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Who Gets In? Determinants of Health Care Access among U.S. Adults

Kayla K. Harris*, Naomi Campbell, Stephanie Miles-Richardson, and Gemechu B. Gerbi

Department of Public Health Education, Morehouse School of Medicine, 720 Westview Dr. SW, Atlanta, GA 30310-1495, USA

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Corresponding Author:** ***Kayla K. Harris, *Department of Public Health Education, Morehouse School of Medicine, 720 Westview Dr. SW, Atlanta, GA 30310-1495, USA.*

Abstract

Background: *Access to health care is a critical determinant of health outcomes, yet disparities persist across demographic and socioeconomic groups in the United States. Understanding these disparities is essential for informing public health policy and improving health equity. This study examined sociodemographic factors associated with health care access among U.S. adults using the 2021 Behavioral Risk Factor Surveillance System (BRFSS) data.*

Methods: *We conducted a cross-sectional analysis of 434,988 U.S. adults from the 2021 BRFSS dataset. Descriptive statistics were used to examine the distribution of health care access by sex, race/ethnicity, age, education, income, and geographic region. Multivariable logistic regression analysis was performed to assess adjusted odds ratios (AORs) and 95% confidence intervals (CIs) for factors associated with access to health care.*

Results: *Overall, 88% of U.S. adults reported having access to health care. Access varied significantly across demographic groups, with women (91.3%) more likely than men (83.9%) to report access. White adults had the highest reported access (90.1%), while Hispanic adults had the lowest (72.8%). Access increased with higher education and income levels and was highest in the North region. In adjusted analysis, men had significantly lower odds of access than women (AOR = 0.48; 95% CI: 0.47–0.49). Compared to White adults, Hispanic (AOR = 0.66; 95% CI: 0.64–0.69), American Indian (AOR = 0.72; 95% CI: 0.63–0.83), and Asian (AOR = 0.89; 95% CI: 0.80–0.98) adults had reduced access. Younger adults, those with lower education or income, and residents in the South and West also had significantly lower odds of reporting health care access.*

Conclusion: *Health care access disparities remain pronounced among U.S. adults, particularly for racial/ethnic minorities, males, younger individuals, and those with lower income or educational attainment. These findings highlight the need for targeted interventions and policy efforts to address barriers and improve equitable access to care across diverse populations.*

1. Introduction

In the United States, access to healthcare remains one of the most persistent determinants of health and well-being. Despite decades of reform, nearly 27 million Americans remain uninsured, and millions more experience unstable or inadequate coverage [1]. Public insurance programs such as Medicaid play a crucial role in mitigating these disparities, particularly for low-income populations, but their future is increasingly uncertain amid political efforts to restrict eligibility, impose work requirements, and reduce federal funding [2]. The recent unwinding of Medicaid's continuous coverage protections following the COVID-19 public health emergency has further heightened concerns about widespread coverage losses, particularly among vulnerable populations [3].

Health insurance status is more than a marker of coverage—it is a gateway to care and, for many, a matter of survival. Insurance has been consistently associated with earlier diagnoses, improved management of chronic conditions, and reduced mortality [4]. Yet, coverage and access to care remain unevenly distributed across the population. Structural inequities rooted in race, ethnicity, income, geography, and employment continue to shape whether individuals maintain a usual source of healthcare, an indicator frequently used in research as a

proxy for healthcare access [5]. Rural residents face additional barriers, including hospital closures and shortages of primary care providers, while marginalized racial and ethnic groups remain disproportionately uninsured or underinsured [6]. These inequities reflect longstanding systemic barriers embedded in the U.S. healthcare system.

Understanding the sociodemographic predictors of healthcare access is therefore essential for advancing equity. Prior studies have documented associations between factors such as income, education, age, and region and the likelihood of having a usual source of care [7]. However, recent shifts in Medicaid policy and the changing landscape of U.S. healthcare make re-examining these predictors both timely and urgent. Using nationally representative data, this study explores sociodemographic and economic factors associated with individuals' likelihood of having a usual source of healthcare in the United States. By identifying populations at greatest risk of lacking access, we aim to contribute to ongoing policy and public health discussions about safeguarding equitable healthcare access amid a shifting policy environment.

2. Methods

2.1. Study Design & Data Source

This study utilized a cross-sectional design based on data from the 2021 Behavioral Risk Factor Surveillance System (BRFSS), an annual, nationally representative survey conducted by the Centers for Disease Control and Prevention (CDC). The BRFSS collects data via telephone interviews from non-institutionalized adults aged 18 years and older across all 50 U.S. states, the District of Columbia, and U.S. territories. The survey covers various health-related risk behaviors, chronic health conditions, and access to health care services [8].

2.2. Study Population

The analytic sample included 434,988 adults who participated in the 2021 BRFSS and provided complete information on health care access and relevant sociodemographic variables, including sex, age, race/ethnicity, education, income, and region of residence.

2.3. Outcome Variable

The primary outcome variable was health care access, assessed by the question: *"Do you have one person or a group of doctors that you think of as your personal health care provider?"* Response options included "Yes, only one," "More than one," "No," "Don't know/Not sure," and "Refused." For analysis, responses of "Yes, only one" and "More than one" were combined and coded as "Yes" (indicating access to healthcare), while "No" was coded as "No" (indicating no access). Participants who answered "Don't know/Not sure" or "Refused" were excluded from the analysis.

2.4. Independent Variables

The key independent variables examined in this study included: sex (male or female), age group (18–24, 25–34, 35–44, 45–54, 55–64, and ≥65 years), race/ethnicity (White, Black, Hispanic, Asian, American Indian/Alaska Native, and Other), educational attainment (no schooling, elementary, some high school, high school graduate, some college, and college graduate), annual household income (<$25,000; $25,000–$49,999; $50,000–$74,999; $75,000–$99,999; and ≥$150,000), and region of residence (North, Midwest, South, and West).

2.5. Statistical Analysis

Descriptive statistics were first used to summarize the distribution of key sociodemographic variables and the prevalence of health care access among U.S. adults aged ≥18 years. Bivariate analyses were then conducted to identify independent associations between each covariate and the outcome variable (health care access). Variables that were statistically significant at $p \leq 0.05$ in the bivariate analysis were included in the final multivariable logistic regression model.

Adjusted odds ratios (AORs) and corresponding 95% confidence intervals (CIs) were calculated to assess the strength and direction of associations between predictor variable and the likelihood of reporting health care access. Records with responses of "Don't know/Not sure," "Refused," or missing values on any of the dependent, independent, or covariate measures were excluded from both bivariate and multivariable analyses to ensure data integrity and reduce potential bias. All analyses were conducted using a two-tailed test with a significant level of $p \leq 0.05$. Statistical analyses were performed using SAS version 9.4 [9].

3. Results

As shown in Table 1, among the 434,988 U.S. adults included in the 2021 BRFSS sample, approximately 88% reported having access to health care, while 12% did not. Health care access varied significantly across

sociodemographic groups. A higher proportion of females (91.3%) reported access compared to males (83.9%). White adults had the highest reported access rate (90.1%), followed by Black (88.6%), Asian (82.6%), and Native American (80.4%) adults, while Hispanic adults had the lowest rate at 72.8%. Educational attainment showed a strong association with access: 91.0% of adults with a college degree reported access, compared to 70.7% with only elementary education and 63.0% among those who never attended school. Access also increased with income, ranging from 84.3% among those earning less than $25,000 to 91.5% among those earning $150,000 or more. Regional differences were observed, with the North reporting the highest access (90.7%) and the West the lowest (84.1%).

Table 1. *Number and Percentage of Respondents Who Reported Access to Healthcare by Select Characteristics: 2021 BRFSS, United States*

Characteristics	Self-Reported Access to Healthcare (N=434, 988)		
	Yes	No	Total
	n (%)	n (%)	n (%)
Overall	382, 278 (88.0)	52, 710 (12.0)	434, 988 (100)
Sex			
Female	213,141 (91.3)	20,245 (8.7)	233,386 (100)
Male	169,137 (83.9)	32,465 (16.1)	201,602 (100)
Race/Ethnicity			
White American	297,116 (90.1)	32,608 (9.9)	329, 724 (100)
Black American	29,109 (88.6)	3757 (11.4)	32,866 (100)
Asian American	9351 (82.6)	1977 (17.4)	11,328 (100)
Native American	5877 (80.4)	1428 (19.6)	7,305 (100)
Hispanic/Latino	27,875 (72.8)	10,405 (27.2)	38,280 (100)
Other	12,950 (83.6)	2535 (16.4)	15,485 (100)
Level of Education			
Never Attended School	375 (63.0)	220 (37.0)	595 (100)
Elementary	5753 (70.7)	2387 (29.3)	8140 (100)
Some High School	13,352 (79.0)	3549 (21.0)	16,901(100)
High School Graduate/ GED Completion	93,841 (85.0)	16,524 (15.0)	110,365 (100)
Some College	105,481 (88.5)	13,720 (11.5)	119,201 (100)
College Graduate	161,647 (91.0)	15,883 (9.0)	177,530 (100)
Level of Income			
Less than $24,999	48,821 (84.3)	9,127 (15.7)	57,948 (100)
$25,000 to $49,999	78,594 (85.8)	13,005 (14.2)	91,599 (100)
$50,000 to $74,999	52675 (89.1)	6434 (10.9)	59,109 (100)
$75,000 to $99,999	43,085 (90.5)	4525 (9.5)	47,610 (100)
$100,000 to $149,999	43,151 (91.0)	4,273 (9.0)	47,424 (100)
$150,000 or more	35,263 (91.5)	3,287 (8.5)	38,550 (100)
Region of Residence			
North	89,881 (90.7)	9,175 (9.3)	99,056 (100)
Midwest	111,174 (88.5)	14,411 (11.5)	125,585 (100)
South	59,034 (87.4)	8,545 (12.6)	67,579 (100)
West	80,686 (84.1)	15,269 (15.9)	95,955 (100)

As shown in Table 2, after adjusting for sex, race/ethnicity, age, education, income, and region, several variables remained significantly associated with health care access. Males were significantly less likely than females to report access (OR = 0.48; 95% CI: 0.47–0.49). Compared to White adults, the odds of access were significantly lower for Hispanic (OR = 0.66; 95% CI: 0.64–0.69), American Indian (OR = 0.72; 95% CI: 0.63–0.83), and Asian (OR = 0.89; 95% CI: 0.80–0.98) adults.

Age was a strong predictor: compared to adults aged 65 or older, those aged 18–24 (OR = 0.12; 95% CI: 0.11–0.14), 25–34 (OR = 0.10; 95% CI: 0.10–0.11), 35–44 (OR = 0.16; 95% CI: 0.15–0.17), 45–54 (OR = 0.29; 95% CI: 0.27–0.30), and 55–64 (OR = 0.52; 95% CI: 0.50–0.54) all had significantly lower odds of access. Educational attainment followed a clear gradient: compared to college graduates, those with no schooling had the lowest odds of access (OR = 0.30; 95% CI: 0.25–0.36), followed by those with

elementary education (OR = 0.37; 95% CI: 0.33–0.42), some high school (OR = 0.56; 95% CI: 0.53–0.59), high school graduates (OR = 0.76; 95% CI: 0.74–0.79), and some college (OR = 0.90; 95% CI: 0.88–0.93).Income also emerged as a strong determinant. Compared to those earning $150,000 or more, the odds of access were significantly lower among those earning less than $25,000 (OR = 0.48; 95% CI: 0.46–0.50), $25,000–$49,999 (OR = 0.57; 95% CI: 0.55–0.59), $50,000–$74,999 (OR = 0.67; 95% CI: 0.64–0.69), and $75,000–$99,999 (OR = 0.78; 95% CI: 0.74–0.81).

Finally, regional differences persisted. Compared to adults in the North, those living in the Midwest (OR = 0.77; 95% CI: 0.75–0.80), South (OR = 0.67; 95% CI: 0.65–0.70), and West (OR = 0.57; 95% CI: 0.55–0.60) were less likely to report access to care.

Table 2. *Multivariable associations between self-reported Accesses to Healthcare among Adults in the United States by select characteristics: 2021 BRFSS*

Characteristics	Self-reported Access to Healthcare (N= 382, 278)	
	AOR	95%CI
Sex		
Female	REF	
Male	0.48	0.47 – 0.49
Age Group		
18 to 24	0.12	0.11 – 0.14
25 to 35	0.10	0.10 – 0.11
35 to 44	0.16	0.15 - 0.17
45 to 54	0.29	0.27 – 0.30
55 to 64	0.52	0.50 – 0.54
65 or older	REF	
Race/Ethnicity		
White American	REF	
Black American	1.12	1.07 - 1.18
Asian American	0.89	0.83 – 0.95
Native American	0.72	0.63 – 0.83
Hispanic/Latino	0.66	0.64 – 0.69
Household Income Level		
Less than $24,999	0.48	0.46 – 0.50
$25,000 to $49,999	0.57	0.55 – 0.59
$50,000 to $74,999	0.67	0.64 – 0.69
$75,000 to $99,999	0.78	0.74 – 0.81
$100,000 to $149,999	0.96	0.91 – 1.01
$150,000 or more	REF	
Education Level		
Never Attended School	0.30	0.25 – 0.36
Elementary	0.37	0.33 – 0.42
Some High School	0.56	0.53 – 0.59
High School Diploma/GED	0.76	0.74 – 0.79
Some College	0.90	0.88 – 0.93
College Graduate	REF	
Region		
North	REF	
Midwest	0.77	0.75 – 0.80
South	0.67	0.65 – 0.70
West	0.57	0.55 – 0.60

4. Discussion

As shown in Table 2, several sociodemographic factors were independently associated with health care access among U.S. adults in the 2021 BRFSS data. These findings highlight structural and systemic barriers that continue to shape who gets access to care in the United States.

Males were significantly less likely than females to report access to health care. This is consistent with prior studies indicating that women are more

likely to engage in preventive services, visit physicians regularly, and maintain health coverage. Social norms, differences in health-seeking behavior, and employment-related insurance coverage disparities may explain this gap. Addressing gender-based barriers requires both cultural and policy interventions to engage men in health care more effectively [10].

Racial and ethnic disparities in health care access remain stark. Compared to White adults, Hispanic, Native Americans, and Asian adults had significantly lower odds of reporting access to care. Interestingly, Black adults in this sample were more likely than White adults to report coverage, reflecting patterns observed in prior studies, potentially due to higher enrollment in public programs such as Medicaid and targeted community outreach initiatives. Nonetheless, persistent inequities across other groups underscore the need for policies that address structural racism, language barriers, and discrimination within the health care system. Culturally competent care, expanding interpreter services, and increasing provider diversity are essential to address these disparities [11].

Access to care improved with age, with older adults (particularly those 65 and above) reporting the highest rates. This is likely due to Medicare eligibility and greater engagement with the health system in later life. In contrast, younger adults—especially those aged 18–34—had significantly lower odds of access, likely reflecting gaps in insurance coverage, limited awareness, and financial barriers. Policy efforts must focus on bridging coverage gaps among young adults, particularly those aging out of parental insurance or ineligible for Medicaid [12].

Educational attainment emerged as a strong predictor of access. Adults with no schooling or elementary education had significantly lower odds of access compared to college graduates. Education influences health literacy, employment opportunities (and thus employer-sponsored insurance), and ability to navigate complex health systems. Strengthening health literacy and simplifying access pathways can help mitigate these effects [13, 14].

Income level was another powerful determinant. Adults earning less than $25,000 annually were significantly less likely to access care than those earning $150,000 or more. Cost-related barriers such as unaffordable premiums, high deductibles, and lack of paid sick leave disproportionately impact low-income individuals. Expanding Medicaid in all states, subsidizing premiums, and reducing out-of-pocket costs are potential strategies to improve access for economically disadvantaged groups [15, 16].

Geographic disparities persisted after adjustment. Adults in the Midwest, South, and West were less likely to report health care access compared to those in the Northeast. This may reflect differences in state-level policies such as Medicaid expansion, provider availability in rural areas, and investment in public health infrastructure. Addressing “medical deserts” and incentivizing provider distribution in underserved areas remain urgent priorities [17, 18].

5. Limitations

Several limitations should be considered when interpreting these findings. First, the BRFSS relies on self-reported data, which may be subject to recall bias or social desirability bias. Second, the cross-sectional design limits our ability to infer causality between sociodemographic factors and health care access. Third, some subpopulations, including marginalized or institutionalized groups, may be underrepresented in the survey, limiting generalizability. Finally, measures of health care access were broad and did not capture nuances such as quality of care, continuity, or timeliness. Future research using longitudinal data and more granular measures could provide a deeper understanding of the mechanisms driving disparities in access.

6. Conclusion

This study underscores persistent and deeply rooted disparities in health care access across the United States. Despite national efforts to expand coverage, access remains uneven, shaped by sociodemographic factors such as sex, race/ethnicity, age, education, income, and region. The findings reveal that younger adults, men, racial and ethnic minorities, those with lower education and income, and residents of the South and West are disproportionately less likely to access care.

Solutions for these inequities require more than just expanding health insurance. These findings reinforce the urgent need for policies that reduce barriers, support underserved communities, strengthen safety-net programs, and ensure culturally competent, affordable, and geographically accessible care. The enactment of the One Big Beautiful Bill Act (H.R. 1) introduces significant changes to Medicaid, including work requirements and funding reductions [19], which may disproportionately

affect low-income and marginalized populations. While the law includes provisions aimed at reducing federal spending, its potential to exacerbate existing disparities emphasizes the necessity for targeted strategies that address structural and social determinants of health. After the COVID-19 pandemic revealed serious gaps in our health system, this study reminds us that it is time for coordinated action. Public health leaders, policymakers, and health systems must work together to close the gap and build a healthier, fairer future for all Americans.

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