Do Racial and Ethnic Differences Exist in Access to Family Planning and Related Preventive Health Services in the United States?

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1. Background

- Almost one-half of pregnancies in the U.S. are unintended, and rates for black and Hispanic women are 2.8 and 2.2 times higher, respectively, than for whites. This racial/ethnic difference persists even among women with incomes above poverty.[1]
- Racial/ethnic differences in contraceptive use may account for some of this variation. While overall use among whites (65%) is only slightly higher than use among Hispanics (59%) or blacks (57%), whites are more likely than Hispanic or black women to use highly effective reversible contraceptives.[2] Blacks and Hispanics are also more likely than whites to experience an accidental pregnancy during the first two years of pill or condom use,[3] a pattern that persists even among higher-income women.[4]
- Effective contraceptive use by women at risk of unintended pregnancy requires ongoing access to qualified health providers that can provide accessible preventive, treatment, and informational services that protect and enhance reproductive wellbeing. Public programs (e.g., Title X, Medicaid FP waivers) have reduced racial/ethnic and income group differences in use of *any* family planning and preventive gynecological (PG) services. However, racial/ethnic differences in use of specific types of FP and PG services continue to exist.[2]
- Once women gain access to care, characteristics of the health system (e.g., organization, financing, access), care process (e.g., provider bias, uncertainty), or individual (e.g., expectations, distrust, language) can produce racial/ethnic differences in care.[5] For example, studies show that standards of reproductive health care,[6] practice patterns,[7] or the availability of methods and services offered can vary across (e.g., Title X clinics, physicians) and within sources of care (e.g., physicians, publicly funded clinics).[8-10] One study[11] also found that blacks and Hispanics who received gynecologic services were less likely than whites to give their experience a positive rating. Studies are needed to examine whether racial/ethnic differences in service use and content persist after adjusting for access and other policy-amenable characteristics of the care-seeking process.

2. Objective and Research Questions

Assess whether racial/ethnic group differences exist in the use and content of birth control (BC) and preventive gynecological (PG) services by women at risk of unintended pregnancy. Specifically, we ask:

- Do racial/ethnic group differences in the use of any BC or any PG services exist, and if so, do they persist after controlling for factors related to access to and use of services?
- Do women who succeed in obtaining any BC or any PG services experience racial/ethnic differences in the content of BC and PG services received?

3. Methods

Data: 2002 National Survey of Family Growth (Female Survey)

Sample: n=3,486 White, black, and Hispanic adult (18–45 years) women who were at risk of unintended pregnancy during the 12 months preceding the NSFG

General Exclusions: Women who were under 18 years, sterilized (for contraceptive and non-contraceptive reasons) 13 or more months prior to the survey, seeking pregnancy, with impaired fertility (i.e., nonsurgically sterile, subfecund, and long interval), not sexually experienced or currently sexually active (in past 12 months), and women who did not self-identify as Hispanic or of White or Black race

Sample for analysis of content of BC (n=2,205) and PG services (n=2,736) restricted to those who reported receipt of any BC or PG services.

Analytic techniques: Bivariate and multivariable regression (bi- and multinomial logistic regression), using Sudaan (V. 9.0.1) software to control for complex design of the NSFG.

Dependent Variables

- **Service Use Measures**
  - **Receipt of any BC service:** Receipt of one or more of the following BC services during 1 or more visits in the 12 months preceding the NSFG: BC method or prescription for a BC method, a checkup or medical test related to using a BC method, or counseling or information about BC (1=Yes)
  - **Receipt of any PG service:** Receipt of a Pap test and/or pelvic exam during 1 or more visits in the 12 months preceding the NSFG (1=Yes)
- **Content of Care Measures**
  - **Content of BC care (3 category):** Receipt of a checkup or test related to using BC or BC counseling/information ("BC test/counseling only"); receipt of a BC method or prescription only ("BC method only"); or receipt of a BC method/prescription and a BC checkup/test or BC counseling/information ("comprehensive BC services")
  - **Content of PG care:** Three measures of content of PG care are defined as follows:
    1. **Type(s) of PG care**: Receipt of single PG service (i.e., Pap test or pelvic exam but not both) or receipt of comprehensive PG services (i.e., receive both a Pap test and pelvic exam)
    2. **BC counseling during PG care:** Respondent reported that PG provider talked to her about using BC (1=Yes)
    3. **EC counseling during PG care:** Respondent reported that PG provider talked to her about using emergency contraception (1=Yes)

Key Independent Variable

- **Race/Ethnicity:** Non-Hispanic white ("white"); non-Hispanic black ("black"); Hispanic English-speaking; and Hispanic Spanish-speaking.

3. Methods *(continued)*

Other Controls

- **Predisposing:** Age: 18–24; 25–29; 30–34; and 35–45 years
  Education: Less than completed high school (HS); completed HS or equivalent (GED); and post-HS (ref)
- **Need/Risk:** Parity: 0, 1, 2 (ref), and >2 live births; 0–1, 2 (ref), and >2 live births
  Marital status: Married (ref), cohabiting, formerly married/separated, never married
- **Enabling:** Income: 0–99% ("poor"); 100%–199% ("low-income"); 200–299%; ≥ 300% (ref)
  Insurance status: Medicaid or other public; uninsured; private (ref)
  Source of BC or PG care: private physician/HMO/other (ref); publicly subsidized clinic that receives Title X funding; publicly subsidized clinic that does not receive Title X funding

Limitations include problems with respondent recall of the services received or failing to classifying specific services received using the NSFG definitions; relatively smaller language-specific Hispanic samples; and no control for service availability and contextual factors.

4. Results: Use of any BC or PG services

Sample Characteristics [Exhibit 1]

Exhibit 1: Percentage (weighted) distribution of main sample, by selected characteristics, according to race/ethnicity

Characteristics	N	All sample (n=3,486)	White (n=1,986)	Black (n=714)	Hispanic: English speaking (n=485)	Hispanic: Spanish speaking (n=299)
Education						
< High school	488	12%	6%	14%	18%	59%
High school or GED	1,026	29%	27%	37%	32%	25%
> High school	1,972	59%	67%	50%	50%	16%
Parity						
0	1,388	41%	45%	34%	38%	12%
1	913	24%	22%	30%	21%	32%
2	732	21%	21%	18%	25%	31%
≥3	453	14%	12%	18%	17%	25%
Income						
0%–99%	681	17%	11%	26%	26%	53%
100%–199%	758	19%	16%	24%	26%	33%
200%–299%	601	19%	19%	19%	19%	9%
≥ 300%	1,446	45%	54%	31%	30%	5%
Health Insurance						
Private	2,261	70%	78%	60%	57%	25%
Medicaid/Other public	658	16%	11%	26%	24%	31%
Uninsured	567	15%	11%	14%	19%	44%
Received any BC services	3,484	63%	65%	59%	59%	60%
Received any PG services	3,484	78%	79%	83%	73%	66%

Multivariate Results: Use of any BC services

- **Race/Ethnicity:** Although blacks had significantly lower odds of using any BC care in the unadjusted model (OR=0.78, $p<.05$), there were no statistically significant, racial/ethnic group differences in the adjusted model once we controlled for predisposing and enabling factors, including age, education, marital status, parity, income, and insurance status.
- **Education:** Women with completed HS (OR=.64, $p<.01$) or less education (OR=.45, $p<.001$) had significantly lower odds of using any BC services compared to women with post-HS education.
- **Insurance:** Uninsured (OR=.58, $p<.001$) women had significantly lower odds of using any BC services compared to privately and Medicaid-insured women.

Multivariate Results: Use of any PG Services

- **Race/Ethnicity:** Blacks had significantly higher odds (OR=1.69, $p<.01$) of using any PG services compared to both whites and Hispanics.
- **Education:** Women with completed HS (OR=.66, $p<.01$) or less education (OR=.56, $p<.01$) had significantly lower odds of using any PG services compared to women with post-HS education.
- **Income:** Poor (OR=.75, $p<.05$) and low-income (OR=.71, $p<.05$) women had significantly lower odds of using PG services compared to those with incomes at or above 300% of poverty.
- **Insurance:** Uninsured women (OR=.4, $p<.001$) had significantly lower odds of receiving any PG services compared to privately and Medicaid-insured women.

5. Results: Content of BC and PG services

Bivariate Results: Content of BC and PG services [Exhibit 2]

Exhibit 2: Percentage (weighted) of sample who reported using any BC or PG services in the 12 months preceding the NSFG, by the types of service(s) received, according to race/ethnicity

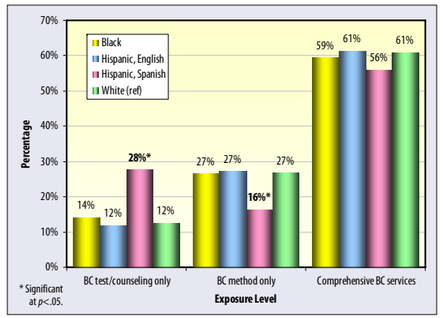
Service Received	Total	White	Black	Hispanic: English speaking	Hispanic: Spanish speaking
Type of BC services *	n=2,205	n=1316	n=421	n=284	n=184
BC test/counseling only	13%	11%	14%	13%	28%
BC method only	25%	27%	25%	28%	21%
Comprehensive BC services	61%	62%	60%	60%	51%
Type of PG services **	n=2,736	n=1,587	n=579	n=364	n=206
Pap or pelvic exam	15%	9%	23%	24%	24%
Comprehensive PG services	85%	91%	77%	76%	76%
BC-related counseling					
Provider discussed using BC	59%	59%	55%	59%	57%
Provider discussed EC	9%	6%	12%†	13%†	19%†

Note: * Chi-square test significant at $p<.05$; ** Chi-square test significant at $p<.01$; † Significantly different from white at $p<.01$.

Multivariate Results: Content of BC services [Exhibits 3 to 5]

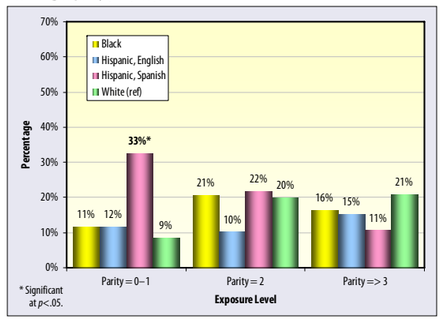
- **Race/Ethnicity**
  - Across all types of BC services, race/ethnicity was significantly ($p<.05$) associated with the probabilities of receiving each type of BC service **[Exhibit 3]**.

Exhibit 3: Predicted receipt of BC services, by race/ethnicity, according to service type (n=2,205)



- There were also significant interactions between race/ethnicity and parity. For women with parity equal to 0 or 1, Hispanic Spanish speakers had a significantly higher probability (33%, $p<.001$) of receiving a BC test/checkup or counseling service only (i.e., no method) compared to black (11%), Hispanic English speakers (12%), and whites (9%) **[Exhibit 4]**.

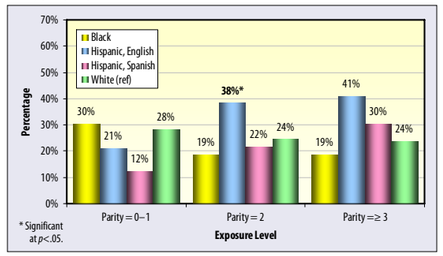
Exhibit 4: Predicted receipt of BC test/checkup or counseling only, by race/ethnicity, according to parity (n=2,205)



5. Results: Content of BC and PG services *(continued)*

- For women with parity=2, Hispanic English speakers had a significantly higher probability (38%, $p<.05$) than blacks (19%) of receiving BC method-only services **[Exhibit 5]**.

Exhibit 5: Predicted receipt of a BC method only, by race/ethnicity, according to parity (n=2,205)

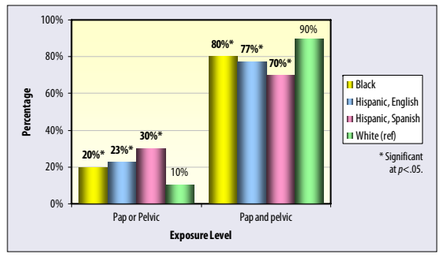


- **Other significant predictors:**
  - **Education:** Compared to women with post-HS education, women with less than an HS education were more likely to receive BC test/checkup or counseling only (11% vs 19%, $p<.05$) or method-only care (25% vs 32%, $p<.05$) rather than comprehensive care.
  - **Source of Care:** Compared to women who receive services from a private MD, HMO, or other source (29%), women whose source of BC services was either a Title X (17%, $p<.01$) or other publicly funded non-Title X clinic (22%, $p<.05$) were significantly less likely to receive method-only care rather than comprehensive care.

Multivariate Results: Content of PG services [Exhibits 6 and 7]

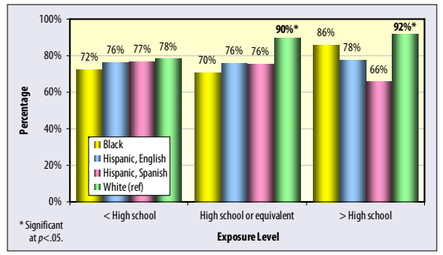
- **Race/Ethnicity:** Blacks (20%), Hispanic English-speakers (23%), and Hispanic Spanish-speakers (30%) had significantly ($p<.001$) higher probabilities than whites (10%) of receiving single rather than comprehensive PG services. Conversely, whites had a significantly higher probability (90%) of receiving comprehensive services than non-white women **[Exhibit 6]**.

Exhibit 6: Predicted receipt of PG services, by race/ethnicity, according to type of service (n=2,736)



- **Race/Ethnicity and Parity:** There were also significant interaction effects between race/ethnicity and education in the content of PG services, as shown in **Exhibit 7**. White women with HS (90%, $p<.01$) or post-HS education (92%, $p<.01$) had significantly higher probabilities of receiving comprehensive PG services compared to black and Hispanic women at the same education levels.

Exhibit 7: Predicted receipt of comprehensive gynecological services (Pap smear and pelvic exam), by race/ethnicity, according to education (n=2,736)

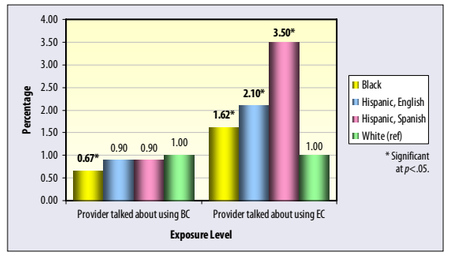


5. Results: Content of BC and PG services *(continued)*

Multivariate Results: BC-Related Content of PG services [Exhibit 8]

- **Race/Ethnicity:** Blacks had significantly lower odds (OR=.67, $p<.01$) than whites of reporting that their PG provider talked to them about using BC. Additionally, Blacks (OR=1.62, $p<.05$), Hispanic English speakers (OR=2.1, $p<.01$), and Hispanic Spanish-speakers (OR=3.5, $p<.01$) had significantly higher odds than whites that their PG provider talked to them about using EC **[Exhibit 8]**.

Exhibit 8: Discussions with PG health provider at the time of PG service about using BC or EC: Adjusted ORs for race/ethnicity (n=2,730)



- **Other significant predictors:**
  - Education: Compared to women with post-HS education, those with completed HS or GED had significantly lower odds (OR=.68, $p<.01$) of reporting that their health provider talked to them about using BC.
  - Source of Care:
    - Compared to women who receive services from a private MD, HMO, or other source, women who received PG services from a Title X (OR=1.71, $p<.01$)or other publicly funded, non Title X clinic (OR=1.47, $p<.05$) had significantly higher odds of reporting that their health provider talked to them about using BC.
    - Similarly, women who received PG services from a Title X (OR=2.31, $p<.001$)or other publicly funded non Title X clinic (OR=2.55, $p<.001$) also had significantly higher odds of reporting that their health provider talked to them about using EC.

6. Discussion

- **Any BC or any PG service use:** There were no significant racial/ethnic differences in use of any BC or any PG services, with the exception of black women's increased odds of using any PG services. Women with an HS or lower education, the uninsured, and the poor and low-income (any PG services only) were at a disadvantage regarding use of any BC or PG care.
- **BC service content:** Hispanic Spanish speakers were more likely to receive services that excluded a BC method. Additionally, compared to women with a post-HS education, those with less than completed HS were more likely to receive single-service (checkup/test or counseling *or* method only) rather than comprehensive care.
- **PG service content:** Black and Hispanic women were less likely than whites to receive comprehensive PG services. However, whites were at a disadvantage in terms of reporting that their PG provider talked to them about EC. Apart from race/ethnicity, less educated women were less likely to receive comprehensive PG services and less likely to report that their doctor talked to them about using BC.
- **Source of care:** Women who received care at Title X or other publicly funded clinics were more likely to receive comprehensive BC rather than method-only care than those who went to a physician/HMO or other source. They were also more likely to report that their PG provider talked to them about using EC and BC (TitIe X clinics only).
- **Summary:** The study highlights the importance of examining the effects of race/ethnicity and other access-related factors across different types and combinations of BC or PG care. It also illustrates how barriers to BC and PG care differ, and how publicly funded clinics and private and public (e.g., Medicaid) health insurance can enhance access for those at risk of unintended pregnancy, particularly the 17.4 million women estimated to be in need of publicly funded family planning services.[12]

References available on request.

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