

Table 1. Model specification

<u>Theoretical Variable</u>	<u>Actual Variable Included/ operational definition</u>	<u>Hypothesize d direction of effect on number of outpatient visits</u>	<u>Rationale</u>
Perceived Health Status	Self-rated health: Very good health Good health Fair health Poor health Reference: excellent health	As perceived health gets worse, expected number of visits should go up.	Self-rated health is thought to be a composite measure of many things. Among other things, it is correlated with physician assessment of health and functional status; both of which would increase number of contacts with outpatient health care.
Hispanic ethnicity Black race (non-Hispanic) Other race	Hispanic ethnicity	↓	People of Hispanic ethnicity in US tend to have lower utilization than whites.
	Black non-Hispanic	↓	US blacks tend to have lower utilization than whites.
	Other race	↔	I would expect the groups that have higher utilization and the groups that have lower utilization to cancel each other out.
	white non-Hispanic is reference category	N/A	
Race/Perceived Health Interactions	Very good health*Hispanic; Very good health*Black; Very good health*other; Good health*Hispanic; Good health*Black; Good health*other race; Fair health*Hispanic; Fair health*Black; Fair health*other race; Poor health*Hispanic; Poor health* Black; Poor health*other race;	??Across each health category I expect that the magnitude of the interaction term will be lower for Hispanics and blacks. In other words, blacks in poor health would not have as big of an increase in utilization compared to blacks in excellent health as I would see in white patients going from excellent to poor health.	I'm not precisely sure about the direction of these terms. However, I believe that the non-predominant culture may access health services less frequently than the predominant culture for many reasons. It is also possible that Blacks and Hispanics formulate health perceptions differently or act on their formulated perceptions differently.
Age		↑	As people get older they need more health care services. Even after controlling for objective and subjective health, there is a perceived need for more care in older patients.
Education level	HS degree College degree Graduate degree Reference: no degree	↑ Compared to people with no degree.	There is a two-way pull on this variable. On one hand, there will be a higher demand for care in the more educated because there is more knowledge of the need for health care. On the other hand there is a higher opportunity cost for seeking health care services so people will be less likely to access health care services
Poverty level	Poor Near poor Low income Middle income Reference: high income	↓	Compared to people in the highest income category, people in lower categories will access fewer services because they have less means to buy services.

Gender	Female	↑	Women tend to seek care more frequently than men for a number of reasons. After controlling for all the demand factors it is likely that they will still access more care. This is likely due to how women are socialized.
Family size	Number of people in household	↓	Larger families will have less expendable income and thus will be able to access care less.
Marital status	Never married	↑	Compared to married persons, I believe that the people in various states of un-marriedness will use more care. My justification for this is that these people have fewer social supports and may look to outside agencies to provide support. This could easily go the other direction, though-i.e. social supports could enhance people's ability and willingness to seek care.
	Divorced/separated		
	Widowed		
	Reference: Married		
Employment status	Employed Reference: unemployed	↓	People who are employed will be less likely to seek care because the opportunity cost is greater. In other words they lose money and work time by taking time out to go to the doctor so they will have a greater barrier to seeking care.
Insurance status	Any public insurance	↓	People who have private health insurance have more available points of care and lower cost of care at a given point of care. Thus they have fewer barriers and more buying power than publicly insured or uninsured.
	Uninsured		
	Reference: private insurance		
Actual amount of disease	Diagnosis count (counted number of diagnoses listed)	↑	The sicker a person is, the more outpatient care he or she will need.
Functional limitation	Any functional limitation	↑	Functionally limited persons are also likely to access outpatient care by virtue of the fact that they will need more assistance than others.
Fair or poor mental health	Self-reported fair or poor mental health Reference: excellent, very good, or good mental health	↑	Poor mental health will increase the impetus to access outpatient care in the same way that poor physical health does. There is more absolute need and thus higher demand.
Proximity and amount of health care available	Not included in model. This could be measured by an urban/rural variable, distance to nearest health care provider, or population size.	N/A	I would expect that the farther away a health care facility is, the less people will use outpatient services. I would also expect that in areas with fewer health care options per capita, the limited supply of health care would decrease utilization.
Usual source of care	not included-could not find a variable for this in MEPS	N/A	I would expect that an individual with a usual source of care would be more likely to access care even after controlling for all the other variables. This is because there is a higher 'supply' of care/lower barrier to accessing care.
Cost of care	Not included in model	N/A	Cost of care is included to some extent in the model with the insurance term. However, the exact cost of services accessed would depend on a combination of the types of services accessed as well as the type of insurance. I would expect that higher cost of care would reduce utilization. Not including this variable might bias my results towards showing a difference when there isn't one.

