\$50 to \$60,000	5.1	2.9	10
\$60 to \$70,000	4.9	2.6	9
\$70 to \$80,000	3.5	3.5	2
\$80 to \$90,000	3.0	1.4	2
\$90 to \$100,000	.	.	.
More than \$100,000	3.6	1.5	5

The same constraints that hold for Table 2.5 in terms of assessing the strength of the relationship in the average lapse in coverage among those insured for only part of 2001 hold for Table 2.6 when considering geographic differences. Nevertheless, respondents in Public Health District 2 had a shorter duration lapse in coverage than did their counterparts, as did respondents in the lowest population density frontier region, although only nominally.

**Table 2.6 Average Lapse in Months of Coverage for Respondents
“Covered for part of year” and those With “No coverage at all”
by Geographic Characteristics**

	Mean	Std. Dev.	N
Total Sample	5.1	2.8	213
Public Health Districts			
District 1: NW-Central	5.0	2.7	114
District 2: North Central-NE	4.8	3.0	28
District 3: South Central-SW	5.5	2.9	35
District 4: SE	5.2	2.8	30
Population Density Regions			
Urban	5.1	2.8	73
Mixed	5.1	2.6	55
Rural	5.3	2.8	60
Frontier	4.5	3.0	19

The primary reason for a lapse in or absence of health care coverage in 2001 was that respondents simply could not afford coverage. Overall, 42% of respondents indicated that they could not afford coverage. The next most frequent responses in descending order of occurrence are having lost or changed jobs (15%), coverage not offered by employers (14%), or that respondents could not obtain coverage (8%). The remaining eight response options accounted for less than 20% of responses and included such reasons as being healthy and not needing coverage to a variety of issues affecting eligibility for coverage. Among those who specified “some other reason,” such issues as just getting married, divorced, or just didn’t have coverage came up several times. Table 2.7 provides the counts and percentages for this question.

**Table 2.7 Primary Reasons Why Adult Respondents
Were Without Health Care Coverage for Part or All of 2001**

	Count	Percent
Couldn't afford coverage	249	42.3
Lost or changed jobs	90	15.3
Employer didn't offer coverage	80	13.6
Couldn't obtain coverage	47	8.0
Healthy and didn't need	27	4.6
Didn't get around to it	19	3.2
Ineligible due to age or leaving school	13	2.2
Pay directly if care needed	13	2.2
Ineligible due to health condition	10	1.7
Person providing coverage lost job	7	1.2
Could always go to E.R.	0	0.0
Other *	33	5.6
Total	588	100.0

*NOTE: Responses for those who answered “Other” were recoded back into the existing categories when possible.

Cost was the single biggest factor cited for what might induce respondents to obtain health care coverage, with 64% of respondents who were uninsured at the time of the study stating that they would obtain coverage if they could afford it (Table 2.8). Sixteen percent of respondents said that they would obtain coverage “if it were available” to them. Interestingly, however, about one-third of the respondents who opted for the “some other reason” category made it clear that they were unlikely to ever have coverage because they saw no necessity in having coverage whether for religious reasons, distrust of the medical profession or insurance industry, or “just because.”⁹

⁹ See the verbatim responses for this question in “Section VII. Statewide Verbatims,” *Volume II: New Mexico Health Care Coverage and Access Study 2002: Technical Report*.

Table 2.8 Assessing the Factors that Might Affect Respondents' Decision to Obtain Coverage among the Uninsured Sample Population

	Count	Percent
If could afford coverage	345	63.9
If it were available	85	15.7
If had dependents who needed it	37	6.9
If health changed and needed coverage	37	6.9
Some other reason	36	6.7
Total	540	100.0

Assessing Employment Correlates and the Status of Health Care Coverage

As expected, Table 2.9 shows that respondents employed full-time in 2001 were more likely to have coverage year round than their counterparts: 82% of respondents employed full-time were covered for the entire year, compared to only 53% of those who worked a variety of short-term jobs. Further, one-third of this latter group had no coverage at all, in contrast to only 10% of those employed full-time. Table 2.10 shows that one's employer makes little difference in coverage status with at three-out-of-four of those who were self-employed and four-out-of-five of those who work for someone else reporting they were covered for the entire year.

Table 2.9 Assessing the Status of Health Care Coverage in 2001 by Labor Market Attachment

	<i>Subgroup Column Totals</i>		Health Care Coverage In 2001		
			No Coverage	Covered Part of Year	Covered Year Round
	<i>Count</i>	<i>Percent</i>	Row Percents (sum to 100.0% across cells)		
Full-time	1937	82.2	10.4	7.2	82.4
Part-time	248	10.5	18.1	6.9	75.0
Multiple jobs	99	4.2	23.2	15.2	61.6
Sequential jobs	72	3.1	33.3	13.9	52.8
Total	2356	100.0			

Table 2.10 Assessing the Status of Health Care Coverage in 2001 By Whether Self-employed or Employed by Someone Else

	<i>Subgroup Column Totals</i>		Health Care Coverage In 2001		
			No Coverage	Covered Part of Year	Covered Year Round
	<i>Count</i>	<i>Percent</i>	Row Percents (sum to 100.0% across cells)		
Worked for someone else	1964	83.0	11.3	8.4	80.3
Self-employed	403	17.0	18.6	4.7	76.7
Total	2367	100.0			

Table 2.11 provides a breakout of coverage status among those who weren't formally employed in 2001 whether due to retirement, disability, working in the home, going to school, or being unable to find a job. Retirees and the disabled were the most likely to indicate that they were covered for the full year, while respondents who were looking for work were the least likely to have been covered for the full year (50% of this group lacked any coverage at all in 2001). The Table also shows that when considering respondents whose primary source of employment was as a homemaker or caretaker this group was slightly more likely than full-time students to indicate that they were without coverage for all of 2001 (26% compared to 23%, respectively).

**Table 2.11 Assessing the Status of Health Care Coverage in 2001
By Situation While Not Working**

	<i>Subgroup Column Totals</i>		Health Care Coverage In 2001		
			No Coverage	Covered Part of Year	Covered Year Round
	<i>Count</i>	<i>Percent</i>	Row Percents (sum to 100.0% across cells)		
Retired	688	71.3	3.1	0.9	96.1
Disabled *	71	7.4	11.3	4.2	84.5
Homemaker/Caretaker *	136	14.1	25.7	5.9	68.4
Full-time student	44	4.6	22.7	27.3	50.0
Looking but couldn't find job	26	2.7	50.0	7.7	42.3
Total	965	100.0			

* NOTE: The "Homemaker" and "Disabled" categories were derived from the list of verbatim responses from respondents who described their situation as "Something else"; the remaining respondents in the "Something else" category are not considered in this analysis because it was unclear what their particular status was in the context of this question.

Whether one is covered can be due to a variety of reasons, with a fundamental reason being the extent to which certain types of industries offer coverage to employees and whether they extend the coverage to families. Table 2.12 shows that the mining and government sectors are most likely to offer health care coverage to their employees and to extend the offer of coverage to employees' families. The agricultural industry is the least likely with only 42% of those employed in this sector offered coverage by employers in 2001. Nevertheless, more than 85% of respondents indicated that coverage was offered to their families if it was offered to them as employees.

Table 2.12 Assessing Health Care Coverage Offered to Respondents by Industry in 2001

	Employee Coverage Offered (in Percent)			Family Coverage Offered (in Percent)		
	Count	No	Yes	Count	No	Yes
	Mining	20	10.0	90.0	17	5.9
Government	355	10.1	89.9	318	3.1	96.9
Manufacturing	95	13.7	86.3	82	9.8	90.2
Transportation/Communication/Utilities	156	21.2	78.8	123	8.1	91.9
Professional Services	827	23.7	76.3	626	4.5	95.5
Financial/Insurance/Real Estate	115	24.3	75.7	87	8.0	92.0
Retail Trade	205	37.6	62.4	128	6.3	93.8
Wholesale Trade	29	48.3	51.7	15	13.3	86.7
Construction	142	48.6	51.4	72	11.1	88.9
Other Services (Hospitality/Rec./etc.)	303	51.5	48.5	146	13.0	87.0
Agriculture	64	57.8	42.2	27	14.8	85.2
Total	2362	29.5	70.5	1656	6.6	93.4

While there are differences in take-up rates across employment sectors, fewer than 39% in any given sector refused the coverage offered by employers (see Table 2.13). Coverage by another family member was the most often cited reason for not enrolling in the plan offered by one's employer with nearly one-third of responses falling in this category. Twenty-seven percent stated that they were covered by "another program," while 23% said that they could not afford the coverage offered by their employer. These results are presented in Table 2.14.

Table 2.13 Health Care Coverage Take-up Rates and the Reasons Why Some Respondents did not Enroll in Employment-based Coverage by Industry in 2001

	Coverage Offered Count	Enrolled in Coverage Count	Take-up Rates Percent
Manufacturing	82	77	93.9
Government	319	284	89.0
Wholesale Trade	15	13	86.7
Agriculture	27	23	85.2
Mining	18	15	83.3
Professional Services	631	488	77.3
Transportation/Communication/Utilities	123	95	77.2
Construction	73	56	76.7
Financial/Insurance/Real Estate	87	66	75.9
Other Services (Hospitality/Recreation/etc.)	147	103	70.1
Retail Trade	128	78	60.9
Total	1650	1297	78.7

Note: The take-up rates were calculated by dividing the number of respondents who actually enroll in coverage by the number offered coverage and multiplying by 100.

Table 2.14 Examining Why Respondents did not Enroll in Employment-based Coverage by Industry in 2001

	Subgroup Column Totals		Covered-another program	Waiting period	Covered-family member	Couldn't afford	Didn't need	Other
	Count	Percent						
	Row Percents (sum to 100.0% across cells)							
Government	34	10.0	26.5	0.0	41.2	8.8	0.0	23.5
Professional Services	136	40.0	27.9	2.9	36.8	21.3	1.5	9.6
Agriculture	4	1.2	0.0	0.0	25.0	0.0	0.0	75.0
Mining	3	0.9	66.7	0.0	33.3	0.0	0.0	0.0
Manufacturing	5	1.5	20.0	0.0	0.0	20.0	0.0	60.0
Construction	17	5.0	35.3	0.0	17.6	11.8	5.9	29.4
Transportation/Communication/Utilities	25	7.4	24.0	8.0	24.0	36.0	0.0	8.0
Wholesale Trade	2	0.6	0.0	0.0	50.0	50.0	0.0	0.0
Retail Trade	50	14.7	26.0	0.0	24.0	36.0	0.0	14.0
Financial/Insurance/Real Estate	18	5.3	27.8	0.0	50.0	11.1	0.0	11.1
Other Services (Hospitality/Rec./etc.)	41	12.1	24.4	2.4	31.7	24.4	4.9	12.2
Total	340	100.0	26.8	2.1	32.6	22.6	1.5	14.4

Assessing Types of Coverage

While respondents might have had a variety of different types of coverage in 2001, the focus of this section is on the type of coverage most relied upon. Table 2.15 shows that a majority of respondents (roughly 58%) relied upon coverage offered either through their or a family member's employment, and only about one-out-of-five relied upon such public programs as Medicaid and Medicare.

Table 2.15 Primary Type of Coverage in 2001

	Count	Percent
Private health insurance through employer	1213	42.9
Private health insurance through family member's employer	433	15.3
Private health insurance other than through employment	154	5.5

Medicaid	149	5.3
Medicare	441	15.6
Medigap	4	0.1
Indian Health Service	43	1.5
Military/Veteran's	148	5.2
Another program	240	8.5
Total	2825	100.0

Looking at aggregate types of coverage across demographic subgroups as depicted in Table 2.16a shows that gender does not appear related to the type of coverage that one has, with a majority of female and male respondents carrying some type of private coverage (61% and 67%, respectively). However, the same cannot be said when considering other demographic factors such as educational attainment, age, and race/ethnicity, nor household income (Table 2.16b). In general, a majority of respondents with less than a high school education relied on public forms of health care coverage, as did respondents 65 and older, and those who have a household income less than \$10,000 per year. Table 2.17 shows little difference in the type of coverage relied upon at the regional level, with a majority of respondents in each of the public health districts and population density regions tending to utilize private health care coverage.

Table 2.16a General Types of Health Care Coverage by Individual-level Demographic Characteristics

	<i>Subgroup Column Totals</i>		Private	Public (Non-specific)	IHS	Military/ Veteran's	Other
	<i>Count</i>	<i>Percent</i>					
	Row Percents (sum to 100.0% across cells)						
Gender	2824	100.0					
Female	1675	59.3	61.5	24.1	1.8	3.7	9.0
Male	1149	40.7	67.4	16.2	1.1	7.5	7.8
Educational Attainment	2815	100.0					
Less than High School	158	5.6	36.7	50.6	2.5	0.6	9.5
High School/GED	601	21.3	53.9	28.5	2.2	5.3	10.1
Some College/Vo-Tech/AA Degree	917	32.6	64.6	18.1	2.0	6.7	8.7
College Graduate	1139	40.5	72.7	14.7	0.7	4.7	7.2
Age	2701	100.0					
19 to 24	181	6.7	64.1	23.8	1.7	5.0	5.5
25 to 34	338	12.5	72.5	9.5	4.1	5.0	8.9
35 to 49	836	31.0	79.4	6.6	2.3	4.2	7.5
50 to 64	769	28.5	76.5	5.9	0.5	7.9	9.2
65 and older	577	21.4	17.7	69.2	0.2	3.8	9.2
Race/Ethnicity	2600	100.0					
White, non-Hispanic	1702	65.5	66.2	20.6	0.1	5.2	8.0
Hispanic	621	23.9	67.0	20.3	0.3	3.1	9.3
Native American	94	3.6	40.4	12.8	36.2	2.1	8.5
Other	183	7.0	52.5	23.5	0.5	13.7	9.8

**Table 2.16b General Types of Health Care Coverage
by Household Income**

	<i>Subgroup Column Totals</i>		Private	Public (Non-specific)	IHS	Military/ Veteran's	Other
	<i>Count</i>	<i>Percent</i>					
	Row Percents (sum to 100.0% across cells)						
Household Income	2295	100.0					
\$10,000 or less	113	4.9	19.5	62.8	1.8	6.2	9.7
\$10 to \$20,000	259	11.3	36.7	40.5	4.6	5.4	12.7
\$20 to \$30,000	298	13.0	56.7	25.2	2.7	5.4	10.1
\$30 to \$40,000	361	15.7	59.0	19.1	1.9	8.6	11.4
\$40 to \$50,000	335	14.6	78.5	10.4	0.9	4.5	5.7
\$50 to \$60,000	219	9.5	77.2	10.0	0.9	5.9	5.9
\$60 to \$70,000	180	7.8	80.0	8.3	1.1	3.3	7.2
\$70 to \$80,000	142	6.2	85.9	3.5	0.0	5.6	4.9
\$80 to \$90,000	80	3.5	83.8	5.0	0.0	2.5	8.8
\$90 to \$100,000	69	3.0	84.1	7.2	0.0	2.9	5.8
More than \$100,000	239	10.4	84.9	6.7	0.4	2.9	5.0

**Table 2.17 Type of Health Care Coverage
by Geographic Characteristics**

	<i>Subgroup Column Totals</i>		Private	Public (Non-specific)	IHS	Military/ Veteran's	Other
	<i>Count</i>	<i>Percent</i>					
	Row Percents (sum to 100.0% across cells)						
Public Health Districts	2796	100.0					
District 1: NW-Central	1473	52.7	65.4	17.9	2.3	5.0	9.4
District 2: North Central-NE	446	16.0	68.2	20.0	1.8	1.8	8.3
District 3: South Central-SW	460	16.5	59.3	23.0	0.2	8.9	8.5
District 4: SE	417	14.9	60.0	29.0	0.0	5.3	5.8
Population Density Regions	2796	100.0					
Urban	936	33.5	65.9	16.1	0.6	6.0	11.3
Mixed	927	33.2	68.3	20.7	1.9	3.0	6.0
Rural	723	25.9	58.9	23.5	2.2	7.9	7.5
Frontier	210	7.5	54.8	31.4	1.4	1.9	10.5

In addition to the type of coverage respondents relied on, respondents were also asked what type of plan they had. For instance, was their plan a health maintenance organization (HMO), a preferred provider plan (PPO), a point-of-service plan (POS), an indemnity plan (fee-for-service), military coverage, or something else? As depicted in Figure 2.3, a plurality of respondents (44%) classified their plan as a HMO and 29% indicated that they utilized a PPO. The next closest classification was “something else”; this category captures the 17% of respondents who did not know how to classify their plan. Table 2.18 shows that HMOs tend to have a higher representation in the more populated urban areas in the state, especially those regions that encompass Albuquerque and Santa Fe.

Figure 2.3 Types of Health Care Plans across the Sample Population

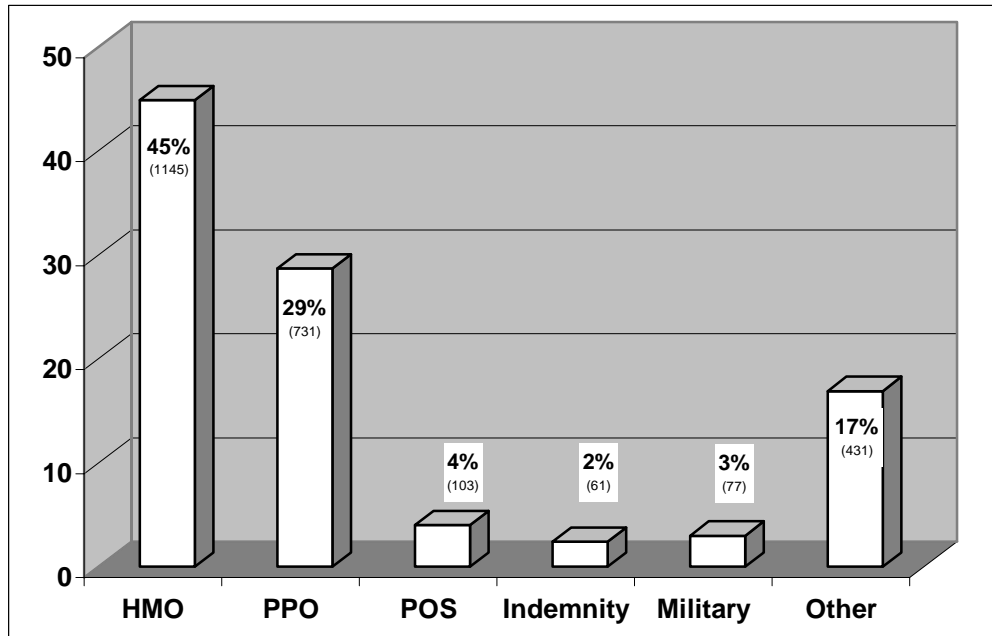


Table 2.18 Type of Health Care Plan by Geographic Characteristics

	<i>Subgroup</i>		HMO	PPO	POS	Indemnity	Military	Other
	<i>Column Totals</i>							
	<i>Count</i>	<i>Percent</i>	<i>Row Percents (sum to 100.0% across cells)</i>					
Public Health Districts	2525	100.0						
District 1: NW-Central	1360	53.9	53.2	25.2	3.3	1.8	2.8	13.6
District 2: North Central-NE	409	16.2	42.0	30.9	5.2	3.3	1.1	17.4
District 3: South Central-SW	401	15.9	33.9	34.7	5.0	3.7	5.0	17.7
District 4: SE	355	14.1	29.3	34.4	4.8	2.3	3.1	26.2
Population Density Regions	2525	100.0						
Urban	868	34.4	54.1	25.3	2.8	2.0	3.1	12.7
Mixed	858	34.0	46.2	30.4	3.3	2.6	2.2	15.4
Rural	620	24.6	36.0	32.3	4.8	2.7	4.2	20.0
Frontier	179	7.1	28.5	26.3	11.7	2.8	1.1	29.6

Assessing Out-of-Pocket Expenses for Health Care Coverage

Despite the fact that many respondents have health care coverage, respondents often have additional out-of-pocket expenses to cover the costs not covered by individual plans. In aggregate, respondents statewide paid an average of \$1,066 in out-of-pocket expenses in 2001; the median out-of-pocket expense was \$400. Table 2.19a breaks the average out-of-pocket costs up across individual-level demographic subgroups and Table 2.19b by household income (an aggregate-level measure). Overall

- women paid slightly less (\$995) and men slightly more (\$1,163) than the statewide average;
- respondents with less than a high school education paid less than their counterparts at \$685, on average, compared to college graduates who paid the most at an average of \$1,198;
- older respondents paid the most, on average, although those age 50 to 64 paid more than those 65 and older (\$1,432 vs. \$1,227), which is much greater than the \$460 paid by respondents aged 19 to 24;
- White, non-Hispanic respondents paid the most, on average, \$1,202 compared to their counterparts, with Native Americans paying the least (an average of \$546); and

- respondents with household incomes greater than \$100,000 paid \$1,770, on average, compared to those who made less, with respondents with household incomes of \$10,000 or less paying about \$612, on average.

Table 2.19a Average Out-of-Pocket Expenses Paid in 2001 by Individual-level Demographic Characteristics

	Mean (in dollars)	Median (in dollars)	Std. Dev. (in dollars)	N
Total Sample	1066.4	400	2762.9	2798
Gender				
Female	995.0	400	1859.1	1612
Male	1163.4	490	3647.3	1186
Educational Attainment				
Less than High School	684.7	137.5	1235.3	146
High School/GED	954.5	300	4405.7	598
Vo-Tech/AA Degree	1046.2	400	2060.8	938
College Graduate	1197.8	500	2231.4	1107
Age Groups				
19 to 24	459.5	140	1188.5	198
25 to 34	653.1	250	1308.3	393
35 to 49	991.6	500	2034.5	887
50 to 64	1431.6	500	4299.4	769
65 and older	1227.3	500	2118.5	424
Race/Ethnicity				
White, non-Hispanic	1201.7	500	3206.1	1686
Hispanic	801.2	300	1511.6	668
Native American	546.3	200	863.0	91
Other	1094.1	500	1994.0	172

Table 2.19b Average Out-of-Pocket Expenses Paid in 2001 by Household Income

	Mean (in dollars)	Median (in dollars)	Std. Dev. (in dollars)	N
Total Sample	1066.4	400	2762.9	2798
Household Income				
\$10,000 or less	611.5	100	1195.9	149
\$10 to \$20,000	676.4	200	1255.7	311
\$20 to \$30,000	837.7	300	1467.6	324
\$30 to \$40,000	887.1	400	1826.2	366
\$40 to \$50,000	1392.4	450	5776.1	324
\$50 to \$60,000	1212.3	500	1987.1	218
\$60 to \$70,000	1281.2	500	2603.5	172
\$70 to \$80,000	1249.3	500	1908.7	137
\$80 to \$90,000	858.0	500	1037.5	83
\$90 to \$100,000	822.6	500	949.3	65
More than \$100,000	1769.7	794	3420.0	240

Table 2.20 shows the highest out-of-pocket expenses based on type of coverage were paid by those who have coverage through the military (\$1,201, on average) compared to those with access to the Indian Health Service who had the lowest average out-of-pocket expenses at \$548. Considering plan types, respondents who participated in an indemnity (fee-for-service) plan had the highest average out-of-pocket expenses at \$2,116 compared to members of HMOs who had the lowest average out-of-pocket expenses at \$940.

**Table 2.20 Average Out-of-Pocket Expenses Paid in 2001
by Health Care Coverage Characteristics**

	Mean (in dollars)	Median (in dollars)	Std. Dev. (in dollars)	N
Total Sample	1066.4	400	2762.9	2798
Type of coverage				
Private	1135.6	500	2141.4	1555
Public (Non-specific)	1071.7	300	2169.1	419
IHS	547.8	200	871.5	36
Military	1200.9	165	8704.2	132
Other	1023.6	500	1566.3	181
Type of plan				
HMO	939.6	400	1950.5	952
PPO	1265.9	500	2247.8	639
POS	1179.7	570	1780.0	91
Indemnity	2116.5	750	4104.6	57
Military	1786.2	50	12019.5	69
Other	1083.5	300	1785.5	318

Table 2.21 shows that there are slight regional variations in the average out-of-pocket expenses paid by respondents in 2001. In general, those who live in the south central/southwest Public Health District pay the lowest costs (\$887), compared to those in the north-central/northeast Public Health District who pay the highest costs (\$1,240). Respondents in rural areas also pay lower costs, on average, at about \$875, compared to those who live in mixed population density areas (such as Santa Fe) who pay the highest costs at about \$1,264.

**Table 2.21 Average Out-of-Pocket Expenses Paid in 2001
by Geographic Characteristics**

	Mean (in dollars)	Median (in dollars)	Std. Dev. (in dollars)	N
Total Sample	1066.4	400	2762.9	2798
Public Health District				
District 1: NW-Central	1082.9	400	3391.5	1420
District 2: North Central-NE	1239.8	500	2015.2	476
District 3: South Central-SW	887.3	300	1768.6	478
District 4: SE	1060.3	500	1987.9	389
Population Density Region				
Urban	1034.1	400	2392.9	891
Mixed	1263.6	500	3787.7	946
Rural	874.9	400	1682.3	702
Frontier	1042.4	375	1646.8	224

Access to Various Health Care Services among New Mexico Adults

This section shifts from a discussion of the degree to which respondents had health care coverage and the types of coverage maintained across various demographic and geographic subgroups to a discussion of actual access to different health care services. In particular, the focus is on whether respondents had a usual place where they received health care and, if not, why not. Then, going one step further, whether respondents needed a particular type of health care “service” is examined, as well as whether they could actually obtain the service if needed. These issues are examined generally for the state and across demographic and geographic subgroups.

Assessing Respondents’ Usual Source for Health Care

Table 3.1 shows that more than 83% of respondents had a usual source for health care (i.e., a regular doctor’s office or clinic, or some sort of regular source for alternative types of health care). Since fewer than 17% of respondents had no usual source for health care, it is quite possible this is why some possibly rely on hospital emergency rooms to meet regular health care needs.

Table 3.1 Assessing the Usual Source for Health Care in 2001

	Count	Percent
No primary person or place	506	15.3
Emergency room	41	1.2
No usual place/Rely on Emergency room	547	16.5
Doctor's office	1574	47.6
Primary care clinic/Community health center	569	17.2
HMO-run clinic	172	5.2
Urgent care center	50	1.5
Hospital outpatient clinic	214	6.5
IHS Hospital or clinic	47	1.4
School clinic	16	0.5
Doctor's office/Clinic	2642	79.8
Some other place	24	0.7
Military clinic/Hospital	77	2.3
Alternative health care provider	7	0.2
Specialist	12	0.4
Other Usual source	120	3.6
Total	3309	100.0

Table 3.2a shows that respondents are slightly more likely to have a usual source for care if they are White, non-Hispanic; female; older; and more educated. Table 3.2b shows that households with higher aggregate incomes are also more likely to have a usual source for care than their counterparts. Table 3.2c shows that, regionally, slightly higher percentages of respondents living in the northwest-central Public Health District and Urban areas have access to a usual source of health care. Nonetheless, most respondents tend to have access to a “usual” source for care.

Table 3.2a Assessing Accessibility to a Usual Source for Health Care Other than an Emergency Room by Individual-level Demographic Characteristics

	<i>Subgroup</i>		No usual source	Have usual source
	<i>Column Totals</i>			
	Count	Percent	Row Percents (sum to 100.0% across cells)	
Gender	3307	100.0		
Female	1972	59.6	14.2	85.8
Male	1335	40.4	19.9	80.1
Educational Attainment	3298	100.0		
Less than High School	212	6.4	32.5	67.5
High School/GED	764	23.2	20.2	79.8
Some College/Vo-Tech/AA Degree	1085	32.9	15.3	84.7
College Graduate	1237	37.5	12.3	87.7
Age Groups	3157	100.0		
19 to 24	246	7.8	28.5	71.5
25 to 34	448	14.2	24.8	75.2
35 to 49	973	30.8	15.8	84.2
50 to 64	882	27.9	13.3	86.7
65 and older	608	19.3	11.2	88.8
Race/Ethnicity	3071	100.0		
White, non-Hispanic	1943	63.3	14.6	85.4
Hispanic	803	26.1	19.9	80.1
Native American	110	3.6	19.1	80.9
Other	215	7.0	15.3	84.7

Table 3.2b Assessing Accessibility to a Usual Source for Health Care Other than an Emergency Room by Household Income

	<i>Subgroup Column Totals</i>		No usual source	Have usual source
	<i>Count</i>	<i>Percent</i>	<i>Row Percents (sum to 100.0% across cells)</i>	
Household Income	2718	100.0		
\$10,000 or less	176	6.5	23.3	76.7
\$10 to \$20,000	367	13.5	22.1	77.9
\$20 to \$30,000	376	13.8	18.4	81.6
\$30 to \$40,000	423	15.6	15.8	84.2
\$40 to \$50,000	367	13.5	17.7	82.3
\$50 to \$60,000	243	8.9	17.3	82.7
\$60 to \$70,000	196	7.2	9.7	90.3
\$70 to \$80,000	149	5.5	9.4	90.6
\$80 to \$90,000	94	3.5	8.5	91.5
\$90 to \$100,000	72	2.6	9.7	90.3
More than \$100,000	255	9.4	11.8	88.2

Table 3.2c Assessing Accessibility to a Usual Source for Health Care Other than an Emergency Room by Geographic Characteristics

	<i>Subgroup Column Totals</i>		No usual source	Have usual source
	<i>Count</i>	<i>Percent</i>	<i>Row Percents (sum to 100.0% across cells)</i>	
Public Health Districts	3266	100.0		
District 1: NW-Central	1675	51.3	13.1	86.9
District 2: North Central-NE	547	16.7	17.2	82.8
District 3: South Central-SW	557	17.1	20.3	79.7
District 4: SE	487	14.9	21.1	78.9
Population Density Regions	3266	100.0		
Urban	1044	32.0	13.4	86.6
Mixed	1107	33.9	17.2	82.8
Rural	851	26.1	18.3	81.7
Frontier	264	8.1	16.7	83.3

Table 3.3 shows that coverage does play a role in whether one has a usual source for health care in terms of reducing the likelihood that respondents would have a usual source. Nevertheless, a majority of respondents (59%) without coverage in 2001 still had a usual source for care compared to only 41% of respondents without coverage who lacked a usual source of care. Only 12% of respondents covered for the entire year lacked a usual source for care compared to the 88% of respondents who were covered and had a usual source for care. Examining how coverage and plan types affect respondents' access to a usual source for care further supports this relationship. The Table shows that 86-93% of respondents covered by any type of plan had a usual source for care, as did 84-91% of those with different plan types.

Table 3.3 Assessing Accessibility to a Usual Source for Health Care Other than an Emergency Room by Status of Health Care Coverage

	<i>Subgroup Column Totals</i>		No usual source	Have usual source
	<i>Count</i>	<i>Percent</i>	<i>Row Percents (sum to 100.0% across cells)</i>	
Status of Coverage	3295	100.0		
No coverage	381	11.6	40.9	59.1
Covered part of year	206	6.3	27.7	72.3
Covered yearlong	2708	82.2	12.1	87.9
Coverage Type	2755	100.0		
Private	1764	64.0	13.4	86.6
Public (Non-specific)	572	20.8	14.2	85.8
IHS	43	1.6	7.0	93.0
Military Veteran's	144	5.2	8.3	91.7
Other	232	8.4	10.3	89.7
Plan Type	2503	100.0		
HMO	1123	44.9	9.3	90.7
PPO	720	28.8	15.4	84.6
POS	101	4.0	9.9	90.1
Indemnity	61	2.4	16.4	83.6
Military	76	3.0	9.2	90.8
Something else	422	16.9	12.6	87.4

However, while assessments based on demographic, geographic, or coverage characteristics may be helpful in illuminating who lacks access to a usual source for care, there are very specific reasons why some respondents do not have a “usual” source for health care. For instance, Table 3.4 shows that just under half of respondents lacking a usual source believe that they are healthy enough that they don’t need a “regular” doctor, although 11% say that their health care plan allows flexibility to select different physicians based on need (so there is not necessarily a requirement to have a usual source for care). Nevertheless, it is also important to note that almost 10% of respondents said that they don’t have a usual source because they do not know where to go.

Table 3.4 Primary Reason Why Some Respondents Do Not Have a Usual Source for Health Care

	Count	Percent
Don't need a doctor	215	46.7
Don't like, trust or believe in doctors	23	5.0
Don't know where to go	44	9.6
Previous doctor is not available or has moved	23	5.0
No insurance	24	5.2
Can't afford it	26	5.7
Language barrier	1	0.2
Care is too far away or not available	13	2.8
Plan allows to choose doctor based on needs	51	11.1
Other	40	8.7
Total	460	100.0

Assessing Health Care Requirements and the Acquisition of Services

Overall, seven-out-of-ten respondents indicated they needed prescription drugs, two-thirds needed routine preventive care, approximately three-out-of-five needed dental care, and just over half needed to see their primary care provider in 2001. Table 3.5 also shows that fewer than half of respondents needed any of the other services, with less than 1% of respondents indicating that they needed care for alcohol and drug abuse problems.¹⁰

Table 3.5 Assessing the Requirements for Different Types of Health Care Services

Type of service	Need Services		Count
	Row Percents (sum to 100.0% across cells)		
	No	Yes	
Prescription drugs	29.7	70.3	3257
Routine preventive care	34.0	66.0	3292
Dental care	38.0	62.0	3304
Primary care provider	44.7	55.3	3291
Eye care	52.1	47.9	3288
Special test and procedures	57.7	42.3	3293
Medical specialists	66.3	33.7	3302
Emergency room services	83.6	16.4	3285
Alternative health care	83.7	16.3	3276
Hospitalization	90.5	9.5	3283
Counseling	92.4	7.6	3279
Care for alcohol/drug abuse	99.4	0.6	3288

While needing a particular type of health care is one thing, actually being able to get it may be another. In Table 3.6 it is evident that respondents tend to have access to care whenever they need it, with the percentage that can access the 12 types of health care services whenever needed ranging from a low of 78% for counseling to a high of 96% for hospitalization. However, it is worth noting almost 13% of respondents did not have access to even routine preventive care whenever they needed it, nor did nearly 16% when it came to accessing primary care providers for emergent health care needs. The situation was similar for access to counseling services, treatment for drug and alcohol abuse, dental care, eye care, medical specialists, special tests and procedures, and alternative health care.

Table 3.6 Assessing the Acquisition of Different Types of Health Care Services

Type of service	Services were received ...			Count
	Never	Sometimes	Whenever	
	Row Percents (sum to 100.0% across cells)			
Hospitalization	1.0	3.2	95.8	310
Emergency room services	2.4	3.5	94.1	538
Prescription drugs	0.8	5.9	93.3	2283
Medical specialists	3.6	7.9	88.5	1108
Eye care	5.9	5.5	88.5	1569
Special test and procedures	3.0	9.1	87.9	1383
Routine preventive care	2.5	10.1	87.4	2166
Dental care	7.1	7.7	85.2	2041
Primary care provider	3.1	12.4	84.4	1810
Alternative health care	5.8	9.8	84.4	533
Care for alcohol/drug abuse	5.0	15.0	80.0	20
Counseling	7.2	14.9	77.9	249

¹⁰ However, a word of caution is in order regarding the responses on the need for substance abuse treatment: social desirability biases can affect respondents' willingness to answer questions of such a personal nature, especially if there is a perception among respondents that their answers will be viewed as socially unacceptable.

Table's 3.7a, 3.7b, and 3.7c reflect the different types of services that respondents may have needed based on three levels of aggregation: basic services, specialty services, and miscellaneous services, respectively. Generally, the Tables show that, with the exception of hospitalization where the frequencies for access were about equal, females were generally less likely to be able to access various types of health care services whenever they needed compared to males. Nevertheless, a majority was still able to do so when needed. At the low end of the range two-thirds of female respondents were able to access substance abuse treatment programs,¹¹ while a high of 96% of female respondents were able to access hospitalization services whenever needed. In contrast, males were less likely to be able to access counseling services (82%) and a high of 96% were able to access hospitalization, emergency room services, and prescription services when needed.

Table 3.7a Assessing the Acquisition of Health Care Services by Gender for Basic Types of Services

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Routine preventive care	2166	100.0			
Female	1388	64.1	2.8	10.8	86.4
Male	778	35.9	1.9	8.7	89.3
Primary care provider	1810	100.0			
Female	1153	63.7	3.6	13.7	82.7
Male	657	36.3	2.4	10.2	87.4
Emergency room services	538	100.0			
Female	347	64.5	2.6	4.3	93.1
Male	191	35.5	2.1	2.1	95.8
Hospitalization	310	100.0			
Female	212	68.4	0.5	3.8	95.8
Male	98	31.6	2.0	2.0	95.9
Prescription drugs	2283	100.0			
Female	1434	62.8	0.9	7.1	92.0
Male	849	37.2	0.7	3.8	95.5

Table 3.7b Assessing the Acquisition of Health Care Services by Gender for Specialty Types of Services

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Special test and procedures	1383	100.0			
Female	901	65.1	3.7	9.8	86.6
Male	482	34.9	1.7	7.9	90.5
Medical specialists	1108	100.0			
Female	670	60.5	4.3	8.5	87.2
Male	438	39.5	2.5	6.8	90.6
Care for alcohol/drug abuse	20	100.0			
Female	6	30.0	16.7	16.7	66.7
Male	14	70.0	0.0	14.3	85.7
Counseling	249	100.0			
Female	167	67.1	5.4	18.6	76.0
Male	82	32.9	11.0	7.3	81.7
Alternative health care	533	100.0			
Female	347	65.1	7.8	9.5	82.7
Male	186	34.9	2.2	10.2	87.6

¹¹ While this service was the least likely to be accessed by females whenever needed, caution is required when interpreting these results since the sample size is very small and could lead to erroneous inferences.

Table 3.7c Assessing the Acquisition of Health Care Services by Gender for Misc. Types of Services

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
			Row Percents (sum to 100.0% across cells)		
Dental care	2041	100.0			
Female	1243	60.9	8.0	8.3	83.7
Male	798	39.1	5.6	6.9	87.5
Eye care	1569	100.0			
Female	984	62.7	7.0	6.1	86.9
Male	585	37.3	4.1	4.6	91.3

Tables 3.8a, 3.8b, and 3.8c through 3.12a, 3.12b, and 3.12c show the findings are similar for the assessments made across a variety of other demographic subgroups including educational attainment, age, race/ethnicity, and geographic differences, all of which are also aggregated by the nature of the services being accessed. Overall, more than seven-out-of-ten respondents have access to each of the various types of health care services whenever needed. The exceptions tend to be for counseling, substance abuse treatment, and alternative health care, although even for these types of services a majority indicated they could receive these services whenever needed.

Table 3.8a Assessing Acquisition to Health Care Services by Educational Attainment for Basic Types of Services

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
			Row Percents (sum to 100.0% across cells)		
Routine preventive care	2160	100.0			
Less than High School	90	4.2	8.9	13.3	77.8
High School/GED	441	20.4	3.6	10.9	85.5
Some College/Vo-Tech/AA Degree	678	31.4	2.7	10.5	86.9
College Graduate	951	44.0	1.2	9.0	89.8
Primary care provider	1806	100.0			
Less than High School	85	4.7	3.5	20.0	76.5
High School/GED	385	21.3	3.9	13.8	82.3
Some College/Vo-Tech/AA Degree	589	32.6	3.7	13.9	82.3
College Graduate	747	41.4	2.3	9.6	88.1
Emergency room services	536	100.0			
Less than High School	40	7.5	2.5	5.0	92.5
High School/GED	132	24.6	3.0	3.8	93.2
Some College/Vo-Tech/AA Degree	182	34.0	2.7	6.0	91.2
College Graduate	182	34.0	1.1	0.5	98.4
Hospitalization	309	100.0			
Less than High School	27	8.7	0.0	0.0	100.0
High School/GED	74	23.9	2.7	5.4	91.9
Some College/Vo-Tech/AA Degree	102	33.0	1.0	2.9	96.1
College Graduate	106	34.3	0.0	2.8	97.2
Prescription drugs	2278	100.0			
Less than High School	120	5.3	3.3	11.7	85.0
High School/GED	490	21.5	0.4	6.3	93.3
Some College/Vo-Tech/AA Degree	748	32.8	1.2	6.6	92.2
College Graduate	920	40.4	0.4	4.3	95.2

**Table 3.8b Assessing Acquisition to Health Care Services
by Educational Attainment for Specialty Types of Services**

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Special test and procedures	1378	100.0			
Less than High School	62	4.5	8.1	19.4	72.6
High School/GED	264	19.2	3.4	11.4	85.2
Some College/Vo-Tech/AA Degree	454	32.9	3.3	8.1	88.5
College Graduate	598	43.4	1.8	7.7	90.5
Medical specialists	1106	100.0			
Less than High School	65	5.9	6.2	6.2	87.7
High School/GED	210	19.0	2.4	10.5	87.1
Some College/Vo-Tech/AA Degree	351	31.7	6.3	7.1	86.6
College Graduate	480	43.4	1.7	7.5	90.8
Care for alcohol/drug abuse	19	100.0			
Less than High School	4	21.1	0.0	25.0	75.0
High School/GED	1	5.3	0.0	0.0	100.0
Some College/Vo-Tech/AA Degree	10	52.6	0.0	20.0	80.0
College Graduate	4	21.1	0.0	0.0	100.0
Counseling	247	100.0			
Less than High School	14	5.7	21.4	7.1	71.4
High School/GED	44	17.8	13.6	9.1	77.3
Some College/Vo-Tech/AA Degree	88	35.6	3.4	21.6	75.0
College Graduate	101	40.9	5.0	12.9	82.2
Alternative health care	532	100.0			
Less than High School	19	3.6	10.5	21.1	68.4
High School/GED	87	16.4	4.6	12.6	82.8
Some College/Vo-Tech/AA Degree	165	31.0	7.3	7.9	84.8
College Graduate	261	49.1	5.0	9.2	85.8

**Table 3.8c Assessing Acquisition to Health Care Services
by Educational Attainment for Misc. Types of Services**

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Dental care	2036	100.0			
Less than High School	77	3.8	19.5	10.4	70.1
High School/GED	376	18.5	9.6	8.5	81.9
Some College/Vo-Tech/AA Degree	656	32.2	8.4	9.9	81.7
College Graduate	927	45.5	4.0	5.6	90.4
Eye care	1567	100.0			
Less than High School	84	5.4	13.1	6.0	81.0
High School/GED	299	19.1	8.4	7.0	84.6
Some College/Vo-Tech/AA Degree	515	32.9	6.2	6.0	87.8
College Graduate	669	42.7	3.6	4.5	91.9

**Table 3.9a Assessing Acquisition to Health Care Services
by Age Group for Basic Types of Services**

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Routine preventive care	2070	100.0			
19 to 24	102	4.9	5.9	13.7	80.4
25 to 34	239	11.5	5.9	12.1	82.0
35 to 49	642	31.0	2.5	13.6	84.0
50 to 64	645	31.2	0.9	8.1	91.0
65 and older	442	21.4	1.1	6.1	92.8
Primary care provider	1734	100.0			
19 to 24	100	5.8	7.0	20.0	73.0
25 to 34	208	12.0	6.7	16.8	76.4
35 to 49	546	31.5	3.7	14.7	81.7
50 to 64	521	30.0	2.1	10.6	87.3
65 and older	359	20.7	0.6	5.8	93.6
Emergency room services	517	100.0			
19 to 24	53	10.3	1.9	5.7	92.5
25 to 34	76	14.7	2.6	7.9	89.5
35 to 49	163	31.5	2.5	3.7	93.9
50 to 64	114	22.1	2.6	2.6	94.7
65 and older	111	21.5	0.9	0.9	98.2
Hospitalization	298	100.0			
19 to 24	19	6.4	0.0	0.0	100.0
25 to 34	45	15.1	0.0	0.0	100.0
35 to 49	82	27.5	2.4	7.3	90.2
50 to 64	70	23.5	1.4	4.3	94.3
65 and older	82	27.5	0.0	1.2	98.8
Prescription drugs	2183	100.0			
19 to 24	125	5.7	0.8	7.2	92.0
25 to 34	252	11.5	1.6	9.5	88.9
35 to 49	644	29.5	1.4	8.1	90.5
50 to 64	667	30.6	0.4	3.7	95.8
65 and older	495	22.7	0.2	3.6	96.2

**Table 3.9b Assessing Acquisition to Health Care Services
by Age Group for Specialty Types of Services**

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Special test and procedures	1321	100.0			
19 to 24	61	4.6	9.8	9.8	80.3
25 to 34	129	9.8	4.7	15.5	79.8
35 to 49	377	28.5	4.0	9.3	86.7
50 to 64	459	34.7	1.5	8.7	89.8
65 and older	295	22.3	0.7	6.8	92.5
Medical specialists	1066	100.0			
19 to 24	59	5.5	10.2	15.3	74.6
25 to 34	95	8.9	8.4	14.7	76.8
35 to 49	277	26.0	4.3	8.3	87.4
50 to 64	330	31.0	2.4	7.3	90.3
65 and older	305	28.6	1.0	4.6	94.4
Care for alcohol/drug abuse	19	100.0			
19 to 24	3	15.8	33.3	0.0	66.7
25 to 34	9	47.4	0.0	22.2	77.8
35 to 49	2	10.5	0.0	0.0	100.0
50 to 64	4	21.1	0.0	0.0	100.0
65 and older	1	5.3	0.0	0.0	100.0
Counseling	239	100.0			
19 to 24	12	5.0	33.3	8.3	58.3
25 to 34	51	21.3	9.8	19.6	70.6
35 to 49	97	40.6	6.2	14.4	79.4
50 to 64	60	25.1	5.0	13.3	81.7
65 and older	19	7.9	0.0	5.3	94.7
Alternative health care	509	100.0			
19 to 24	29	5.7	13.8	13.8	72.4
25 to 34	62	12.2	4.8	6.5	88.7
35 to 49	179	35.2	6.1	11.7	82.1
50 to 64	168	33.0	6.5	7.1	86.3
65 and older	71	13.9	0.0	5.6	94.4

**Table 3.9c Assessing Acquisition to Health Care Services
by Age Group for Misc. Types of Services**

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Dental care	1934	100.0			
19 to 24	135	7.0	11.9	10.4	77.8
25 to 34	262	13.5	9.2	10.7	80.2
35 to 49	621	32.1	8.1	9.3	82.6
50 to 64	573	29.6	5.1	6.5	88.5
65 and older	343	17.7	3.5	4.4	92.1
Eye care	1481	100.0			
19 to 24	90	6.1	7.8	12.2	80.0
25 to 34	159	10.7	5.7	8.8	85.5
35 to 49	433	29.2	8.8	6.2	85.0
50 to 64	456	30.8	5.9	4.4	89.7
65 and older	343	23.2	1.7	2.6	95.6

**Table 3.10a Assessing Acquisition to Health Care Services
by Race/Ethnicity for Basic Types of Services**

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Routine preventive care	2033	100.0			
White, non-Hispanic	1368	67.3	2.5	8.8	88.7
Hispanic	482	23.7	2.7	12.2	85.1
Native American	51	2.5	0.0	9.8	90.2
Other	132	6.5	2.3	9.1	88.6
Primary care provider	1703	100.0			
White, non-Hispanic	1123	65.9	2.9	11.0	86.1
Hispanic	415	24.4	2.7	16.1	81.2
Native American	51	3.0	5.9	21.6	72.5
Other	114	6.7	5.3	9.6	85.1
Emergency room services	505	100.0			
White, non-Hispanic	316	62.6	1.6	3.5	94.9
Hispanic	129	25.5	3.1	3.1	93.8
Native American	16	3.2	0.0	12.5	87.5
Other	44	8.7	2.3	4.5	93.2
Hospitalization	301	100.0			
White, non-Hispanic	196	65.1	1.0	2.6	96.4
Hispanic	75	24.9	1.3	5.3	93.3
Native American	8	2.7	0.0	12.5	87.5
Other	22	7.3	0.0	0.0	100.0
Prescription drugs	2186	100.0			
White, non-Hispanic	1445	66.1	0.6	5.3	94.0
Hispanic	521	23.8	1.3	7.5	91.2
Native American	70	3.2	1.4	2.9	95.7
Other	150	6.9	0.7	6.0	93.3

**Table 3.10b Assessing Acquisition to Health Care Services
by Race/Ethnicity for Specialty Types of Services**

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Special test and procedures	1310	100.0			
White, non-Hispanic	918	70.1	2.9	8.2	88.9
Hispanic	280	21.4	2.5	9.3	88.2
Native American	35	2.7	0.0	14.3	85.7
Other	77	5.9	2.6	14.3	83.1
Medical specialists	1049	100.0			
White, non-Hispanic	733	69.9	2.6	7.1	90.3
Hispanic	213	20.3	6.1	6.6	87.3
Native American	32	3.1	3.1	12.5	84.4
Other	71	6.8	4.2	14.1	81.7
Care for alcohol/drug abuse	18	100.0			
White, non-Hispanic	8	44.4	0.0	25.0	75.0
Hispanic	7	38.9	0.0	14.3	85.7
Native American	2	11.1	0.0	0.0	100.0
Other	1	5.6	0.0	0.0	100.0
Counseling	238	100.0			
White, non-Hispanic	161	67.6	6.8	15.5	77.6
Hispanic	52	21.8	11.5	7.7	80.8
Native American	10	4.2	0.0	60.0	40.0
Other	15	6.3	0.0	0.0	100.0
Alternative health care	512	100.0			
White, non-Hispanic	375	73.2	4.5	8.5	86.9
Hispanic	91	17.8	6.6	9.9	83.5
Native American	16	3.1	0.0	37.5	62.5
Other	30	5.9	10.0	13.3	76.7

**Table 3.10c Assessing Acquisition to Health Care Services
by Race/Ethnicity for Misc. Types of Services**

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Dental care	1927	100.0			
White, non-Hispanic	1298	67.4	5.9	6.2	87.8
Hispanic	432	22.4	8.1	11.3	80.6
Native American	68	3.5	7.4	17.6	75.0
Other	129	6.7	10.1	7.0	82.9
Eye care	1490	100.0			
White, non-Hispanic	956	64.2	5.0	4.3	90.7
Hispanic	379	25.4	7.9	7.1	85.0
Native American	54	3.6	5.6	14.8	79.6
Other	101	6.8	6.9	5.0	88.1

**Table 3.11a Assessing Acquisition to Health Care Services
by Public Health District for Basic Types of Services**

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Routine preventive care	2150	100.0			
District 1: NW-Central	1148	53.4	2.3	9.9	87.8
District 2: North Central-NE	355	16.5	2.0	8.7	89.3
District 3: South Central-SW	335	15.6	2.7	11.6	85.7
District 4: SE	312	14.5	3.2	10.3	86.5
Primary care provider	1796	100.0			
District 1: NW-Central	973	54.2	2.9	11.9	85.2
District 2: North Central-NE	279	15.5	2.9	14.0	83.2
District 3: South Central-SW	290	16.1	2.1	15.5	82.4
District 4: SE	254	14.1	5.1	9.4	85.4
Emergency room services	530	100.0			
District 1: NW-Central	253	47.7	2.0	4.0	94.1
District 2: North Central-NE	85	16.0	2.4	2.4	95.3
District 3: South Central-SW	96	18.1	1.0	6.3	92.7
District 4: SE	96	18.1	3.1	1.0	95.8
Hospitalization	306	100.0			
District 1: NW-Central	144	47.1	0.7	4.2	95.1
District 2: North Central-NE	46	15.0	2.2	4.3	93.5
District 3: South Central-SW	63	20.6	0.0	1.6	98.4
District 4: SE	53	17.3	1.9	1.9	96.2
Prescription drugs	2264	100.0			
District 1: NW-Central	1183	52.3	1.3	5.7	93.1
District 2: North Central-NE	364	16.1	0.0	4.7	95.3
District 3: South Central-SW	363	16.0	0.6	7.4	92.0
District 4: SE	354	15.6	0.6	6.2	93.2

**Table 3.11b Assessing Acquisition to Health Care Services
by Public Health District for Specialty Types of Services**

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Special test and procedures	1373	100.0			
District 1: NW-Central	727	52.9	2.1	9.5	88.4
District 2: North Central-NE	238	17.3	3.4	6.3	90.3
District 3: South Central-SW	216	15.7	4.2	11.6	84.3
District 4: SE	192	14.0	3.6	7.8	88.5
Medical specialists	1098	100.0			
District 1: NW-Central	579	52.7	3.5	7.6	88.9
District 2: North Central-NE	187	17.0	3.2	8.0	88.8
District 3: South Central-SW	169	15.4	4.1	9.5	86.4
District 4: SE	163	14.8	3.1	5.5	91.4
Care for alcohol/drug abuse	19	100.0			
District 1: NW-Central	7	36.8	0.0	28.6	71.4
District 2: North Central-NE	5	26.3	0.0	0.0	100.0
District 3: South Central-SW	2	10.5	0.0	50.0	50.0
District 4: SE	5	26.3	0.0	0.0	100.0
Counseling	246	100.0			
District 1: NW-Central	144	58.5	6.9	13.9	79.2
District 2: North Central-NE	49	19.9	8.2	24.5	67.3
District 3: South Central-SW	30	12.2	3.3	10.0	86.7
District 4: SE	23	9.3	8.7	8.7	82.6
Alternative health care	529	100.0			
District 1: NW-Central	249	47.1	5.2	9.2	85.5
District 2: North Central-NE	129	24.4	6.2	12.4	81.4
District 3: South Central-SW	75	14.2	6.7	6.7	86.7
District 4: SE	76	14.4	5.3	10.5	84.2

**Table 3.11c Assessing Acquisition to Health Care Services
by Public Health District for Misc. Types of Services**

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Dental care	2028	100.0			
District 1: NW-Central	1069	54.5	6.1	8.4	85.5
District 2: North Central-NE	371	16.5	4.9	7.5	87.6
District 3: South Central-SW	320	15.8	11.6	5.6	82.8
District 4: SE	268	13.2	7.8	8.2	84.0
Eye care	1552	100.0			
District 1: NW-Central	812	54.0	5.2	5.8	89.0
District 2: North Central-NE	256	14.8	6.3	3.9	89.8
District 3: South Central-SW	241	15.5	7.5	7.1	85.5
District 4: SE	243	15.7	7.0	5.3	87.7

Table 3.12a Assessing Acquisition to Health Care Services by Population Density Region for Basic Types of Services

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Routine preventive care	2150	100.0			
Urban	745	34.7	2.0	10.2	87.8
Mixed	724	33.7	2.1	9.7	88.3
Rural	531	24.7	3.2	10.0	86.8
Frontier	150	7.0	3.3	11.3	85.3
Primary care provider	1796	100.0			
Urban	612	34.1	2.8	11.8	85.5
Mixed	607	33.8	2.3	13.5	84.2
Rural	443	24.7	4.5	11.7	83.7
Frontier	134	7.5	3.0	13.4	83.6
Emergency room services	530	100.0			
Urban	154	29.1	2.6	1.9	95.5
Mixed	179	33.8	1.1	4.5	94.4
Rural	153	28.9	3.3	4.6	92.2
Frontier	44	8.3	0.0	2.3	97.7
Hospitalization	306	100.0			
Urban	80	26.1	1.3	2.5	96.3
Mixed	98	32.0	0.0	3.1	96.9
Rural	92	30.1	1.1	5.4	93.5
Frontier	36	11.8	2.8	0.0	97.2
Prescription drugs	2264	100.0			
Urban	741	32.7	1.3	5.9	92.7
Mixed	762	33.7	0.3	4.2	95.5
Rural	565	25.0	1.2	7.4	91.3
Frontier	196	8.7	0.0	7.7	92.3

Table 3.12b Assessing Acquisition to Health Care Services by Population Density Region for Specialty Types of Services

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Special test and procedures	1373	100.0			
Urban	473	34.5	1.5	8.9	89.6
Mixed	466	33.9	3.0	7.9	89.1
Rural	338	24.6	3.8	9.5	86.7
Frontier	96	7.0	5.2	13.5	81.3
Medical specialists	1098	100.0			
Urban	368	33.5	3.5	6.5	89.9
Mixed	369	33.6	3.0	6.5	90.5
Rural	280	25.5	4.3	10.0	85.7
Frontier	81	7.4	2.5	9.9	87.7
Care for alcohol/drug abuse	39	100.0			
Urban	20	51.3	0.0	40.0	60.0
Mixed	5	12.8	0.0	0.0	100.0
Rural	8	20.5	0.0	16.7	83.3
Frontier	6	15.4	0.0	0.0	0.0
Counseling	246	100.0			
Urban	96	39.0	9.4	11.5	79.2
Mixed	81	32.9	1.2	19.8	79.0
Rural	55	22.4	7.3	16.4	76.4
Frontier	14	5.7	21.4	7.1	71.4
Alternative health care	529	100.0			
Urban	154	29.1	5.8	6.5	87.7
Mixed	195	36.9	5.6	12.8	81.5
Rural	132	25.0	3.8	10.6	85.6
Frontier	48	9.1	10.4	6.3	83.3

Table 3.12c Assessing Acquisition to Health Care Services by Population Density Region for Misc. Types of Services

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
			Row Percents (sum to 100.0% across cells)		
Dental care	2028	100.0			
Urban	694	34.2	5.3	7.1	87.6
Mixed	707	34.9	6.6	8.2	85.1
Rural	475	23.4	9.3	8.4	82.3
Frontier	152	7.5	8.6	7.2	84.2
Eye care	1552	100.0			
Urban	499	32.2	5.4	4.6	90.0
Mixed	536	34.5	5.8	4.7	89.6
Rural	394	25.4	6.3	7.1	86.5
Frontier	123	7.9	8.1	8.9	82.9

Examining access from another perspective, Tables 3.13a, 3.13b, and 3.13c show that coverage does affect access to services whenever needed. However, the affect is nominal, at best. At least a plurality of respondents can access each of the twelve services whenever needed despite their coverage status. Table's 3.14a, 3.14b, and 3.14c through 3.15a, 3.15b, and 3.15c show that even when considering types of coverage or the type of plan one is on also has little affect on access to services when needed. This is good from the standpoint of consistency, since all types of coverage and plans tend to offer respondents a similar degree of access. Nevertheless, while access does not appear to be a major issue in aggregate, the fact that even minimal disparities in access are apparent can be problematic if the disparities differentially affect diverse groups of respondents. Consequently, logistic regression was used to provide insight into what factors might be predictive of disparities in access to a variety of health care services. The output is provided in Table 3.16.

Table 3.13a Assessing Acquisition to Health Care Services by Status of Health Care Coverage for Basic Types of Services

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
			Row Percents (sum to 100.0% across cells)		
Routine preventive care	2158	100.0			
No coverage	128	5.9	28.1	22.7	49.2
Covered part of year	100	4.6	5.0	19.0	76.0
Covered yearlong	1930	89.4	0.6	8.7	90.7
Primary care provider	1804	100.0			
No coverage	130	7.2	27.7	27.7	44.6
Covered part of year	100	5.5	5.0	20.0	75.0
Covered yearlong	1574	87.3	1.0	10.5	88.5
Emergency room services	535	100.0			
No coverage	61	11.4	13.1	9.8	77.0
Covered part of year	46	8.6	6.5	6.5	87.0
Covered yearlong	428	80.0	0.2	2.1	97.7
Hospitalization	309	100.0			
No coverage	20	6.5	10.0	0.0	90.0
Covered part of year	20	6.5	0.0	10.0	90.0
Covered yearlong	269	87.1	0.4	2.6	97.0
Prescription drugs	2278	100.0			
No coverage	158	6.9	6.3	18.4	75.3
Covered part of year	126	5.5	4.0	17.5	78.6
Covered yearlong	1994	87.5	0.2	4.0	95.8

**Table 3.13b Assessing Acquisition to Health Care Services
by Status of Health Care Coverage for Specialty Types of Services**

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Special test and procedures	1378	100.0			
No coverage	97	7.0	22.7	19.6	57.7
Covered part of year	72	5.2	5.6	25.0	69.4
Covered yearlong	1209	87.7	1.2	7.2	91.6
Medical specialists	1103	100.0			
No coverage	76	6.9	27.6	17.1	55.3
Covered part of year	57	5.2	10.5	12.3	77.2
Covered yearlong	970	87.9	1.2	6.8	92.0
Care for alcohol/drug abuse	19	100.0			
No coverage	4	21.1	0.0	0.0	100.0
Covered part of year	4	21.1	0.0	50.0	50.0
Covered yearlong	11	57.9	0.0	9.1	90.9
Counseling	247	100.0			
No coverage	41	16.6	31.7	19.5	48.8
Covered part of year	21	8.5	9.5	38.1	52.4
Covered yearlong	185	74.9	1.1	11.4	87.6
Alternative health care	532	100.0			
No coverage	75	14.1	14.7	18.7	66.7
Covered part of year	36	6.8	11.1	22.2	66.7
Covered yearlong	421	79.1	3.8	7.1	89.1

**Table 3.13c Assessing Acquisition to Health Care Services
by Status of Health Care Coverage for Misc. Types of Services**

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Dental care	2034	100.0			
No coverage	180	8.8	35.6	13.3	51.1
Covered part of year	109	5.4	19.3	17.4	63.3
Covered yearlong	1745	85.8	3.3	6.6	90.1
Eye care	1566	100.0			
No coverage	128	8.2	31.3	8.6	60.2
Covered part of year	81	5.2	27.2	12.3	60.5
Covered yearlong	1357	86.7	2.3	4.7	93.0

**Table 3.14a Assessing Acquisition to Health Care Services
by Type of Health Care Coverage for Basic Types of Services**

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
			Row Percents (sum to 100.0% across cells)		
Routine preventive care	1950	100.0			
Private	1285	65.9	0.5	8.8	90.7
Public, (Non-specific)public	405	20.8	1.2	10.6	88.1
IHS	15	0.8	0.0	20.0	80.0
Military/Veteran's	92	4.7	1.1	8.7	90.2
Other	153	7.8	0.7	10.5	88.9
Primary care provider	1599	100.0			
Private	1022	63.9	1.1	10.6	88.4
Public, (Non-specific)public	345	21.6	0.9	11.3	87.8
IHS	21	1.3	9.5	38.1	52.4
Military/Veteran's	70	4.4	1.4	8.6	90.0
Other	141	8.8	0.7	17.0	82.3
Emergency room services	454	100.0			
Private	255	56.2	0.8	1.2	98.0
Public, (Non-specific)public	130	28.6	0.8	4.6	94.6
IHS	6	1.3	0.0	16.7	83.3
Military/Veteran's	27	5.9	0.0	0.0	100.0
Other	36	7.9	0.0	5.6	94.4
Hospitalization	283	100.0			
Private	144	50.9	0.7	2.8	96.5
Public, (Non-specific)public	100	35.3	0.0	2.0	98.0
IHS	3	1.1	0.0	33.3	66.7
Military/Veteran's	14	4.9	0.0	0.0	100.0
Other	22	7.8	0.0	9.1	90.9
Prescription drugs	2025	100.0			
Private	1276	63.0	0.2	4.7	95.1
Public, (Non-specific)public	457	22.6	0.7	5.7	93.7
IHS	22	1.1	4.5	0.0	95.5
Military/Veteran's	92	4.5	0.0	3.3	96.7
Other	178	8.8	0.0	7.9	92.1

**Table 3.14b Assessing Acquisition to Health Care Services
by Type of Health Care Coverage for Specialty Types of Services**

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Special test and procedures	1225	100.0			
Private	781	63.8	0.9	6.7	92.4
Public, (Non-specific)public	276	22.5	1.8	10.9	87.3
IHS	12	1.0	8.3	33.3	58.3
Military/Veteran's	58	4.7	0.0	5.2	94.8
Other	98	8.0	2.0	10.2	87.8
Medical specialists	980	100.0			
Private	552	56.3	1.4	7.6	90.9
Public, (Non-specific)public	276	28.2	2.2	4.3	93.5
IHS	10	1.0	10.0	10.0	80.0
Military/Veteran's	51	5.2	0.0	7.8	92.2
Other	91	9.3	0.0	11.0	89.0
Care for alcohol/drug abuse	16	100.0			
Private	7	43.8	0.0	14.3	85.7
Public, (Non-specific)public	5	31.3	0.0	20.0	80.0
IHS	1	6.3	0.0	0.0	100.0
Military/Veteran's	1	6.3	0.0	0.0	100.0
Other	2	12.5	0.0	50.0	50.0
Counseling	206	100.0			
Private	129	62.6	0.8	13.2	86.0
Public, (Non-specific)public	41	19.9	4.9	7.3	87.8
IHS	3	1.5	0.0	66.7	33.3
Military/Veteran's	12	5.8	0.0	16.7	83.3
Other	21	10.2	9.5	19.0	71.4
Alternative health care	443	100.0			
Private	303	68.4	4.0	7.6	88.4
Public, (Non-specific)public	74	16.7	8.1	8.1	83.8
IHS	4	0.9	0.0	25.0	75.0
Military/Veteran's	16	3.6	6.3	0.0	93.8
Other	46	10.4	0.0	8.7	91.3

**Table 3.14c Assessing Acquisition to Health Care Services
by Type of Health Care Coverage for Misc. Types of Services**

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Dental care	1764	100.0			
Private	1184	67.1	2.4	6.6	91.0
Public, (Non-specific)public	316	17.9	5.4	9.2	85.4
IHS	26	1.5	19.2	15.4	65.4
Military/Veteran's	94	5.3	7.4	6.4	86.2
Other	144	8.2	11.8	7.6	80.6
Eye care	1359	100.0			
Private	837	61.6	2.5	4.7	92.8
Public, (Non-specific)public	325	23.9	4.9	4.3	90.8
IHS	16	1.2	0.0	31.3	68.8
Military/Veteran's	61	4.5	3.3	11.5	85.2
Other	120	8.8	5.8	3.3	90.8

**Table 3.15a Assessing Acquisition to Health Care Services
By Type of Health Care Plan for Basic Types of Services**

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Routine preventive care	1791	100.0			
HMO	847	47.3	0.5	9.8	89.7
PPO	522	29.1	0.6	8.6	90.8
POS	78	4.4	0.0	6.4	93.6
Indemnity	39	2.2	2.6	7.7	89.7
Military	43	2.4	2.3	9.3	88.4
Something else	262	14.6	1.9	11.8	86.3
Primary care provider	1457	100.0			
HMO	701	48.1	0.4	12.0	87.6
PPO	389	26.7	1.0	9.0	90.0
POS	65	4.5	1.5	4.6	93.8
Indemnity	29	2.0	10.3	13.8	75.9
Military	34	2.3	0.0	11.8	88.2
Something else	239	16.4	2.9	14.6	82.4
Emergency room services	392	100.0			
HMO	169	43.1	0.0	1.8	98.2
PPO	96	24.5	1.0	3.1	95.8
POS	17	4.3	0.0	0.0	100.0
Indemnity	1	0.3	0.0	0.0	100.0
Military	16	4.1	0.0	0.0	100.0
Something else	93	23.7	2.2	3.2	94.6
Hospitalization	237	100.0			
HMO	101	42.6	0.0	3.0	97.0
PPO	54	22.8	1.9	1.9	96.3
POS	10	4.2	0.0	0.0	100.0
Indemnity	3	1.3	0.0	0.0	100.0
Military	7	3.0	0.0	0.0	100.0
Something else	62	26.2	0.0	8.1	91.9
Prescription drugs	1838	100.0			
HMO	846	46.0	0.5	4.4	95.2
PPO	516	28.1	0.0	4.5	95.5
POS	79	4.3	1.3	6.3	92.4
Indemnity	45	2.4	4.4	6.7	88.9
Military	47	2.6	0.0	2.1	97.9
Something else	305	16.6	0.7	6.6	92.8

**Table 3.15b Assessing Acquisition to Health Care Services
By Type of Health Care Plan for Specialty Types of Services**

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Special test and procedures	1128	100.0			
HMO	508	45.0	1.2	7.7	91.1
PPO	338	30.0	1.5	5.6	92.9
POS	44	3.9	0.0	2.3	97.7
Indemnity	31	2.7	3.2	6.5	90.3
Military	25	2.2	0.0	4.0	96.0
Something else	182	16.1	1.1	14.3	84.6
Medical specialists	884	100.0			
HMO	390	44.1	2.3	6.4	91.3
PPO	239	27.0	1.7	6.7	91.6
POS	37	4.2	0.0	10.8	89.2
Indemnity	24	2.7	4.2	12.5	83.3
Military	17	1.9	0.0	0.0	100.0
Something else	177	20.0	2.8	7.3	89.8
Care for alcohol and drug abuse	16	100.0			
HMO	2	12.5	0.0	0.0	100.0
PPO	5	31.3	0.0	20.0	80.0
POS	0	0.0	0.0	0.0	0.0
Indemnity	0	0.0	0.0	0.0	0.0
Military	1	6.3	0.0	0.0	100.0
Something else	8	50.0	12.5	25.0	62.5
Counseling	189	100.0			
HMO	80	42.3	2.5	12.5	85.0
PPO	48	25.4	0.0	12.5	87.5
POS	7	3.7	0.0	0.0	100.0
Indemnity	7	3.7	0.0	0.0	100.0
Military	6	3.2	0.0	0.0	100.0
Something else	41	21.7	14.6	14.6	70.7
Alternative health care	393	100.0			
HMO	147	37.4	6.1	8.8	85.0
PPO	147	37.4	2.7	6.1	91.2
POS	17	4.3	0.0	5.9	94.1
Indemnity	11	2.8	0.0	9.1	90.9
Military	10	2.5	10.0	10.0	80.0
Something else	61	15.5	1.6	13.1	85.2

**Table 3.15c Assessing Acquisition to Health Care Services
By Type of Health Care Plan for Misc. Types of Services**

Type of service	Subgroup Column Totals		Services were received ...		
	Count	Percent	Never	Sometimes	Whenever
Row Percents (sum to 100.0% across cells)					
Dental care	1624	100.0			
HMO	729	44.9	3.4	6.7	89.8
PPO	499	30.7	2.0	7.0	91.0
POS	70	4.3	4.3	4.3	91.4
Indemnity	39	2.4	2.6	2.6	94.9
Military	41	2.5	7.3	7.3	85.4
Something else	246	15.1	9.3	11.0	79.7
Eye care	1223	100.0			
HMO	543	44.4	3.5	4.6	91.9
PPO	348	28.5	2.9	5.5	91.7
POS	54	4.4	5.6	1.9	92.6
Indemnity	35	2.9	2.9	5.7	91.4
Military	27	2.2	3.7	11.1	85.2
Something else	216	17.7	4.6	7.9	87.5

As evident in Table 3.16, coverage was the only common variable in the logistic regression models that proved to be a strong predictor among all of the demographic, geographic, and

coverage variables used to predict disparities in access across all types of services. Individually, age and household income were other good predictors of disparities in access to preventive care, medical specialists, and dental care; as were age and being Native American for access to primary care physicians; age, household income, and being Hispanic for access to special tests; household income for access to eye care; there were no additional predictors for access to prescriptions.

Table 3.16 Logistic Regression Model Analyzing Access to Health Care Services in 2001 by Demographic and Geographic Subgroups and whether Respondents Have Coverage¹²

Access to...	Preventive Care	PCP	Special Tests	Specialists	Dental Care	Eye Dr.	Rx
Count	1567	1291	1009	795	1469	1114	1648
Chi-square	210.3	204.0	112.3	91.1	222.6	144.7	98.8
Model P-value	<0.0001	<0.0001	<0.0001	<0.0001	<0.0001	<0.0001	<0.0001
Constant							
Coef/SE	-3.3	-1.7	-2.3	-1.9	-1.5	-0.9	0.6
Chi-square	10.9	3.0	5.4	3.7	2.1	0.8	0.4
P-value	0.0009	0.0830	0.0197	0.0553	0.1456	0.3665	0.5207
Age							
Coef/SE	3.6	2.9	3.3	3.1	2.4	1.6	1.5
Chi-square	13.1	8.5	10.6	9.6	5.6	2.4	2.3
P-value	0.0003	0.0035	0.0011	0.0019	0.0175	0.1199	0.1259
Education							
Coef/SE	1.1	-0.7	0.9	0.2	-1.1	0	0
Chi-square	1.2	0.5	0.8	0	1.3	0	0
P-value	0.2722	0.4607	0.3571	0.8529	0.2537	0.9618	0.9971
Gender							
Coef/SE	-0.3	1.0	0.6	-0.2	-0.6	0.3	0.3
Chi-square	0.1	1.0	0.3	0	0.4	0.1	0.1
P-value	0.7621	0.3092	0.5554	0.8387	0.5416	0.7686	0.7707
Hispanic							
Coef/SE	1.3	1.3	2.7	0.3	-1.2	-0.3	-1
Chi-square	1.8	1.7	7.0	0.1	1.3	0.1	1.1
P-value	0.1772	0.1873	0.0080	0.7607	0.2487	0.7880	0.3054
Native American							
Coef/SE	0.0	-3.1	0.0	-0.5	0.0	0.9	-1.1
Chi-square	0.0	9.4	0.0	0.2	0.0	0.8	1.2
P-value	0.9939	0.0022	0.9942	0.6437	0.9866	0.3821	0.2740
Household Income							
Coef/SE	2.2	1.4	2.1	2.3	5.2	2.5	-0.5
Chi-square	4.9	1.8	4.5	5.4	27.1	6.3	0.2
P-value	0.0273	0.1760	0.0335	0.0201	<0.0001	0.0123	0.6374
PHD-2							
Coef/SE	-0.9	-0.2	-0.6	0.2	1.5	0.7	0
Chi-square	0.8	0.0	0.3	0.0	2.3	0.5	0
P-value	0.3586	0.8331	0.5731	0.8253	0.1262	0.4611	0.9931
PHD-3							
Coef/SE	0.1	1.2	-1.4	-0.1	-1.9	-1.3	1.2
Chi-square	0.0	1.3	2.0	0	3.7	1.6	1.4
P-value	0.9089	0.2472	0.1610	0.9331	0.0538	0.2051	0.2409
PHD-4							
Coef/SE	-0.7	-1.3	-1.0	1.4	0.3	-0.2	0.7
Chi-square	0.4	1.6	1.0	1.8	0.1	0.1	0.5
P-value	0.5109	0.1996	0.3168	0.1761	0.8023	0.8142	0.4705
Covered							
Coef/SE	8.2	8.3	4.9	4.8	8.1	7.9	5
Chi-square	66.7	69.0	24.3	22.9	64.8	62.4	25.1
P-value	<0.0001	<0.0001	<0.0001	<0.0001	<0.0001	<0.0001	<0.0001

¹² Only the Public Health Districts were used in this analysis since, from a policy perspective, it is easier to assess unmet needs and provide for the delivery of services if addressed within a framework already in use in NM. Also, the small sample sizes for the other services limits their usefulness in these models and, thus, were excluded. Finally, bold values are statistically significant at the 95% level of confidence or better, thus we would **not** expect to see the described relationships by chance more than 5-out-of-100 times. Finally,

In addition to being asked if different services were needed and whether respondents had access to them whenever needed, those respondents who had limited or no access were asked why this was the case. The top two factors that explain differential access to health care services are scheduling and availability problems, and having no way to pay. The single biggest factor explaining access problems pertaining to obtaining routine preventive care, access to primary care physicians, and treatment for substance abuse was problems relating to scheduling and availability. Having no way to pay was the singled biggest factor affecting access to special tests and procedures, medical specialists, dental care, emergency rooms, counseling, alternative health care, and prescription drugs. All of the reasons given for limited access to various health care services are provided in Table 3.17. Note that when payment was the primary factor affecting access the second major factor was scheduling and availability, and vice versa.

Table 3.17 Assessing Why Respondents were Unable to Obtain Health Care Services When Needed

Type of service	No way to pay	Couldn't get there	No time	Some other reason				Count
				Scheduling/ Availability	Coverage problems	Trouble communicating	Other	
Row Percents (sum to 100.0% across cells)								
Routine preventive care	32.4	4.6	13.7	40.7	0.4	1.2	7.1	241
Primary care provider	28.9	3.8	15.6	45.6	1.1	0.4	4.6	263
Special test/procedures	48.0	3.3	8.7	28.0	3.3	0.7	8.0	150
Medical specialists	44.3	3.5	10.4	28.7	0.0	0.0	13.0	115
Dental care	68.1	1.8	6.4	17.0	0.0	0.0	6.7	282
Eye care	74.3	0.6	6.4	10.5	0.6	0.0	7.6	171
Emergency room	46.4	3.6	3.6	25.0	0.0	0.0	21.4	28
Hospitalization	25.0	16.7	0.0	25.0	8.3	0.0	25.0	12
Care-alcohol/drug abuse	0.0	0.0	0.0	50.0	0.0	0.0	50.0	2
Counseling	58.0	6.0	12.0	20.0	2.0	0.0	2.0	50
Alternative health care	73.8	2.5	8.8	8.8	0.0	0.0	6.3	80
Prescription drugs	64.0	3.5	1.8	13.2	1.8	0.0	15.8	114

Table's 3.18 and 3.19 address the issue of cost from two different perspectives: Table 3.18 examines the reasons why respondents could not get services because they had no way to pay, and Table 3.19 examines how those respondents who actually received services paid for them. With the exception of treatment for substance abuse problems, the primary reason why respondents could not pay for health care services (therefore making it difficult or impossible to receive them) was because they had no coverage for such services. Payment was not the primary reason why those respondents who addressed substance abuse treatment issues were precluded from receiving such treatment, thus it is excluded from the analysis presented in Table 3.18. However, the caveat to this latter issue is that it is unclear whether this would be the case had the sample size for this subgroup been larger (n=20).¹³

¹³ However, a word of caution is in order regarding the responses on the need for substance abuse treatment: social desirability biases can affect respondents' willingness to answer questions of such a personal nature, especially if there is a perception among respondents that their answers will be viewed as socially unacceptable.

Table 3.18 Assessing Why Respondents Cannot Pay for Health Care Services

Type of service	No coverage	Insurance did Not cover	Provider wouldn't Accept insur.	Some other reason	Count
	Percent (values sum to 100.0% across the columns)				
Routine preventive care	86.2	7.7	0.0	6.2	65
Primary care provider	92.5	6.0	1.5	0.0	67
Special test/procedures	74.1	13.8	3.4	8.6	58
Medical specialists	74.4	14.0	4.7	7.0	43
Dental care	75.0	19.9	3.2	1.9	156
Eye care	72.4	22.4	1.0	4.1	98
Emergency room services	100.0	0.0	0.0	0.0	12
Hospitalization	66.7	33.3	0.0	0.0	3
Counseling	83.3	12.5	0.0	4.2	24
Alternative health care	55.1	32.7	8.2	4.1	49
Prescription drugs	62.3	24.6	4.9	8.2	61

Note: treatment for substance abuse problems is not considered in this Table because none of the respondents who needed such treatment indicated that payment issues precluded them from receiving such treatment.

Table 3.19 shows that respondents tended to be covered in full for services relating to special tests/procedures, medical specialists, emergency room visits, hospitalization, and counseling. In contrast, a plurality of respondents indicated that costs for routine preventive care, their primary care provider, dental care, eye care, and prescription drugs were only covered in part. Finally, a plurality of respondents who received substance abuse treatment paid out-of-pocket for such treatment and a majority indicated they typically paid out-of-pocket for alternative health care.

Table 3.19 Assessing Payments for Health Care Services

Type of service	Not paid for by anyone	Paid out-of-pocket	Covered In part	Covered in full	Count
	Percent (values sum to 100.0% across the columns)				
Routine preventive care	1.0	8.6	48.8	41.6	2084
Primary care provider	1.1	8.2	50.2	40.6	1728
Special test/procedures	1.4	8.4	38.3	51.9	1329
Medical specialists	1.1	8.3	43.6	47.0	1054
Dental care	1.7	29.3	42.0	27.0	1886
Eye care	1.6	33.8	40.3	24.3	1458
Emergency room services	4.2	12.4	34.7	48.6	518
Hospitalization	1.3	5.3	34.3	59.0	300
Care for alcohol/drug abuse	16.7	44.4	16.7	22.2	18
Counseling	3.5	24.2	35.7	36.6	227
Alternative health care	4.4	53.1	29.3	13.2	501
Prescription drugs	1.0	17.0	60.3	21.7	2244

Coverage and Access Issues Among Children and Immigrants to the U.S.

The household survey included general questions about health care coverage for children under the age of 19 years old and also explored specific health care needs of a subset of those children. Thirty-eight percent of respondent households (n=1305) had children under the age of 19 years. The number of children per household ranged from 1 to 7, with an average of about two children per household. This section of the survey examining the health care coverage and needs of children focused on only one child per household: the child under the age of 18 who had the most recent birthday. Questions about those children were asked only of respondents who self-identified as the specified child's parent or legal guardian.

At the household level, 89% of the households with children reported that all of the children in their households had healthcare coverage; in 3% of households only some of the children were covered; and in 8 % of households none of the children were covered.

When asked to focus on one specific child a subset of 1,073 children emerged. Parents were asked whether the child was covered continuously for the entire year, covered for part of the year, or not covered at all during 2001. Eighty-seven percent of this subset of children was covered

continuously, 6% were not covered at all, and 7% were covered for part of the year. The average number of months of health care coverage for those children who were only covered for part of the year was about four months. Table 4.1 compares the two different measures of health care coverage for children.

Table 4.1 Health Care Coverage for Children

Coverage of any Children in Household			Coverage of Subset of Children		
In the household...	Count	Percent	Thinking specifically about 1 child...	Count	Percent
All children covered	1137	88.9	Fully covered	934	87.0
Some children covered	34	2.7	Partially covered	71	6.6
No children covered	108	8.4	Not covered at all.	68	6.3
Total	1279	100.0	Total	1073	100.0

Note: The difference in the number of households who have children (1279) and the number of children in the subset (1073) can be attributed to respondents who dropped out of the survey or those for whom data is missing.

The remainder of the analyses in this section focuses on the demographics and health care needs of the subset of 1,073 children. The only demographics directly associated with this group of children are age and Public Health District. Any other demographics presented in this section are those of the parent or guardian who was the respondent and must be interpreted with caution. The results are presented in Table 4.2.

**Table 4.2 Individual and Household Demographic Characteristics
by Level of Health Care Coverage in 2001**

	<i>Subgroup Column Totals</i>		Health Care Coverage In 2001		
	<i>Count</i>	<i>Percent</i>	No Coverage	Part of Year	Year Round
			Row Percents (sum to 100.0% across cells)		
Public Health Districts	<i>1057</i>	<i>100.0</i>			
District 1: NW-Central	<i>544</i>	<i>51.5</i>	5.7	5.7	88.6
District 2: North Central-NE	<i>161</i>	<i>15.2</i>	6.2	8.1	85.7
District 3: South Central-SW	<i>195</i>	<i>18.4</i>	7.2	9.2	83.6
District 4: South East	<i>157</i>	<i>14.9</i>	7.0	5.7	87.3
Marital Status of Respondent	<i>1071</i>	<i>100.0</i>			
Married	<i>760</i>	<i>71.0</i>	5.7	6.3	88.0
Other	<i>311</i>	<i>29.0</i>	8.0	7.4	84.6
Ethnicity of Respondent	<i>1019</i>	<i>100.0</i>			
White, non-Hispanic	<i>579</i>	<i>56.8</i>	6.0	6.6	87.4
Hispanic	<i>340</i>	<i>33.4</i>	7.6	6.2	86.2
Native American	<i>42</i>	<i>4.1</i>	2.4	9.5	88.1
Other	<i>58</i>	<i>5.7</i>	5.2	5.2	89.7
Household Income	<i>945</i>	<i>100.0</i>			
\$10,000 or less	<i>50</i>	<i>5.3</i>	8.0	18.0	74.0
\$10,000-\$20,000	<i>109</i>	<i>11.5</i>	13.8	10.1	76.1
\$20,000-\$30,000	<i>126</i>	<i>13.3</i>	8.7	8.7	82.5
\$30,000-\$40,000	<i>161</i>	<i>17.0</i>	6.8	8.7	84.5
\$40,000-\$50,000	<i>112</i>	<i>11.9</i>	3.6	7.1	89.3
\$50,000-\$60,000	<i>81</i>	<i>8.6</i>	7.4	3.7	88.9
\$60,000-\$70,000	<i>80</i>	<i>8.5</i>	2.5	5.0	92.5
\$70,000-\$80,000	<i>53</i>	<i>5.6</i>	3.8	1.9	94.3
\$80,000-\$90,000	<i>40</i>	<i>4.2</i>	2.5	2.5	95.0
\$90,000-\$100,000	<i>30</i>	<i>3.2</i>	3.3	0.0	96.7
More than \$100,000	<i>103</i>	<i>10.9</i>	0.0	1.9	98.1
Mean Age of Children	<i>-NA-</i>	<i>-NA-</i>	9.5 years	8.4 years	10.3 years

Table 4.2 compares selected individual and household demographics for children who were covered for all of 2001, those who were covered part of the time, and those child who were not covered at all in 2001. Public Health District 1 has the highest percentage of children who were covered year-round (89%), with Districts 2 and 3 having the largest percentage of children with only partial or no coverage. Additionally, dual parent households tend to have higher continuous coverage rates than other types of households, with Native American households nominally more likely to have children who were continuously covered in 2001. Considering household income, the

effects discussed in Section II persist: children from affluent households are more likely to have coverage year-round than their counterparts from less affluent households. When asked why a child was without continuous coverage (n=124), the top three reasons were: can't afford it (34.1%), couldn't get it (18.2%) and the child wasn't born yet (14.3%).

Assessing Types of Coverage among Children

Respondents were asked to indicate “what types of coverage this child had in 2001?” As shown in Table 4.3, 95% of children with year-round coverage were covered under their parents' employee health care, and children with partial coverage were more likely to be covered by Medicaid/New MexiKids (12%).¹⁴ Although several respondents mentioned that their child was covered by more than one type of insurance, majorities at the full coverage level and the partial coverage level relied on only one type of insurance coverage.

Table 4.3 Health Care Insurance Coverage Type by Degree of Coverage in 2001

Coverage Type	Subgroup Column Totals		Covered Year round	Part of year
	Count	Percent	Row Percents (sum to 100.0% across cells)	
Medicaid/New MexiKids	291	24.3	88.0	12.0
Medicare	30	2.5	90.0	10.0
Indian Health Services	26	2.2	92.3	7.7
US Military/Veterans	61	5.1	95.1	4.9
Parent's Employee	677	56.6	95.3	4.7
Other Private Insurance	112	9.4	91.1	8.9

Assessing Access to Health Care Services among Children

The level of health care coverage plays a major role in the kind of health care services a parent/guardian sought for their children in 2001. Nearly 34% of children who were not covered by health care insurance did not see any health care provider in 2001, only 5% of those with full coverage and about 8% of those with partial coverage did not avail themselves of any of the types of health care services listed. This relationship is statistically significant at the < .0001 level. Table 4.4 presents the number and percentage of respondents who said their child saw a health care provider for the stated reason, relative to the level of coverage in 2001. Chi Square statistics and their related p-values were calculated; an asterisk indicates statistically significant relationships.

**Table 4.4 Percent of Children Who Were Seen for...<<reason>>
by Level of Health Care Coverage in 2001
n=1073**

Reason	Covered continuously		Part of year		Not Covered	
	Count	Percent	Count	Percent	Count	Percent
Not seen at all in 2001**	48	5.1	6	8.5	23	33.8
Primary Care**	699	74.8	55	77.5	22	32.4
Preventive Care**	474	50.7	32	45.1	13	19.1

¹⁴ Generally, children are not covered under Medicare. Despite this, some respondents indicated the coverage was Medicare thus it was included as specified.

Dental Care**	570	61.0	25	35.2	22	32.4
Eye Care**	303	32.4	15	21.1	7	10.3
Prescription Drugs**	533	57.1	41	57.7	18	26.5
Required Check-up*	251	26.9	18	25.4	9	26.9
Emergency Care at ER	12	20.0	19	26.8	187	17.6
Overnight Hospital Stay	42	4.5	5	7.0	2	2.9
Treatment for Drugs or Alcohol	0	0	0	0	0	0
Counseling/Mental Health	54	5.8	3	4.2	2	2.9
Special tests or Procedures	186	19.9	14	19.7	8	11.8
Some Other Reason	96	10.3	11	15.5	3	4.4

** Statistically significant relationship at the <.0001 level. * Statistically significant relationship at the .05 level.

More than a third of children not covered by health insurance did not see a health care professional in 2001. Those children who were not covered by health care insurance were less likely to have used any of the routine health care services than their fully and partially covered counterpart. Although the uninsured were roughly 6% of the sample population, the disparity in use of basic medical services is striking. In emergency or specialized care situations, the disparities between the un-, under-, and fully insured are not statistically significant, although the general pattern still holds.

When asked whether there was a particular person or place their child usually went to for health care in 2001, 91% of covered children went to a doctor's office, primary care, or community clinic. The next most mentioned place for the provision of health care services was an urgent care center (82%), 64% had no particular person or place, and 33% went to emergency rooms. Finally, 50% of children without coverage relied on emergency rooms as did 17% of those covered for only part of the year.

Table 4.5 Person or Place Child Usually Went for Health Care by Level of Health Care Coverage in 2001

	Covered continuously	Part of year	Not Covered	Count
	Row Percents (sum to 100.0% across cells)			
No Particular Person or Place	63.6	6.4	30.0	110
Doctor's Office	91.0	6.0	3.1	586
Primary care or community clinic	91.4	5.1	3.6	197
Urgent Care center	82.4	11.8	5.9	17
Emergency Room	33.3	16.7	50.0	6

Health Care Requirements among Immigrants in New Mexico Households: A Caveat

The information provided in this section cannot be used to generalize to the status of the population of immigrants living in New Mexico. The survey contains six questions that are subject to social desirability biases (due to legal vs. illegal status, among other potential types of bias), has unit-of-analysis problems, and an overall lack of generalizability. Further, research conducted on

the health care coverage and access issues for this special population should take advantage of alternative methods appropriate to evaluating the health care status of immigrants in New Mexico. Thus, the findings presented herein for immigrants need to be interpreted with great caution.

Fifty-seven households participating in the 2002 Household Health Care Coverage and Access Study indicated that there was at least one immigrant living there. Of those households, 35% (20) reported the immigrant(s) did not have any health care coverage. There were approximately 2.2 immigrants per household with about 1.1 immigrants covered per household. Finally, because the specific questions regarding immigrant access to health care were in the last quarter of the survey, there were only 49 respondent households with immigrants remaining to answer those questions since some households ended the survey before reaching this series of questions. Of these, 11 respondents indicated immigrants in their household's required health care services and all of them were able to get the services whenever they needed them. Immigrants were seen for the full range of services, except drug and alcohol abuse treatment, which was not needed.

Summary and Conclusions: Areas for Further Research

Throughout this report the assessments of the status and continuity of health care coverage throughout New Mexico have provided information at two levels. First, the insured population and the continuity in coverage across the state and by diverse subgroups have been defined. Second, issues affecting both the insured and uninsured (whether continuously or for only part of the year) have been defined. In understanding these issues this report has moved the level of knowledge one step further toward understanding access to reliable and affordable health care in New Mexico. However, this is only a starting point. Further research is needed, thus this study should be considered as a template for moving forward. Specifically, any further research should be directed toward understanding how to overcome the disparities identified in this report, even those that seem to only nominally affect diverse subgroups throughout New Mexico. Such an endeavor should involve more extensive assessments utilizing survey research and a variety of qualitative research tools.

To this end, research should include, at the very least, focus groups to provide necessary anecdotal support of the findings herein and to identify any foci lacking in this study but which might enhance understanding of those most directly affected by lapses in or an absence of coverage. Citizen conferences and town hall meetings are other techniques that would prove beneficial. Both of these research methods promote neutral forums whereby average citizens can be brought together with a diverse set of "experts" from all sectors of the health care arena to collectively learn from each other and come to a consensus on ways to resolve some of New Mexico's most pressing health care issues, especially those that can be addressed through informed policy-making. This is an important issues for not only New Mexico, but for that segment of the public that is least likely to have any significant source of health care coverage and lacks access to even routine preventive care and primary care providers who might be needed to address emergent health problems.

Table 5.1 shows that there is strong support for taking research and policy-making to the next step with regard to finding ways to assure that there are affordable programs in place to cover the unmet needs for basic health care in New Mexico. When asked to rate on a scale from zero to ten where zero is not at all important and ten is extremely important to rate how important it is to address this issue, 88% of respondents rated the importance above the scale midpoint of five. Further, 66% of respondents rated the level of importance as extremely important. In contrast, only about 12% answered at the scale midpoint or below. A graphic depiction is provided in Figure 5.1.

Table 5.1 Assessing Respondents' Attitudes Regarding the Importance of Programs for Assuring Unmet Needs for Basic Health Care are Provided for in New Mexico

Importance of Addressing Unmet Needs		
	Count	Percent
0 Not at all important	110	3.5
1	15	0.5
2	28	0.9
3	31	1.0
4	25	0.8
5	180	5.8
6	68	2.2
7	115	3.7
8	318	10.2
9	179	5.7
10 Extremely Important	2051	65.7
Total	3120	100.0

Descriptive Statistics	
Mean	8.7
Median	10.0
Std. Dev.	2.5

Figure 5.1 Assessing Respondents' Attitudes Regarding the Importance of Programs for Assuring Unmet Needs for Basic Health Care are Provided for in New Mexico

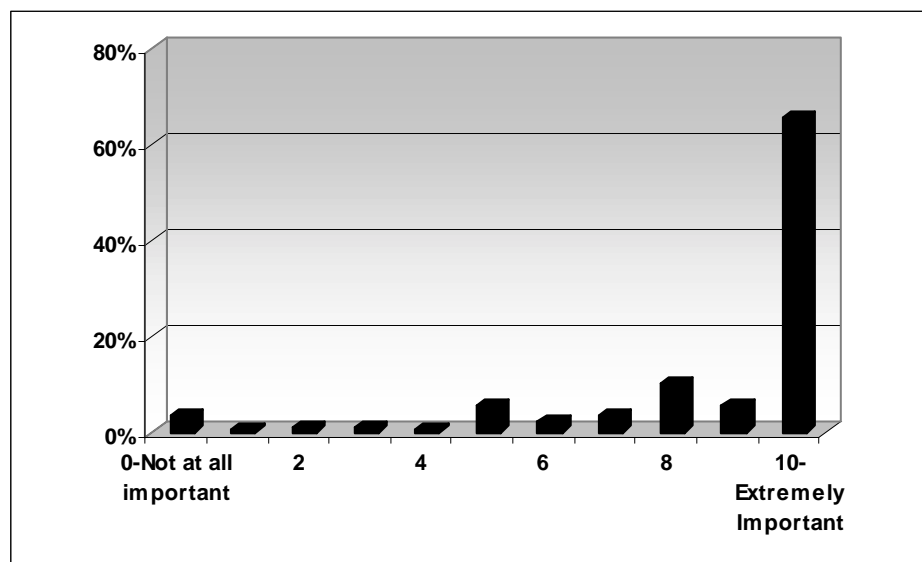


Table 5.2 examines attitudes on affordable programs across aggregate levels of coverage among respondents statewide. The results shown in the Table are from an Analysis of Variance model (ANOVA) and are based on a one-tailed test assessing the effects of coverage on attitudes.¹⁵ Overall, while the mean values across all groups are high, there is a statistically significant difference across the population depending on whether respondents had no coverage at all in 2001, were covered part of the year, or were covered continuously for the entire year. The model is statistically significant (F-value=5.4 and P-Value < .05), with the one-tailed tests showing that attitudes of respondents with coverage for the entire year different significantly from respondents covered for only part of the year or not covered at all.

¹⁵ In a one-tailed test we are testing not only whether there is a relationship, but also the directionality of the hypothesized relationship; those with coverage for the entire year will place less importance on programs for addressing unmet needs than either respondents covered for part of the year or not covered at all in 2001.

Table 5.2 Assessing the Effects of Coverage on Respondents' Attitudes Regarding the Importance of Programs for Assuring Unmet Needs for Basic Health Care

	Mean	Model	
		F-Value	P-Value
Not covered at all	9.0	5.4	.0044
Covered part of year	8.9		
Covered continuously	8.6		

One other aspect that needs to be considered when assessing respondents' attitudes on assuring New Mexicans can meet their unmet needs for basic health care is to consider respondent evaluations on the state of the health care system in New Mexico. Table 5.3a shows that a plurality of respondents (43%) believes that "our health care system requires major changes to make it work better" and 23% believe that it needs to be completely rebuilt, compared to 28% who believe it only needs minor changes and 6% who believe it is just fine the way it is. In the ANOVA Table 5.3b shows that attitudes about the status of the health care system in New Mexico do play a role in the strength of respondents' attitudes about the importance of assuring that there are affordable programs available to help New Mexicans cover unmet needs for basic health care. Overall, respondents who believe that the health care system in New Mexico is just fine the way it is do not attribute the same degree of importance to such programs as respondents who believe the system needs minor changes, major changes, or that it needs to be completely rebuilt. Respondents who believe there need to be major changes in the system or that it needs to be completely rebuilt do not differ from each other, however.

Table 5.3a Attitudes Regarding the State of Health Care in New Mexico

	Count	Percent
Our health care system works just fine the way it is	174	5.9
Our health care system requires MINOR changes	816	27.5
Our health care system requires MAJOR changes	1288	43.3
Our health care system needs to be completely rebuilt	694	23.4
Total	2972	100.0

Table 5.3b Assessing the Effects of Attitudes Pertaining to Respondents' Evaluations of the Status of the Health Care System in New Mexico on Attitudes Regarding the Importance of Programs for Assuring Unmet Needs for Basic Health Care

	Mean	Model	
		F-Value	P-Value
Our health care system works just fine the way it is	7.1	51.2	<.0001
Our health care system requires MINOR changes	8.2		
Our health care system requires MAJOR changes	9.1		
Our health care system needs to be completely rebuilt	9.1		

Table's 5.4a and 5.4b also provide the results of several ANOVA models examining the effects of demographics and geography on attitudes regarding affordable programs to help New Mexicans meet their unmet basic health care needs. All but one of the models are statistically significant and indicate that demographics and geography are strong predictors of attitudes about the importance of assuring that there are affordable programs available to help New Mexicans cover unmet needs for basic health care. The exception is for educational attainment and population density regions, with no variation in attitudes across either subgroup on this issue. However, females are have stronger views on the importance of assuring affordable access, as do respondents under age 65, those with lower household incomes, Hispanics, and respondents in Public Health District 2.

Table 5.4a Assessing the Effects of Individual and Household Demographics on Attitudes Regarding the Importance of Programs for Assuring Unmet Needs for Basic Health Care

	Mean	Model			
		F-Value	P-Value		
Gender					
Female	9.0	90.6	<.0001		
Male	8.2				
Educational Attainment					
Less than High School	8.7	0.4	.7223		
High School/GED	8.7				
Some College/Vo-Tech/AA Degree	8.7				
College Graduate	8.6				
Age Groups					
19 to 24	8.7	10.8	<.0001		
25 to 34	8.8				
35 to 49	8.9				
50 to 64	8.8				
65 and older	8.1				
Household Income					
\$10,000 or less	9.0	2.6	.0039		
\$10 to \$20,000	9.0				
\$20 to \$30,000	8.9				
\$30 to \$40,000	8.8				
\$40 to \$50,000	8.8				
\$50 to \$60,000	8.5				
\$60 to \$70,000	8.8				
\$70 to \$80,000	8.3				
\$80 to \$90,000	8.9				
\$90 to \$100,000	8.6				
More than \$100,000	8.4				
Race/Ethnicity					
White, non-Hispanic	8.6			7.4	.0006
Hispanic	9.0				
Native American	8.6				

Table 5.4b Assessing the Effects of Geography on Attitudes Regarding the Importance of Programs for Assuring Unmet Needs for Basic Health Care

	Mean	Model	
		F-Value	P-Value
Public Health Districts			
District 1: NW-Central	8.6	2.5	.0585 *
District 2: North Central-NE	8.9		
District 3: South Central-SW	8.7		
District 4: SE	8.6		
Population Density Regions			
Urban	8.6	1.0	.3768
Mixed	8.7		
Rural	8.7		
Frontier	8.8		

Note: statistically significant in a one-tailed test, which is consistent with the hypothesis for this test.

As the foregoing indicate, finding a way to assure that New Mexicans have access to health care coverage and at least basic health care services is important to respondents, and not just among those who currently have unmet needs. However, it is also clear in this report that not enough is known about the segment of the New Mexico population where coverage and access disparities are the greatest. This report has only offered a glimpse into this population. Hence, further research must focus on this population so even greater strides can be made to assure that all New Mexicans have the opportunity to live healthy lives.