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Sociodemographic Differences in Nonfinancial Access Barriers to Health Care Among Adults: United States, 2022

by Amanda E. Ng, Ph.D., M.P.H., Dzifa Adjaye-Gbewonyo, Ph.D., M.P.H., and James M. Dahlhamer, Ph.D.

Abstract

Objective—Nonfinancial access barriers to care describe various reasons why adults may delay or not get medical care, beyond cost. This report focuses on five access barriers to care and describes the percentage of U.S. adults who delayed or did not get medical care in the past 12 months because of 1) being too busy with work or other commitments; 2) an appointment not being available when needed; 3) not being able to get to the doctor's office or clinic when open; 4) difficulty finding a doctor, clinic, or hospital that would accept their health insurance; and 5) it taking too long to get to the doctor's office or clinic from their house or work.

Methods—Data from the 2022 National Health Interview Survey were used to produce estimates of the percentage of adults who delayed or did not get medical care in the past 12 months because of those access barriers to care, overall and by selected sociodemographic characteristics.

Results—Among U.S. adults in 2022, 12.5% delayed or did not get medical care in the past 12 months because they were too busy to go to a provider, 10.6% could not find an available appointment when needed, 4.6% were unable to get to a provider when open, 4.4% had difficulty finding a doctor compatible with their health insurance, and 2.4% responded that it takes too long to get to a provider. Percentages varied by sociodemographic characteristics.

Conclusion—This study provides nationally representative estimates of selected nonfinancial access barriers to medical care, both overall and for selected sociodemographic groups. Findings suggest that nonfinancial access barriers to care are widespread in the United States, and ongoing monitoring may help to address inequities in access to care.

Keywords: health equity • healthcare use • social determinants of health • National Health Interview Survey (NHIS)

Introduction

Increasing access to comprehensive, high-quality healthcare services is one of the goals of Healthy People 2030—the nation's current 10-year initiative to monitor and improve public health through quantifiable objectives (1). Barriers to accessing health care can cause delays in timely medical treatment and preventive care, leading to poor health outcomes (2,3). Additionally, access barriers may impact certain segments of the population more than others and further contribute to health disparities. Identifying and better understanding access inequities can help to inform these barriers in support of attaining Healthy People 2030 goals.

Previous research has found that nonmonetary factors, including appointment availability and transportation access, are common barriers to healthcare access and may be more widespread overall than financial barriers (4). However, much of the literature on nonfinancial access barriers to care in the United States is limited and based on studies that are not generalizable to the adult population (3,5); the few nationally representative studies are either based on data that are no longer current (4,6) or provide limited

detail on the specific nonfinancial access barriers under study (2,7).

The present study aims to expand this evidence base by providing updated estimates on several nonfinancial access barriers to care in the U.S. adult population by selected sociodemographic factors using the National Health Interview Survey (NHIS), a nationally representative data source.

Methods

Data source

This analysis used data from the Sample Adult module of the 2022 NHIS, a nationally representative household survey of the U.S. civilian noninstitutionalized population. NHIS is conducted continuously throughout the year by the National Center for Health Statistics (NCHS). Interviews are typically completed face-to-face in respondents' homes, with follow-ups conducted by telephone as needed. Data collection procedures were disrupted due to the COVID-19 pandemic, and during 2022, 55.7% of the Sample Adult interviews were conducted at least partially by telephone (8). The Sample Adult response rate was 47.7% (8). For more information about NHIS, visit its website: https://www.cdc.gov/nchs/nhis.htm.

Measures

Nonfinancial access barriers to care

NHIS regularly monitors delayed or unmet need for medical care due to cost (9,10) and fielded additional questions in 2022 related to nonfinancial access and transportation barriers to care (11) to provide a more comprehensive view of barriers to health care in the United States. Similar questions on nonfinancial access barriers to care were fielded in the 2011–2018 NHIS. Measures of nonfinancial access barriers to care were based on a "yes" response to a series of five questions asking whether the respondent delayed or did not get medical care in the past 12 months because of 1) difficulty finding a doctor, clinic, or hospital that would accept their health insurance (subsequently referred to as "difficulty finding a provider compatible with their insurance"); 2) an appointment not being available when needed; 3) not being able to get to the doctor's office or clinic when open (subsequently referred to as "unable to get to a provider when open"); 4) it taking too long to get to the doctor's office or clinic from their house or work (subsequently referred to as "takes too long to get to a provider"); and 5) being too busy with work or other commitments (subsequently referred to as "too busy to go to a provider"). These items were included as emerging content in the 2022 NHIS, in part because they were the most widespread nonfinancial access barriers to care in the United States according to data from the 2007 Health Tracking Household Survey (HTHS), a nationally representative data collection of 9,407 U.S. households that asked questions of adults on health insurance coverage, use of health services, health care satisfaction, and health conditions, in addition to unmet healthcare needs (4).

Selected sociodemographic characteristics

Race and Hispanic origin—Based on responses to two race and Hispanic-origin questions, respondents were categorized as follows: American Indian and Alaska Native non-Hispanic (subsequently, American Indian and Alaska Native); Asian non-Hispanic (subsequently, Asian); Black non-Hispanic (subsequently, Black); Native Hawaiian and Pacific Islander non-Hispanic (subsequently, Native Hawaiian and Pacific Islander); White non-Hispanic (subsequently, White); Other and multiple races non-Hispanic (subsequently, other and multiple races); and Hispanic. Categories shown for non-Hispanic adults are for those who selected only one racial group, except for other and multiple races. Adults categorized as Hispanic may be of any race or combination of races. Analyses were limited to the race and Hispanic-origin groups for which data were reliable and sufficiently powered to make group comparisons.

Family income —Based on a percentage of the federal poverty level (FPL), which was calculated from the family's income in the previous calendar year and family size using the U.S. Census Bureau's poverty thresholds (12). Family income was imputed when missing (13). Five categories were used in analyses: less than 100% FPL, 100% to 199% FPL, 200% to 299% FPL, 300% to 399% FPL, and 400% FPL or greater.

Highest level of education—Based on years of school completed or the highest degree obtained. Categories are less than high school diploma or GED, high school diploma or GED, some college, and bachelor's degree or higher.

Employment status—A respondent was considered employed if they were working at or were on temporary leave from a paid job or business in the last week; worked, but not for pay at a family business; or had seasonal or contract work in the past 12 months.

Urbanization—Metropolitan size and status were determined using the 2013 NCHS urban–rural classification scheme for counties (14,15), by merging the geographic federal information processing standard codes for the county of household residence with the county-level federal information processing standard codes from the classification scheme's data set. The six-level NCHS urban–rural classification is based on metropolitan statistical area status defined by the Office of Management and Budget, according to published standards that are applied to U.S. Census Bureau data. This report includes the four-level condensed NCHS urban–rural classification that is available in the public-use data set: large central metropolitan (similar to inner cities), large fringe metropolitan (similar to suburbs), medium and small metropolitan, and nonmetropolitan (15,16). Large metropolitan areas have populations of 1 million or more. Metropolitan areas with populations of less than 1 million were classified as medium (250,000–999,999 population) or small (less than 250,000 population) (15).

Insurance coverage—Adults were classified as privately insured, publicly insured, or uninsured at the time of the interview. Private health insurance coverage included any comprehensive private insurance plan, including

those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. This excludes plans that pay for only one type of service, such as dental, vision, or prescription drugs. Public health coverage includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plans, Medicare, and military plans. Adults were considered uninsured if they did not have any of the coverage plans described previously, if they only had Indian Health Service coverage, or only had a private plan that paid for one type of service, such as dental, vision, or prescription drugs. Estimates are presented for the working-age population ages 18–64.

Statistical analyses

Percentages of each nonfinancial access barrier to care were calculated overall and by selected sociodemographic characteristics. These estimates excluded unknown values from the denominators, and differences between percentages were assessed with two-sided pairwise tests at the 0.05 alpha level. Linear and quadratic trends by age group, family income, education, and urbanization level were evaluated using orthogonal polynomials.

All estimates were weighted and calculated using SAS-callable SUDAAN software (17) to account for the complex sample design of NHIS. 95% confidence intervals were generated using the Korn–Graubard method for complex surveys. All estimates presented meet NCHS data presentation standards for proportions (18).

Results

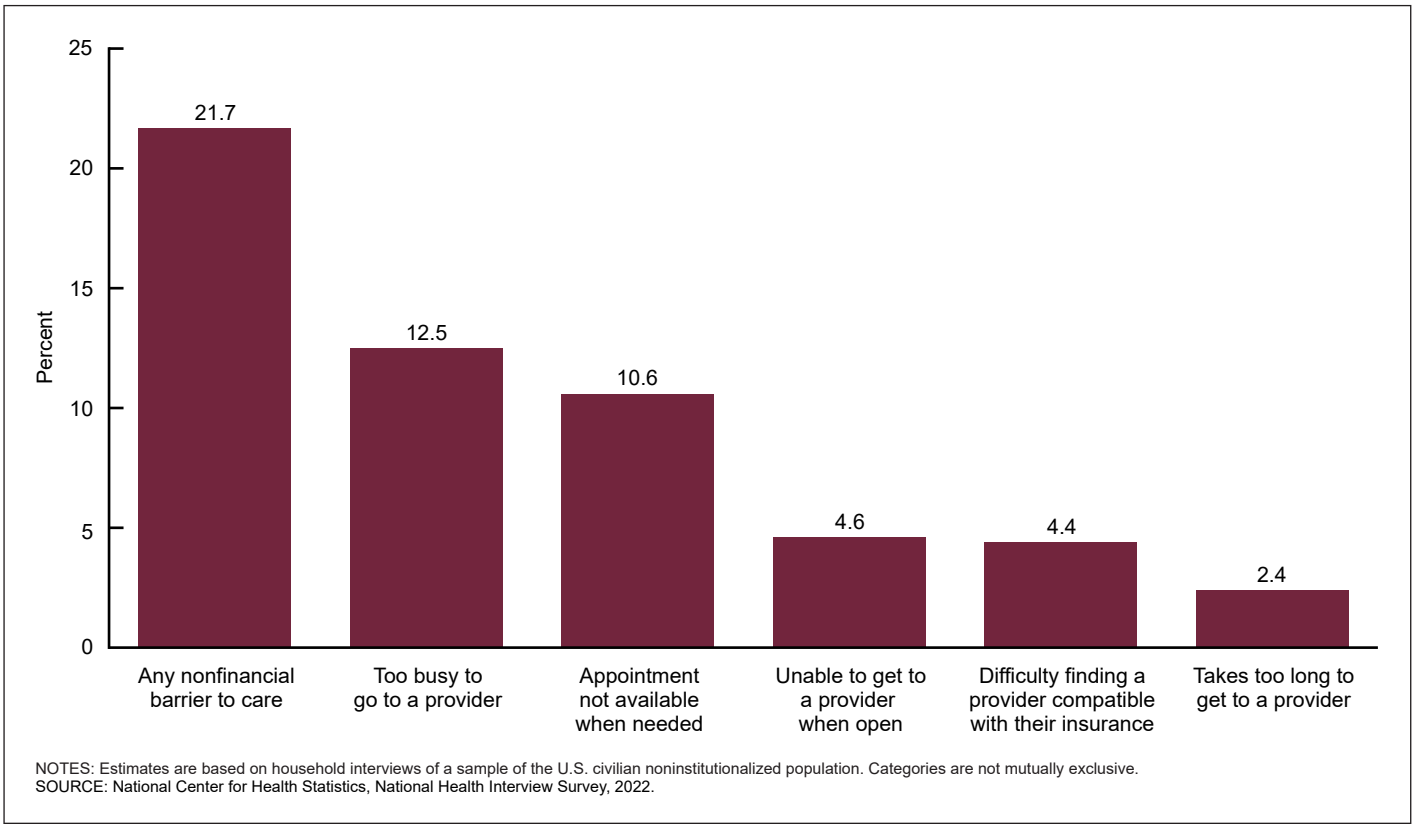
Overall prevalence

In 2022, 21.7% of adults delayed or did not get medical care in the past 12 months because of at least one of five selected nonfinancial access barriers to care (Figure 1, Table). Specifically, 12.5% of adults delayed or did not get medical care because they were too busy to go to a provider, 10.6% could not find an available appointment when needed, 4.6% were unable to get to a provider when open, 4.4% had difficulty finding a provider compatible with their health insurance, and 2.4% reported that it took too long to get to the provider.

Too busy to go to a provider

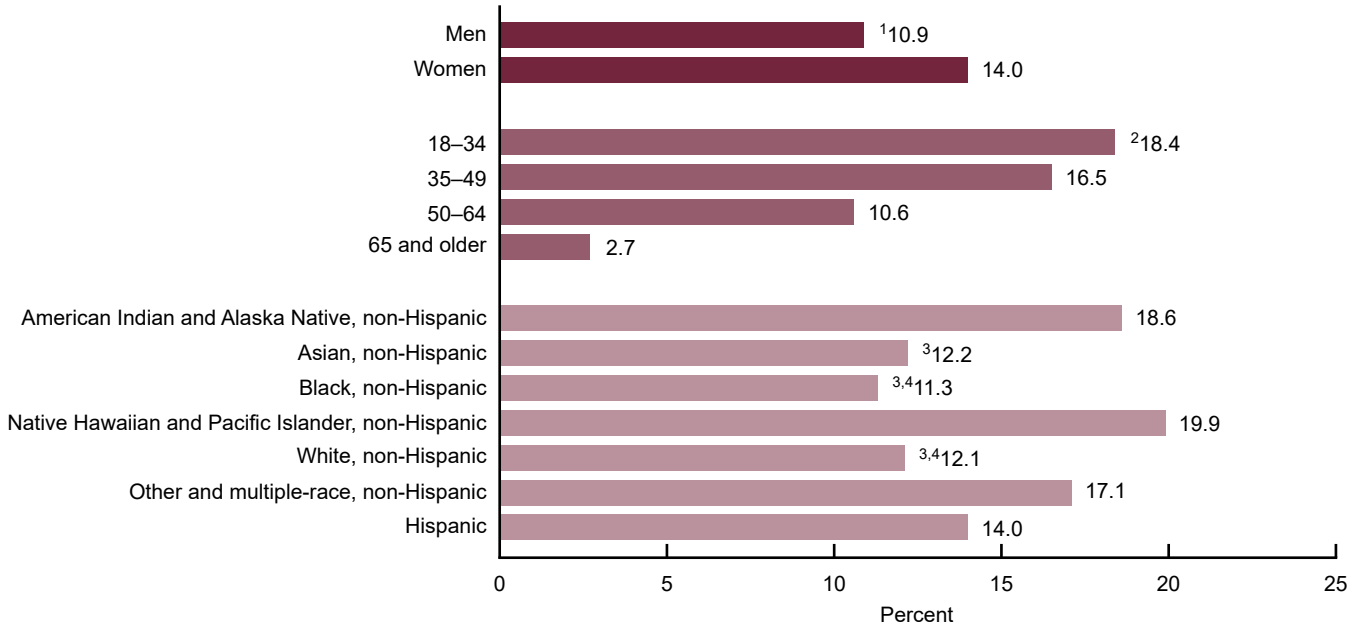
Women were more likely than men to delay or not get medical care in the past 12 months because they were too busy to go to a provider (14.0% compared with 10.9%), and the percentage varied with increasing age group (from 18.4% for adults ages 18–34 to 2.7% for adults age 65 and older) (Figure 2, Table). White adults were less likely to delay or not get medical care because they were too busy to go to a provider (12.1%) compared with Hispanic (14.0%) and other and multiple-race (17.1%) adults. Other and multiple-race adults were more likely than Asian (12.2%) and Black (11.3%) adults to cite this reason. Black adults were also less likely to delay or not get medical care because they were too busy

Figure 1. Percentage of adults who delayed or did not get medical care in the past 12 months for selected reasons: United States, 2022



NOTES: Estimates are based on household interviews of a sample of the U.S. civilian noninstitutionalized population. Categories are not mutually exclusive.
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2022.

Figure 2. Percentage of adults who delayed or did not get medical care in the past 12 months because they were too busy to go to a provider, by sex, age group, and race and Hispanic origin: United States, 2022



[1]Significantly different from women.
[2]Significant quadratic trend by age.
[3]Significantly different from other and multiple-race non-Hispanic adults.
[4]Significantly different from Hispanic adults.
NOTE: Estimates are based on household interviews of a sample of the U.S. civilian noninstitutionalized population.
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2022.

to go to a provider than Hispanic adults. Observed differences between American Indian and Alaska Native (18.6%) and Native Hawaiian and Pacific Islander (19.9%) adults compared with the other race and Hispanic-origin groups were not significant due to insufficient power from small sample sizes.

The percentage of adults who delayed or did not get medical care because they were too busy to go to a provider increased with family income (from 10.6% of adults with family incomes less than 100% FPL to 13.2% of adults with family incomes at 400% FPL or greater) and education level (9.4% for adults with less than a high school diploma or GED to 15.4% for adults with a bachelor's degree or higher) (Table). Employed adults (17.0%) were more likely than unemployed adults (5.0%) to cite this reason. The percentage of adults who delayed or did not get medical care because they were too busy decreased with increasing rurality from 14.4% in large central metropolitan areas to 10.3% in nonmetropolitan areas. Uninsured adults were least likely to delay or not get medical care because they were too busy to go to a provider (11.7%) compared with privately insured (16.4%) and publicly insured (15.0%) adults.

Appointment not available when needed

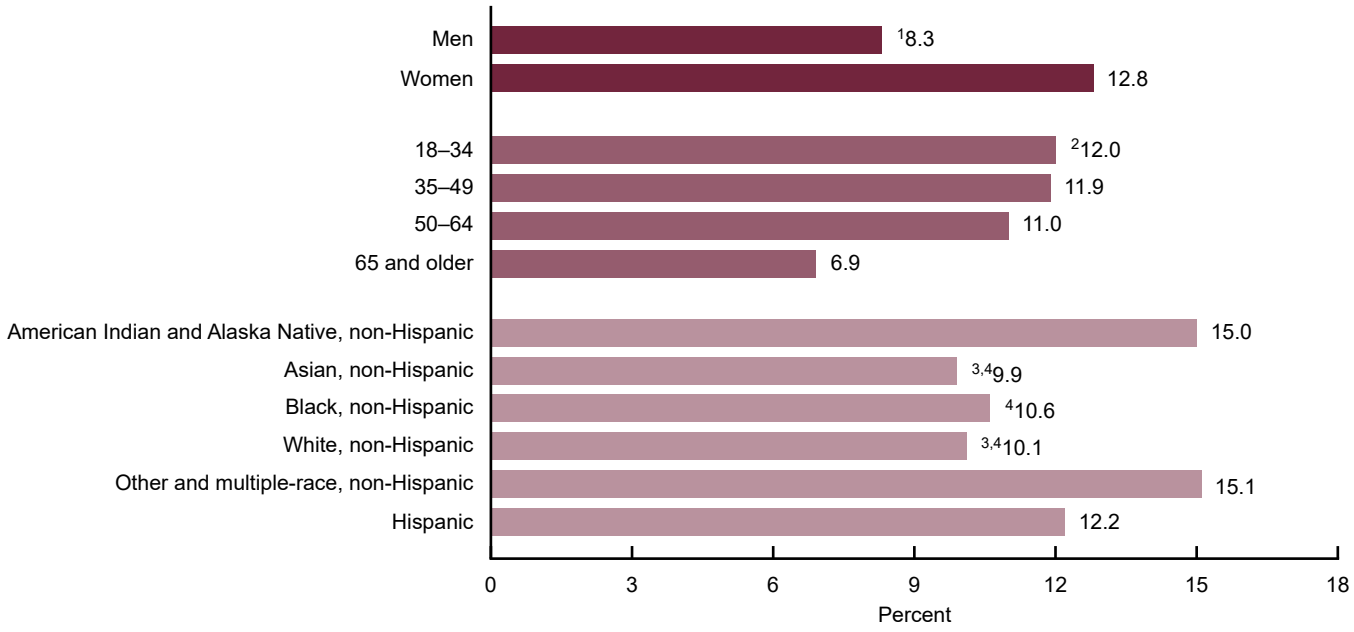
Women were more likely than men to delay or not get medical care in the past 12 months because an appointment was not available when needed (12.8% compared with 8.3%) (Figure 3, Table). The percentage reporting this difficulty was less likely among adults age 65 and older (6.9%) compared with adults younger than age 65. Asian (9.9%) and White (10.1%) adults were less likely to report an appointment was not available when needed compared with Hispanic (12.2%) and other and multiple-race (15.1%) adults. Black adults (10.6%) were also less likely to report an appointment was not available when needed compared with other and multiple-race adults. Observed differences between American Indian and Alaska Native adults and the other race and Hispanic-origin groups were not significant.

The percentage of adults reporting an appointment was not available when needed increased with increasing education (from 7.7% for adults with less than a high school diploma or GED to 12.6% for adults with a bachelor's degree or higher), and employed adults were more likely to cite this reason compared with unemployed adults (11.2% and 9.6%, respectively) (Table). The percentage decreased with urbanization level (from 11.7% for adults in large central metropolitan areas to 8.5% for adults in nonmetropolitan areas). Privately insured adults were less likely to report an appointment was not available when needed (11.8%) compared with publicly insured adults (14.9%) but more likely than uninsured adults (6.6%). Publicly insured adults were more likely to report this reason compared with uninsured adults.

Unable to get to a provider when open

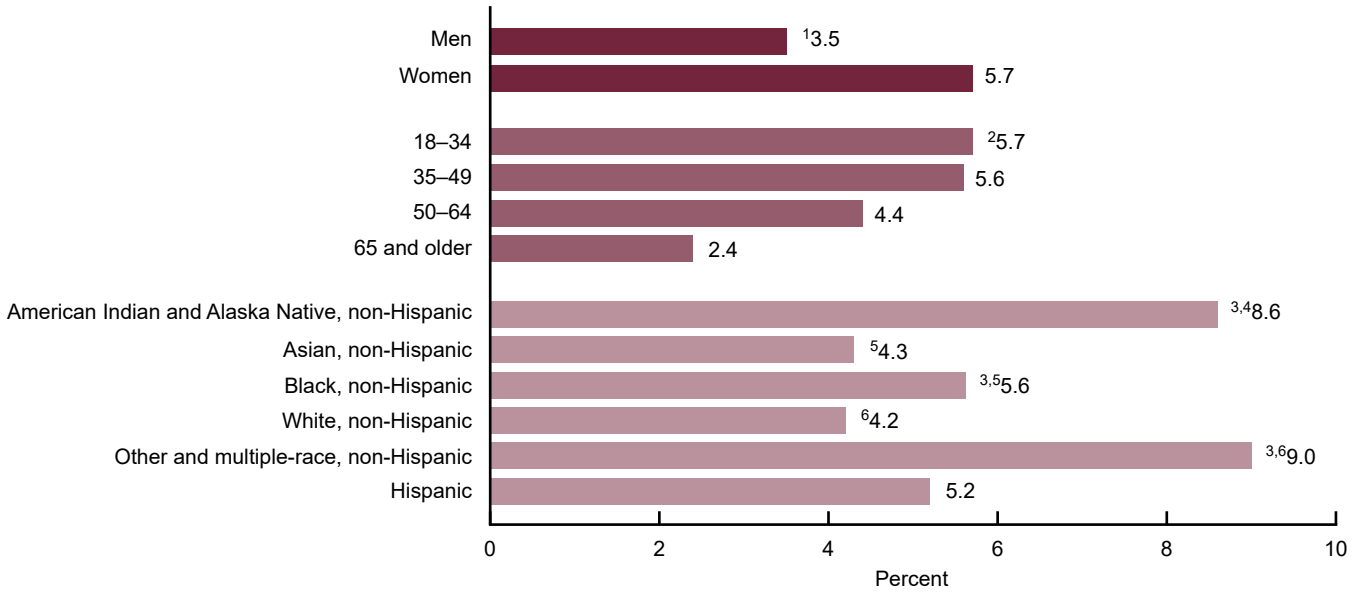
Similar to other nonfinancial access barriers to care, women were more likely than men (5.7% and 3.5%) to

Figure 3. Percentage of adults who delayed or did not get medical care in the past 12 months because an appointment was not available when needed, by sex, age group, and race and Hispanic origin: United States, 2022



[1]Significantly different from women.
[2]Significant quadratic trend by age.
[3]Significantly different from Hispanic adults.
[4]Significantly different from other and multiple-race non-Hispanic adults.
NOTE: Estimates are based on household interviews of a sample of the U.S. civilian noninstitutionalized population.
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2022.

Figure 4. Percentage of adults who delayed or did not get medical care in the past 12 months because they could not get to a provider when open, by sex, age group, and race and Hispanic origin: United States, 2022



[1]Significantly different from women.
[2]Significant quadratic trend by age.
[3]Significantly different from White non-Hispanic adults.
[4]Significantly different from Asian non-Hispanic adults.
[5]Significantly different from other and multiple-race non-Hispanic adults.
[6]Significantly different from Hispanic adults.
NOTE: Estimates are based on household interviews of a sample of the U.S. civilian noninstitutionalized population.
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2022.

delay or not get medical care in the past 12 months because they could not get to a provider when open (Figure 4, Table). The percentage of adults reporting this reason was lower among adults age 65 and older (2.4%) compared with adults younger than 65. American Indian and Alaska Native adults (8.6%) were more likely than Asian (4.3%) and White (4.2%) adults to be unable to get to a provider when open. Differences between American Indian and Alaska Native adults and other groups were not significant. Black (5.6%) and Hispanic (5.2%) adults were more likely than White adults (4.2%) to be unable to get to a provider when open, and other and multiple-race adults (9.0%) were more likely than Asian, Hispanic, White, and Black adults to encounter this difficulty.

The percentage of adults who could not get to a provider when open decreased with increasing income (from 7.5% for adults with family incomes less than 100% FPL to 3.5% for adults with family incomes at 400% FPL or greater), and was higher among employed adults compared with unemployed adults (4.8% and 4.1%, respectively) (Table). Publicly insured adults were most likely to be unable to get to a provider when open (8.9%) compared with privately insured (4.5%) and uninsured (4.1%) adults.

Difficulty finding a provider compatible with their insurance

Women were more likely to delay or not get medical care in the past 12 months because of difficulty finding a provider compatible with their insurance compared with men (5.2% and 3.6%, respectively) (Figure 5, Table). The percentage of adults reporting this difficulty tended to decrease with increasing age (from 6.0% for ages 18–34 to 1.9% for 65 and older). Hispanic adults were more likely to have difficulty finding a provider compatible with their insurance (6.4%) compared with Asian (4.5%) and White (3.6%) adults. Black (5.3%) and other and multiple-race (6.5%) adults were more likely to have difficulty finding a provider compatible with their insurance compared with White adults.

Focusing on socioeconomic measures, the percentage of adults who had difficulty finding a provider compatible with their insurance decreased with increasing family income (7.9% for family incomes less than 100% FPL to 2.7% for family incomes at 400% FPL or greater) (Table). Regarding education, adults with less than a high school education or GED had a higher percentage of difficulty finding a provider compatible with their insurance (5.5%) compared with other education level groups (high school diploma or GED: 4.4%, some college: 4.4%, bachelor's degree or higher: 4.1%). The percentage of adults reporting difficulties finding a provider compatible with their insurance declined with increasing rurality (from 4.7% in large central metropolitan areas to 3.3% in nonmetropolitan areas). Finally, privately insured adults were least likely to have difficulty finding a provider that was compatible with their insurance (3.7%) compared with publicly insured (10.6%) and uninsured (6.3%) adults. Uninsured adults were also less likely to report this experience compared with publicly insured adults.

Takes too long to get to a provider

Women were more likely than men (3.0% and 1.6%) to delay or not get medical care in the past 12 months because it takes too long to get to a provider (Figure 6, Table). The percentage of adults who reported this reason was lower among adults age 65 and older (1.3%) compared with adults younger than 65. White adults were less likely to delay or not get medical care because it takes too long to get to a provider (1.8%) compared with Black (2.6%), Hispanic (3.5%), and other and multiple-race (4.6%) adults.

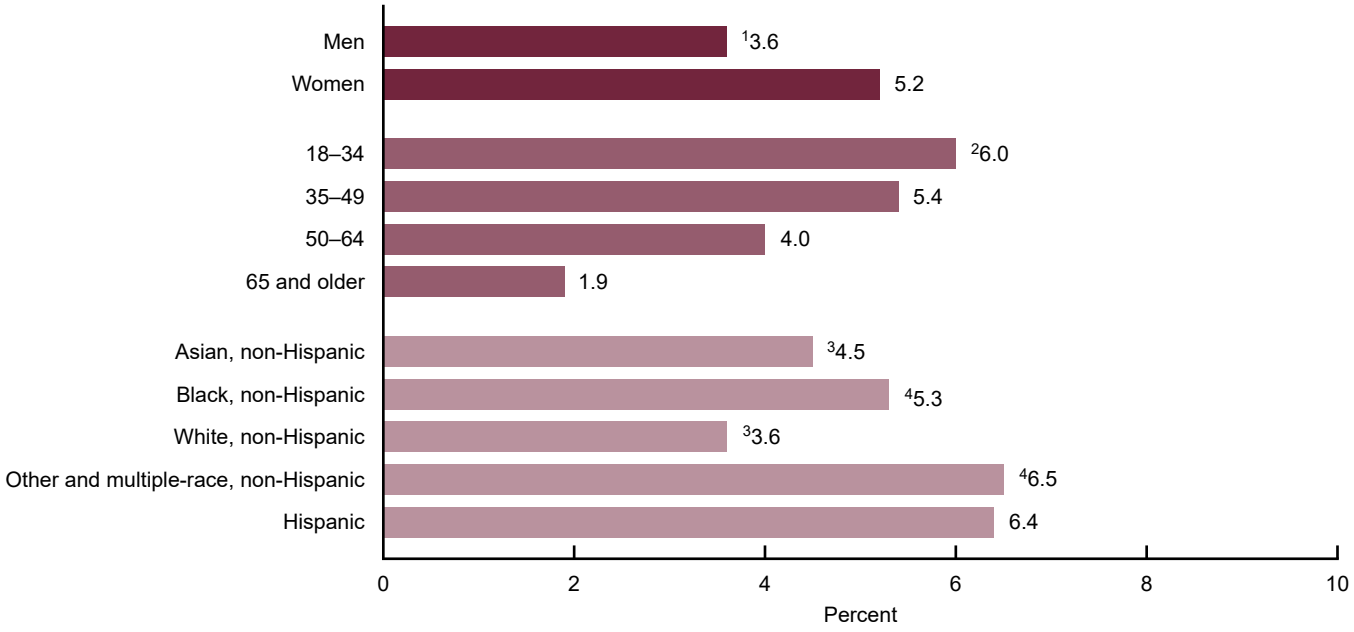
The percentage of adults reporting this barrier to care decreased with family income (from 4.7% for adults with family incomes less than 100% FPL to 1.4% for adults with family incomes at 400% FPL or greater), while 3.6% of adults with less than a high school diploma or GED encountered this barrier, the highest among all education level groups (Table). The percentage of adults reporting that it takes too long to get to a provider varied significantly by urbanization level, with a high of 2.9% of adults living in large central metropolitan areas to a low of 1.9% of adults living in large fringe metropolitan areas. Privately insured adults were least likely to cite this reason as a barrier to care (2.0%) compared with publicly insured (4.6%) and uninsured (3.4%) adults.

Discussion

Using data from the 2022 NHIS, this report examined the percentage of adults who delayed or did not get medical care in the past 12 months due to five selected nonfinancial access barriers to care, overall and by selected sociodemographic characteristics. Overall, 21.7% of adults delayed or did not get medical care in 2022 because of at least one of the selected nonfinancial access barriers to care.

The overall prevalence estimates presented here are similar to nationally representative estimates based on 2007 HTHS data (4) showing that despite the 15-year gap between the 2007 HTHS and the 2022 NHIS, these barriers persist. In both studies, too busy with work or other commitments to go to a provider was the most widespread nonfinancial barrier cited (2007 HTHS: 13.9%; 2023 NHIS: 12.5%), followed by an appointment not being available when needed (2007 HTHS: 8.2%; 2023 NHIS: 10.6%). A higher percentage of adults in the HTHS study reported an inability to get to the doctor's office or clinic when it was open (7.0% compared with 4.6% in the current study) and that it took too long to get to the doctor's office or clinic (4.2% compared with 2.4% in the current study), while a slightly higher percentage of adults in the current study reported that the healthcare provider would not accept their health insurance (4.4% compared with 3.8% in the HTHS study). In one other nationally representative study using 2011 NHIS data (6), 5.9% of adults reported not being able to get an appointment soon enough, 3.4% reported the healthcare provider did not accept their insurance, and 3.0% reported the doctor's office or clinic was not open when they could get there. All three estimates are lower than those reported in the current study.

Figure 5. Percentage of adults who delayed or did not get medical care in the past 12 months because of difficulty finding a provider that would accept their insurance, by sex, age group, and race and Hispanic origin: United States, 2022



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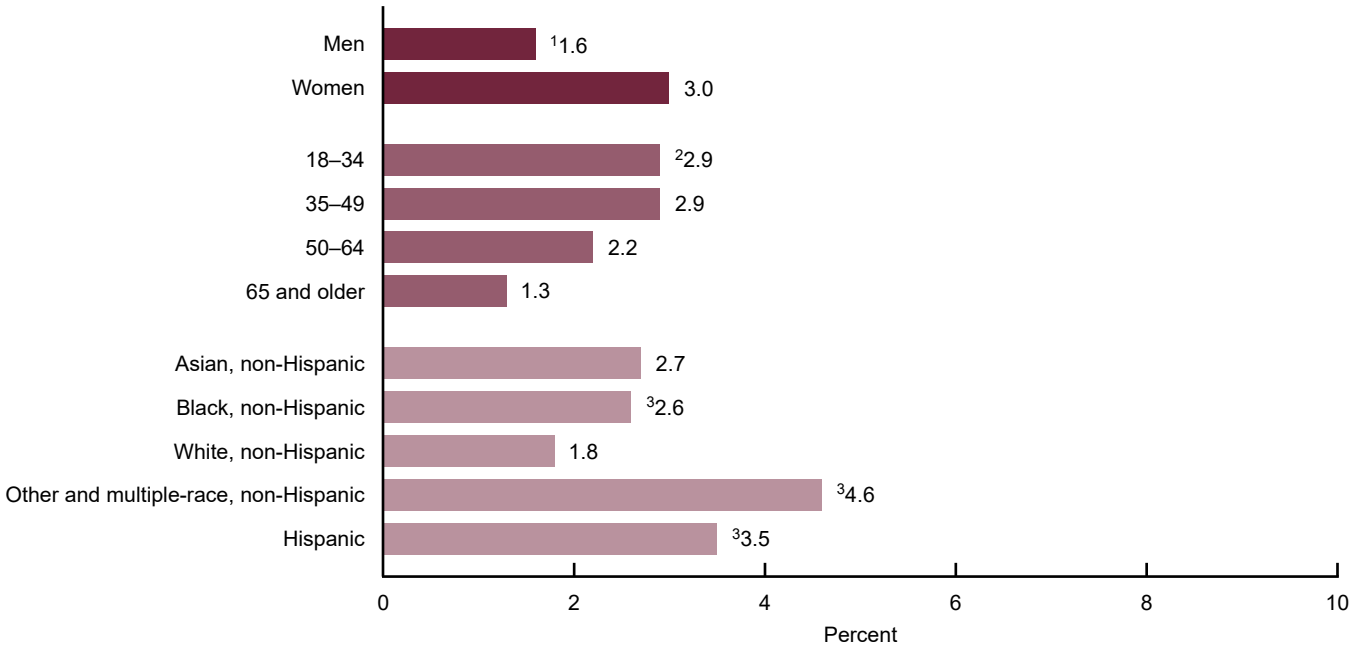
NOTE: Estimates are based on household interviews of a sample of the U.S. civilian noninstitutionalized population.
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2022..

Figure 6. Percentage of adults who delayed or did not get medical care in the past 12 months because it takes too long to get to a provider, by sex, age group, and race and Hispanic origin: United States, 2022



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[2]Significant quadratic trend by age.
[3]Significantly different from White non-Hispanic adults.
NOTE: Estimates are based on household interviews of a sample of the U.S. civilian noninstitutionalized population.
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2022.

Focusing on results by selected sociodemographic characteristics, this report found that a greater percentage of women reported each nonfinancial barrier to care compared with men, while the percentage of adults reporting each barrier decreased with increasing age. The findings for both age and sex align with previous research on nonfinancial access barriers to care (4,5,7). Other research also suggests that men are less likely to seek care than women (19), and younger adults face more barriers to care compared with older adults, potentially due to limited knowledge of available services (20), which may begin to explain these findings.

White adults had the lowest percentage of delaying or not getting medical care for all nonfinancial access barriers except being too busy to take the time and being unable to get an appointment. This is consistent with findings from a smaller community sample (5) but differs from national estimates based on HTHS data showing that Black adults, rather than White adults, had the lowest prevalence of nonfinancial access barriers to care (4). Although sample sizes limited the ability to present estimates for all outcomes for all race and Hispanic-origin groups, or to detect significant differences between groups, either American Indian and Alaska Native adults or Native Hawaiian and Pacific Islander adults tended to have the highest prevalence of nonfinancial access barriers to medical care when estimates met NCHS standards of reliability. Previous studies did not report estimates for these groups.

By socioeconomic status, associations with employment status were apparent for reasons related to the timing of healthcare access (for example, appointment was not available when needed, could not get to doctor's office when open, too busy to take the time), with employed adults more likely to cite these reasons compared with unemployed adults. This is consistent with previous findings based on a large, national sample (4) and a small sample of uninsured and underserved clients of a free clinic (21).

A significant linear trend was observed between total family income and four of the five barriers analyzed, with adults from families with lower incomes more likely to report delaying or not getting needed medical care due to most nonfinancial access barriers. This is consistent with past research on the topic (2,4,22). Conversely, adults with higher family incomes were more likely to report being too busy to take the time to seek medical care. Similar to income, the prevalence of delaying or not getting medical care due to nonfinancial access barriers generally decreased with education; however, the percentage of adults who delayed or did not get medical care because they were too busy to take the time, or an appointment was not available when needed, increased with education. Previous findings on this relationship are also mixed, with some research showing higher education levels to be related to delaying or not getting medical care due to nonfinancial access barriers (21), and other research showing the opposite (2). In part, differences in findings may be due to differences in analytic samples, the type of nonfinancial access barriers included in the study, and whether the barriers were analyzed separately or as a single composite measure.

Regarding urbanization level, the prevalence of most selected reasons for delaying or not getting medical care decreased with decreasing urbanization level, with a significant trend for all except for being unable to get to a provider when open. Unlike most other barriers, the percentage of adults who delayed or did not get medical care because it takes too long to get to the doctor's office did not decrease with increasing rurality. This differs somewhat from existing research finding that adults living in rural areas face greater transportation-related barriers (for example, long distances to providers, insufficient public transport) to accessing care compared with adults living in urban areas (23,24). Qualitative studies, for example, have suggested that long distances to service providers, more common in rural areas, negatively influence care-seeking, especially routine care (25,26).

When examining nonfinancial access barriers to care by health insurance status, privately insured adults were least likely to have difficulty finding a provider with compatible insurance and to report that it takes too long to get to a provider. This aligns with previous research showing that privately insured adults are less affected by nonfinancial access barriers to care compared with publicly insured adults (4). Uninsured adults were least likely to report barriers to care, such as an appointment not being available when needed, being unable to get to a provider when open, and being too busy to go to a provider compared with privately and publicly insured adults. Previous work has also suggested that uninsured adults have lower prevalence of not getting an appointment soon enough, it taking too long to get to the doctor's office, and difficulty finding a provider that would accept their health insurance compared with adults with Medicaid (4). Given that uninsured adults are less likely to have a usual place of care (27), some of these nonfinancial access barriers may be less applicable.

The analyses reported here have some limitations. First, all answers to the nonfinancial barrier questions were self-reported and subject to recall error. Because all questions asked about the past 12 months, nonfinancial access barriers encountered more recently may have been easier to recall and taken precedence over others occurring in the beginning of the reference period. Relatedly, no attempt was made to determine the severity of the unmet medical need. Nonfinancial access barriers connected to more severe and important medical events may have also taken precedence over others. Finally, all analyses presented in this report were unadjusted. A next step is to determine if the associations observed between a given sociodemographic characteristic and nonfinancial access barriers to care still exist when adjusting for other sociodemographic and health-related measures.

Conclusion

This study updates nationally representative estimates of nonfinancial access barriers to care, both overall and for key sociodemographic subgroups.

Results suggest that nonfinancial access barriers to care remain a persistent problem for U.S. adults. For example, 10.6% of U.S. adults delayed or did not get needed medical care because an

appointment was not available when needed, and 12.5% reported being too busy with work or other commitments to take the time.

Research has found that nonfinancial barriers reduce access to medical care, even after controlling for financial barriers such as total family income and health insurance coverage (5,28,29). In addition, unmet healthcare needs due to cost and nonfinancial barriers experienced in adolescence have been shown to be an independent predictor of poor physical and mental health outcomes in adulthood (30). Finally, research suggests that nonfinancial access barriers to care may lead to an increased use of emergency departments for nonurgent care, resulting in unnecessary costs to the U.S. healthcare system (31). Many studies in this area focus on financial barriers to healthcare access, however, there are reasons unrelated to cost that may prevent adults from having access to care. Focusing on nonfinancial access barriers to care, in addition to financial barriers, is important for informing why adults in the United States may have unmet care needs, and for bridging existing disparities in access.

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Table. Percentage and sample size of adults who delayed or did not get medical care in the past 12 months for selected reasons, by selected characteristics: United States, 2022

Characteristic	Sample size	Too busy to go to a provider	Appointment was not available when needed	Unable to get to a provider when open	Difficulty finding a provider compatible with their insurance	Takes too long to get to a provider
		Percent (95% confidence interval)				
Total	27,651	12.5 (12.0–13.0)	10.6 (10.2–11.1)	4.6 (4.3–4.9)	4.4 (4.1–4.7)	2.4 (2.1–2.6)
Sex						
Men	12,598	[1]10.9 (10.3–11.6)	[1]8.3 (7.7–8.9)	[1]3.5 (3.1–3.9)	[1]3.6 (3.2–4.0)	[1]1.6 (1.4–1.9)
Women	15,050	14.0 (13.2–14.8)	12.8 (12.1–13.6)	5.7 (5.3–6.2)	5.2 (4.8–5.7)	3.0 (2.7–3.4)
Age group						
18–34	5,747	[2]18.4 (17.3–19.5)	[2]12.0 (11.1–13.0)	[2]5.7 (5.1–6.4)	[2]6.0 (5.3–6.7)	[2]2.9 (2.4–3.4)
35–49	6,164	16.5 (15.3–17.6)	11.9 (11.0–12.9)	5.6 (4.9–6.3)	5.4 (4.7–6.0)	2.9 (2.5–3.4)
50–64	6,905	10.6 (9.7–11.5)	11.0 (10.2–11.9)	4.4 (3.9–5.0)	4.0 (3.4–4.6)	2.2 (1.8–2.6)
65 and older	8,771	2.7 (2.3–3.1)	6.9 (6.3–7.6)	2.4 (2.1–2.8)	1.9 (1.6–2.3)	1.3 (1.0–1.6)
Race and Hispanic origin						
American Indian and Alaska Native, non-Hispanic	187	18.6 (9.4–31.4)	15.0 (10.1–21.1)	[3,4]8.6 (5.0–13.7)	*	*
Asian, non-Hispanic	1,663	[5]12.2 (10.5–14.2)	[5,6]9.9 (8.4–11.6)	[5]4.3 (3.2–5.5)	[6]4.5 (3.4–5.8)	2.7 (1.9–3.7)
Black, non-Hispanic	3,112	[5,6]11.3 (9.9–12.7)	[5]10.6 (9.3–12.0)	[3,5]5.6 (4.7–6.7)	[3]5.3 (4.4–6.4)	[3]2.6 (2.0–3.4)
Native Hawaiian and Pacific Islander, non-Hispanic	73	19.9 (11.3–31.2)	*	*	*	*
White, non-Hispanic	18,242	12.1 (11.5–12.8)	10.1 (9.6–10.7)	4.2 (3.8–4.5)	3.6 (3.3–4.0)	1.8 (1.6–2.1)
Other and multiple-race, non-Hispanic	431	[3]17.1 (13.3–21.6)	[3]15.1 (11.7–19.0)	[3]9.0 (6.3–12.5)	[3]6.5 (4.2–9.5)	[3]4.6 (2.6–7.5)
Hispanic	3,943	[3]14.0 (12.8–15.3)	[3]12.2 (11.0–13.5)	[3,5]5.2 (4.4–6.1)	[3]6.4 (5.5–7.4)	[3]3.5 (2.9–4.2)
Family income as a percentage of federal poverty level						
Less than 100%	2,788	[7]10.6 (9.0–12.3)	11.2 (9.7–12.9)	[7]7.5 (6.2–8.9)	[7]7.9 (6.6–9.3)	[7]4.7 (3.7–5.8)
100%–199%	4,852	12.1 (10.9–13.5)	11.1 (10.0–12.3)	6.0 (5.2–6.9)	6.2 (5.4–7.2)	3.3 (2.7–4.0)
200%–299%	4,320	12.2 (11.1–13.5)	10.4 (9.3–11.6)	5.0 (4.2–5.8)	5.8 (4.9–6.9)	2.5 (2.0–3.2)
300%–399%	3,670	12.4 (11.0–13.8)	10.2 (9.0–11.5)	4.0 (3.3–4.8)	3.4 (2.6–4.2)	2.1 (1.5–2.8)
400% or greater	12,021	13.2 (12.5–14.0)	10.5 (9.9–11.2)	3.5 (3.1–3.9)	2.7 (2.4–3.1)	1.4 (1.2–1.7)
Highest level of education						
Less than high school diploma or GED	2,369	[8]9.4 (8.0–11.0)	[8]7.7 (6.5–9.0)	5.1 (4.1–6.2)	[8]5.5 (4.5–6.7)	[9]3.6 (2.8–4.5)
High school diploma or GED	6,983	9.6 (8.7–10.5)	8.5 (7.7–9.4)	4.5 (3.9–5.1)	4.4 (3.9–5.1)	2.2 (1.9–2.7)
Some college	7,738	13.0 (12.1–14.0)	11.4 (10.6–12.3)	5.0 (4.5–5.7)	4.4 (3.9–5.0)	2.3 (1.9–2.7)
Bachelor's degree or higher	10,412	15.4 (14.6–16.3)	12.6 (11.8–13.4)	4.3 (3.8–4.8)	4.1 (3.6–4.6)	2.0 (1.7–2.4)
Employment status						
Employed	15,359	[10]17.0 (16.3–17.8)	[10]11.2 (10.6–11.8)	[10]4.8 (4.4–5.3)	4.6 (4.2–5.0)	2.3 (2.1–2.6)
Unemployed	11,104	5.0 (4.5–5.5)	9.6 (8.9–10.3)	4.1 (3.7–4.6)	4.1 (3.6–4.6)	2.4 (2.1–2.8)

See footnotes at end of table.

Table. Percentage and sample size of adults who delayed or did not get medical care in the past 12 months for selected reasons, by selected characteristics: United States, 2022—Con.

Characteristic	Sample size	Too busy to go to a provider	Appointment was not available when needed	Unable to get to a provider when open	Difficulty finding a provider compatible with their insurance	Takes too long to get to a provider
Urbanization level		Percent (95% confidence interval)				
Large central metropolitan	8,321	[11]14.4 (13.5–15.4)	[11]11.7 (10.9–12.6)	5.1 (4.5–5.7)	[11]4.7 (4.2–5.3)	[12]2.9 (2.5–3.4)
Large fringe metropolitan	6,480	12.4 (11.4–13.5)	10.3 (9.5–11.2)	4.3 (3.8–5.0)	4.5 (3.9–5.1)	1.9 (1.6–2.4)
Medium and small metropolitan	8,539	11.7 (10.7–12.7)	10.7 (9.8–11.6)	4.6 (4.1–5.2)	4.6 (4.0–5.2)	2.1 (1.8–2.5)
Nonmetropolitan	4,311	10.3 (8.9–11.7)	8.5 (7.3–9.8)	4.1 (3.4–5.0)	3.3 (2.6–4.1)	2.4 (1.8–3.1)
Health insurance[13]						
Private	12,900	[14]16.4 (15.6–17.1)	[14,15]11.8 (11.2–12.5)	[15]4.5 (4.1–5.0)	[14,15]3.7 (3.3–4.1)	[14,15]2.0 (1.8–2.3)
Public	2,789	[14]15.0 (13.2–16.9)	[14]14.9 (13.4–16.6)	[14]8.9 (7.7–10.3)	[14]10.6 (9.3–12.0)	4.6 (3.8–5.5)
Uninsured	2,046	11.7 (10.1–13.4)	6.6 (5.4–7.9)	4.1 (3.1–5.3)	6.3 (5.1–7.6)	3.4 (2.6–4.5)

* Estimate does not meet National Center for Health Statistics standards of reliability.
[1]Significantly different from women ($p < 0.05$).
[2]Significant quadratic trend by age group ($p < 0.05$).
[3]Significantly different from White non-Hispanic adults ($p < 0.05$).
[4]Significantly different from Asian non-Hispanic adults ($p < 0.05$)
[5]Significantly different from other and multiple-race non-Hispanic adults ($p < 0.05$).
[6]Significantly different from Hispanic adults ($p < 0.05$).
[7]Significant linear trend by family income ($p < 0.05$).
[8]Significant linear trend by education ($p < 0.05$).
[9]Significant quadratic trend by education ($p < 0.05$).
[10]Significantly different from unemployed adults ($p < 0.05$).
[11]Significant linear trend by urbanization level ($p < 0.05$).
[12]Significant quadratic trend by urbanization level ($p < 0.05$).
[13]Measure limited to adults ages 18–64 because most adults ages 65 and older are eligible for Medicare.
[14]Significantly different from uninsured adults ($p < 0.05$).
[15]Significantly different from publicly insured adults ($p < 0.05$).

SOURCE: National Center for Health Statistics, National Health Interview Survey, 2022.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Disease Control and Prevention
National Center for Health Statistics
3311 Toledo Road, Room 4551, MS P08
Hyattsville, MD 20782–2064

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