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| --- | --- | --- | --- | --- | --- | --- | --- |
| Author,  Year of publication  Country | Study design | Aim | Population | Emergency Care Indicators | Socio-economic Determinants of Health (SEDH) | Statistics | Key Conclusion |
| INSURANCE STATUS | | | | | | | |
| Berlin, C., et al.  2016  Switzerland | Nation-wide cross-sectional study | To determine if patient characteristics affected the rate of revascularization in acute STEMI patients. | Patients with acute ST-Segment elevation myocardial Infarction (n=9,696) | **Specific procedures**  **Revascularization rate** | **Insurance status**  **(Ref: public)**  **a. Half Private**  **b. Private** | **RP (relative proportion):**  **a. 1.05 (95% CI 0.98-1.13)**  **b. 1.06 (95% CI 0.96-1.17)** | No association was found between insurance status and revascularization rate. |
| Bradshaw, P. J., et al  2015  Australia | Population-based cohort study | To determine whether quality indicator-based outcomes of permanent pacemaker (PPM) implantation were comparable for publicly and privately insured patients | Adults implanted with a PPM between 1995 and 2009. (n=9,748) | **Specific procedures**  **1. Emergency implant of PPM (%)**  **Delay to treatment**  **2. Time to PPM implementation for emergency cases**  **3. Length of stay (LOS) for emergency cases** (≥ 2 days) | **Insurance status (Public vs Private)** | **1. 60% vs 33%, *(p<0.001)*, non adjusted**  **2. Adjusted Odds ratio 0.89 (95% CI 0.78-1.03) *(p=0.11)***  **3. Adjusted Odds ratio 0.91 (95% CI 0.79-1.04) *(p=0.17)*** | Publicly insured patients are more likely to have emergency implant of a PPM.  There were no differences identified in outcomes between publicly and privately insured patients. |
| Casey, S. D. and Mumma, B. E.  2018  United States | Retrospective cohort study | To evaluate the association of patient insurance status with hospital treatments and outcomes following out-of-hospital cardiac arrest | Adult patients with a “present on admission” diagnosis of cardiac arrest (patient admitted from the ED to an acute care hospital) (n=38,163) | **1. Good neurologic recovery**  **2. In-hospital mortality** (Survivalto hospital discharge)  **Specific procedures**  **3. Cardiac catheterization**  **4. DNR[[1]](#footnote-1) within 24h**  **5. Treatment at 24/7 PCI[[2]](#footnote-2) center** (STEMI[[3]](#footnote-3) center) | **Insurance status**  **(Ref: private insurance)**  **a. Medicare insurance**  **b. Government insurance** | **Odds ratios with 95% confidence intervals (CI 95%)**  **1.a. 0.85 (0.79-0.91)**  **1.b. 0.94 (0.88-1.01)**  **2.a. 0.78 (0.73-0.83)**  **2.b. 0.65 (0.61-0.69)**  **3.a. 1.25 (1.15-1.36)**  **3.b. 1.24 (1.13-1.36)**  **4.a. 0.44 (0.40-0.48)**  **4.b. 0.56 (0.51-0.61)**  **5.a. 0.87 (0.82-0.94)**  **5.b. 0.91 (0.85-0.98)** | Insurance status is independently associated with the likelihood of good neurological recovery, survival to hospital discharge, treatment at a 24/7 PCI center, receiving a DNR order within 24 h of admission and undergoing cardiac catheterization in patients experiencing out-of-hospital Cardiac Arrest. |
| Davis, E. E., et al.  2010  United States | Retrospective cohort study | To examine the frequency of return visits for treating dental health problems in hospital emergency rooms for patients without access to private dental services | Individuals without access to private dental services (n=7,846) | **ED visits** (Dental-related) | **Insurance status** (Private (commercial), public, Medicare or Self-pay) | - | Patients without insurance are much more likely to resort to the ED for dental problems than those with private coverage |
| DeLeire, T., et al.  2010  United States | Case-crossover study | To examine if expanding Medicaid to low-income childless adults impacts ED use. | Low-income childless adults (n=9,619) | **1. Total ED visits**  **2. ACSCs ED visits**  **3. Specific ED visits** (for mental health/ drug/alcohol)  **4. Unclassified ED visits** | **Insurance status** (comparison before and after introduction of public insurance) | **Predicted increase after introduction of insurance (%):**  **1. 46%, p<0.01**  **2. 38,7%, p<0.01**  **3. 343.9%, p<0.01**  **4. 89.8%, p<0.01** | Public insurance coverage expansions to childless adults have the potential to improve health and reduce costs by increasing access to outpatient care, ED visits and reducing hospitalizations. |
| Kerr, J., et al.  2014  United States | Retrospective cohort study | To determine factors associated with ED utilization for HIV-infected patients | HIV-infected South Carolina residents (n=4,947) | **Total ED visits** | **Insurance status**  **(Ref: private)**  a. Self-pay  b. Medicare  c. Medicaid d.Indigent/charity  e. HMO | **Incidence rate ratio (95%CI)**  **a. 0.65 (0.61-0.70)**  **b. 0.88 (0.82-0.95)**  **c. 1.26 (1.18-1.36)**  **d. 1.65 (1.47-1.86)**  **e. 1.08 (0.95-1.23)** | Insurance type is associated with ED utilization. There is a need to evaluate HIV primary care systems to increase access and develop interventions to reduce preventable ED visits. |
| Lines, L. M., et al.  2019  United States | Retrospective cohort study | To compare primary care sensitive (PCS) conditions ED use for public versus private insurees | People under age 65 in the Massachusetts All-Payer Claims Data (n=2,269,455) | **Preventable ED visits** | **Insurance status**  **(Ref: private)**  **Any public insurance** | **Rate ratio (95%CI)**  **2.53 (2.49-2.56)** | Public insurance is associated with more PCS ED use. Statewide labour shortages and low reimbursement rates from public insurance may provide inadequate access to care that may otherwise help reduce PCS ED use. |
| Livingood, W. C., et al.  2016  United States | Retrospective, population-based study | To clarify some of the factors associated with the use of ED for initial cancer diagnoses | Patients with a primary or any secondary diagnosis of cancer (n=989) | **ED-associated initial diagnoses** (of cancer) | **Insurance status**  **(Ref: private)**  **a. Medicaid,  b. Medicare  c. Uninsured** | **Relative risk (95%CI)**  **a. 3.10 (1.87-5.39)**  **b. 4.35 (2.63-7.54)**  **c. 2.67 (1.60-4.65)** | There is a significant relationship between health insurance and ED-associated initial cancer diagnosis. |
| Mazurenko, O., et al.  2010  United States | Retrospective pre/post cohort study | To examine the impact of Nevada's Medicaid expansion on changes in rates of hospital ED admissions for ACSCs | Patient hospitalized  A. Pre-expansion of Medicaid (n=107,940)  B. Post-expansion of Medicaid (n=106,016) | **ACSCs Emergency hospital admission** | **Insurance status** (Medicaid or Uninsured) | **Odds ratio (95%CI)**  **A. 0.50 (0.16-0.83)**  **B. 0.62 (0.29-0.94)** | Uninsured patients are more likely to be admitted through the ED for ACSCs, regardless of Medicaid expansion. |
| Metcalfe, D., et al.  2018  United States | Retrospective cohort study | To identify socioeconomic disparities in Emergency General Surgery (EGS) and whether they are more likely to be associated with major adverse events (MAEs) or a failure to respond (FTR) appropriately to such events | Patients presenting EGS with acute surgical conditions (n=1,345,199) | **1.Major adverse events** (MAEs) **[[4]](#footnote-4)**  **2. In-hospital mortality**  **3. Failure to rescue** (FTR)[[5]](#footnote-5) | **Insurance status**  **(Ref: private)**  **a. Public**  **b. Uninsured** | **Odds ratio (95% CI)**  **1.a. 1.18 (1.16-1.20)**  **1.b. 1.16 (1.13-1.19)**  **2.a. 0.96 (0.92-1.01)**  **2.b. 1.28 (1.16-1.41)**  **3.a. 1.01 (0.95-1.07)**  **3.b. 1.20 (1.06-1.36)** | Lack of insurance is an independent risk factor for in-hospital mortality, due to both excess MAEs and FTR. |
| SOCIAL DEPRIVATION | | | | | | | |
| Cookson, R., et al.  2018  United Kingdom | Whole-population study at the small-area level | To present a new and improved analytical approach to integrating health equity into mainstream healthcare quality assurance | Clinical Commissioning Groups-Lower Super Output area (CCG-LSOA)[[6]](#footnote-6)  (CCGs, n=209)  (LSOAs, n=32,844) | **Potentially avoidable emergency admissions** | **Social deprivation**  **Index of Multiple Deprivation (IMD)**  (between the most and least deprived neighbourhoods) | **Absolute gradient index (95% CI)**  **927/100,000 (912-942)**  (The mean rate of potentially avoidable emergency admissions: 792/100,000 people) | Administrative data on inequality in healthcare quality within similar populations served by different healthcare organizations can provide useful information for healthcare quality assurance. |
| Fairley, L., et al.  2011  Scotland (UK) | Longitudinal  retrospective analysis between 1980 and 2000 | To examine whether individual social class, area deprivation or both are related to emergency Caesarean sections in Scotland and investigate changes over time | Women with live singleton birth  A. 1980-1981 (n=133,555)  B. 1990-1991 (n=128,933)  C. 1999-2000 (n=102,285) | **Emergency admission** (for Caesarean section) | **a. Social class**  (divided in 6 classes)  **Social deprivation**  **b. Index of area deprivation** (Carstairs score)[[7]](#footnote-7) | **Odds ratio (95%CI)**  **A.a. 1.14 (1.04-1.25)**  **A.b. 1.18 (1.05-1.32)**  **B.a. 1.13 (1.04-1.23)**  **B.b. 1.13 (1.02-1.26)**  **C.a. 1.02 (0.93-1.12)**  **C.b. 1.02 (0.93-1.13)** | In 1980-81 and 1990-91, both individual social class and area deprivation were associated with emergency C-sections. In 1999-2000, there was no significant association. |
| Lazzarino, A. I., et al.  2011  United Kingdom | Retrospective cohort study | To identify any stroke patient groups being excluded from appropriate use of brain imaging based on levels of social deprivation | Patients with a principal emergency admission diagnosis of stroke (n=209,174) | **Specific procedure 1. Brain scan, at any time**  **2. Brain scan on the same day of admission** | **Social deprivation**  **Index of area deprivation** (Carstairs score, in 5 quartiles)[[8]](#footnote-8)  **(Ref: Least deprived)**  **a. Second**  **b. Third**  **c. Fourth**  **d. Most deprived** | **Odds ratio (95%CI)**  **1.a. 0.98 (0.92-1.05)**  **1.b. 0.99 (0.93-1.06)**  **1.c. 0.99 (0.93-1.06)**  **1.d. 0.97 (0.91.1.04)**  **2.a. 0.95 (0.90-1.00)**  **2.b. 0.93 (0.88-0.98)**  **2.c. 0.91 (0.86-0.96)**  **2.d. 0.94 (0.89-0.99)** | More-deprived patients have less chance of being scanned in a timely fashion. |
| Levin, K. A., et Crighton E. M.  2017  United Kingdom | Ecological small-area study (during the course of RCOP[[9]](#footnote-9) programme) | To examine mean length of stay (LOS) and rates of emergency bed days during the RCOP in Glasgow City | Data zones of household residents of Glasgow City aged 65 years and over | **1. Bed days** (after emergency admission)  **2. Length of stay** (after emergency admission) | **Social deprivation**  **Index of area deprivation**  **SIMD[[10]](#footnote-10)**  **(Ref: SIMD 1, most deprived)**  **a. SIMD 2**  **b. SIMD 3**  **c. SIMD 4**  **d. SIMD 5 (least deprived)** | **Relative risks (95% CI)**  **1.a. 0.89 (0.87-0.91)**  **1.b. 0.79 (0.76-0.81)**  **1.c. 0.67 (0.65-0.69)**  **1.d. 0.60 (0.58-0.62)**  **2.a 1.03 (1.01-1.04)**  **2.b. 1.01 (0.99-1.02)**  **2.c. 0.99 (0.97-1.004)**  **2.d. 0.96 (0.94-0.98)** | The rate of emergency bed days rose with increasing deprivation, while no significant inequalities were observed for length of stay. |
| Lines, L. M., et al.  2017  United States | Retrospective cohort study | To explore associations between ED use and neighbourhood poverty | Patients with commercial insurance (n=64,623) | **1. Total ED visits**  **2. Preventable ED visits** | **Social deprivation** (Percent living in poverty in CT/10[[11]](#footnote-11)) | **z-score (p-value)**  **1. 5.84 (<0.01)**  **2. 6.2 (<0.01)** | People in lower-income neighbourhoods, remain more likely to go to the ED, have more ED visits, and have more PCS ED visits than people in higher-income neighbourhoods. |
| Shulman, R., et al.  2018  Canada | Population-Based Cohort Study | To determine if the combination of socio-economic status and mental health visits in adolescence are associated with diabetes-related ED visits in early adulthood | Patient with a diagnosis of diabetes prior to their 15th birthday (n=8,491) | **ED visits** (diabetes-related) | **Social deprivation**  **Index of Marginalization area** (based on the Ontario Marginalization Index (ON-MARG)[[12]](#footnote-12), divided in 5 quintiles)  **(Ref: least deprived)** | **Rate ratio (95%CI)**  **3.15 (1.79-5.54)** | Socio-economic status combined with mental health visits is associated with an increase in risk of diabetes-related ED visits in early adulthood for people with childhood-onset diabetes. |
| Thorne, K., et al.  2016  United Kingdom | Record linkage study | To identify whether social deprivation has any effect on mortality risk after emergency admission with hip fracture | Patients emergency admitted with hip fracture in England (n=455,862) and Wales (n=29,733) | **1. 30-day mortality** (following hip fracture)  **2. 90-day mortality** (following hip fracture)  **3. 365-day mortality** (following hip fracture) | **a. Social deprivation** (2007 Indices of Multiple Deprivation (IMD, cf footnote 15) for England, divided in 5 quintiles)  **(Ref: least deprived)**  **Most deprived**  **b. Social deprivation**  (2008 Welsh Index of Multiple Deprivation (WIMD)[[13]](#footnote-13) for Wales, divided in 5 quintiles)  **(Ref: least deprived)**  **Most deprived** | **Odds ratio (95% CI)**  **1.a. 1.187 (1.147-1.228)**  **1.b. 1.136 (0.991-1.302)**  **2.a. 1.185 (1.154-1.217)**  **2.b. 1.135 (1.022-1.261)**  **3.a. 1.154 (1.128-1.181)**  **3.b. 1.203 (1.100-1.317)** | There is a positive association between social deprivation and increased mortality at 30 days post-admission for hip fracture in both England and Wales. This association is still evident at 90 and 365 days. |
| Vanasse, A., et al.  2012  Canada | Retrospective cohort study | To compare ED use in patients with mood disorder based on the dwelling sector level of material and social deprivation | Patients aged 18 years or older hospitalized with a diagnosis of mood disorder (n=177,850) | **Total ED visits** (during the year following the diagnosis of mood disorder) | **Social deprivation**  (Combination of material and social deprivation quintiles based on the INSPQ deprivation index)[[14]](#footnote-14)  **(Ref: least deprived)**  **Most deprived**  **a. Women**  **b. Men** | **Relative risk**  **a. 3.82**  **b. 3.25** | There is a gradient between the level of disadvantage in the neighbourhood of residence and the rate of ED visits. |
| Vanasse, A., et al.  2014  Canada | Retrospective cohort study | To measure and compare ED use in relation to the level of material and social deprivation of the area of residence | Patients aged 30 years or older with diagnosis of hypertension without diagnosis of CVD (n=276,793) | **Frequent ED visits** (4 or more visits per year) | **Social deprivation**  (INSPQ deprivation index)[[15]](#footnote-15)  **(Ref: least deprived)**  **Most deprived** | **Relative risk**  **1.47** | The risk of being frequent users is 47% higher for people living in the most materially and socially deprived areas than for people living in the least deprived areas. |
| INSURANCE STATUS AND SOCIAL DEPRIVATION | | | | | | | |
| Whitney, R. L., et al.  2017  United States | Retrospective cohort study | To examine individual predictors of rehospitalization among individuals with advanced cancer | Patients diagnosed with advanced breast, colorectal, non-small-cell lung, or pancreatic cancer (n=25,032) | **Rehospitalizations** (among individuals with advanced cancer in the year after diagnosis)[[16]](#footnote-16) | **a. Social deprivation** (area-based socioeconomic status (SES) quintile)[[17]](#footnote-17)  **(Ref: Highest)**  **i. Upper-middle**  **ii. Middle**  **iii. Lower-middle**  **iv. Lowest**  **b. Insurance status**  **(Ref: Private)**  **i. Public**  **ii. Uninsured** | **Incidence rate ratio (95% CI)**  **a.i. 1.09 (1.02-1.18)**  **a.ii. 1.13 (1.05-1.22)**  **a.iii. 1.14 (1.05-1.24)**  **a.iv. 1.29 (1.18-1.42)**  **b.i. 1.37 (1.23-1.47)**  **b.ii. 1.17 (1.02-1.35)** | Rehospitalisation rates are significantly associated with sociodemographic characteristics, such as insurance status and socioeconomic quintile. |
| INCOME | | | | | | | |
| Singhal, A., et al.  2016  United States | Retrospective cohort study | To determine the factors associated with a subsequent dentist visit after a dental ED visit | Adults enrolled in Medicaid (n=2,430) | **Subsequent dentist visit after a dental ED visit** | **Reportable income (Ref: no)**  **a. Yes** | **Hazard ratio (95% CI)**  **a. 1.05 (0.94-1.18)** | No effect of reportable income on subsequent dentist visits was found after a dental ED visit among adults enrolled in Medicaid. |
| INSURANCE STATUS AND INCOME | | | | | | | |
| Finnegan, M. A., et al.  2017  United States | Observational, population-based study | To determine what factors are associated with an increased risk of ED visits following major joint replacement surgical procedures | Adult undergoing total hip or knee arthroplasty (n=152,783) | **1. Total ED readmission** (following intervention, within 30 days)  **2. Specific ED readmission** (following intervention, pain-related, within 30 days) | **a. Insurance status (Ref: private)**  **i. Medicare**  **ii. Medicaid**  **b. Median household income**  **(Ref: Highest quartile)**  **i. Second**  **ii. Third**  **iii. Fourth** | **Odds ratio (95%CI)**  **1.a.i. 1.38 (1.29-1.47)**  **1.a.ii 2.28 (2.04-2.55)**  **1.b.ii 0.98 (0.91-1.05)**  **1.b.iii 0.96 (0.89-1.03)**  **1.b.iv 0.97 (0.90-1.05)**  **2.a.i 1.62 (1.40-1.87)**  **2.a.ii 1.68 (1.36-2.09)**  **2.b.i 1.12 (0.96-1.31)**  **2.b.ii 1.00 (0.85-1.17)**  **2.b.iii 1.04 (0.87-1.23)** | Medicaid patients had almost double the risk of an ED or pain-related ED visit following a surgical procedure. No association between median household income quartile and increased risk for an ED visit was found. |
| Ladha, K. S., et al.  2011  United States | Retrospective cohort study | To determine whether re-presentation to ED after discharge from hospital is related to insurance status and socioeconomic factors such as neighbourhood income level | Trauma patients (n=6,675) | **Total ED readmission**  (Re-presentation to the ED within 30 days of discharge) | **a. Insurance status**  **(Ref: private)**  **i. Public**  **ii. Uninsured**  **b. Median household income**  **(Ref: >40,000 $)**  **i. 20,000-40,000 $**  **ii. <20,000 $** | **Odds ratio (95%CI)**  **a.i 1.64 (1.30-2.06)**  **a.ii 1.60 (1.20-2.14)**  **b.i 1.42 (1.14-1.77)**  **b.ii 1.77 (1.37-2.29)** | Re-presentation to ED is associated with being uninsured or under-insured and with lower neighbourhood income level. |
| Moy, E., et al.  2014  United States | Retrospective cross-sectional analysis | To identify factors associated with the frequency of missed acute myocardial infarction (AMI) diagnosis in the ED | Patient evaluated for chest pain or cardiac conditions within 1 week of hospitalization (n=111,973) | **ED missed diagnoses[[18]](#footnote-18)** (of acute myocardial infarction (AMI)) | **a. Insurance status**  **(Ref: private)**  **i.Medicare**  **ii. Medicaid**  **iii. Uninsured**  **b. Median household income**  **(Ref: highest)**  **i. Moderate**  **ii. Low**  **iii. Lowest** | **Odds ration (p-value)**  **a.i. 0.801 (p=0.0389)**  **a.ii. 1.124 (p=0.3938)**  **a.iii 0.871 (p=0.2798)**  **b.i. 1.067 (p=0.6111)**  **b.ii. 1.006 (p=0.9606)**  **b.iii. 0.906 (p=0.4550)** | The associations between missed diagnoses and expect payers (other than Medicare) and household income were not significant when controlling for other demographic and clinical conditions. |
| Shah, A. A., et al.  2015  United States | Retrospective population-based cohort study | To determine the predictors of in-hospital complications and mortality among emergency general surgery (EGS) patients | Patient 16 and older with primary diagnosis and sub-diagnosis of an EGS condition[[19]](#footnote-19) (n=32,910,446) | **1.Major adverse events**  **2. In-hospital mortality** | **a. Insurance status**  **(Ref: private)**  **i. Government**  **ii. Uninsured**  **b. Median household Income quartile (Ref: lowest)**  **i. Second**  **ii. Third**  **iii. Fourth** | **Odds ratio (95% CI)**  **1.a.i. 1.15 (1.14-1.15)**  **1.a.ii 1.06 (1.04-1.08)**  **1.b.i. 1.01 (1.00-1.02)**  **1.b.ii. 1.03 (1.02-1.04)**  **1.b.iii 1.00 (1.00-1.02)**  **2.a.i. 1.08 (1.06-1.10)**  **2.a.ii 1.25 (1.20-1.30)**  **2.b.i. 0.98 (0.96-0.99)**  **2.b.ii. 0.92 (0.90-0.93)**  **2.b.iii. 0.86 (0.84-0.88)** | Uninsured patients were at higher risk for death compared to government or private insured patients. Patients in the highest income quartile had the least likelihood of mortality after an EGS condition. |
| EDUCATION LEVEL WITH/WITHOUT INSURANCE STATUS | | | | | | | |
| Yap, S., et al.  2018  Australia | Retrospective cohort study | To examine patients’ characteristics associated with presenting to ED around the time of diagnosis | Patient newly diagnosed with non-small cell lung cancer (n=647) | **“Emergency presenters”** (presenting to an emergency department around the time of diagnosis) | **a. Education level**  **(Ref: no school certificate)**  **i. School certificate**  **ii. Trade/Certificate/ Diploma/HSC**  **iii. University degree**  **b. Insurance status**  **(Ref: private)**  **Not private** | **Odds ratio (95% CI)**  **a.i. 0.97 (0.58-1.63)**  **a.ii. 0.67 (0.41-1.11)**  **a.iii 0.49 (0.24-0.99)**  **b.1.28 (0.86-1.90)** | The risk of being an “emergency presenters” seems to follow an educational-level gradient. |
| Stecksén, A., et al.  2014  Sweden | Retrospective cohort study | To test whether patient education level is associated with receiving reperfusion treatment | Patients with ischemic stroke (n=85,885) | **Specific procedure**  **Reperfusion therapy** | **Education level**  **(Ref: primary)**  **a. Secondary**  **b. University** | **Odds ratio (95%CI)**  **a. 1.08 (1.00-1.17)**  **b. 1.14 (1.03-1.26)** | Reperfusion therapy for stroke is associated with higher patient education level. |
| HEALTH LITERACY | | | | | | | |
| Balakrishnan, M. P., et al.  2017  United States | Observational cross-sectional study | To determine the association of health literacy with preventable ED visits | Adults and English-speaking patients. (Excluded patients with impaired vision, hearing problems, being in police custody, or being too ill to participate) (n=1,201) | **1. Total potentially preventable ED visits**  **2. Potentially preventable ED visits resulting in hospital admission**  **3. Potentially preventable treat-and-release ED visits** | **Health literacy** (assessed by the Rapid Estimate of Adult Literacy in Medicine (REALM)[[20]](#footnote-20))  Limited (REALM < 61) versus adequate (REALM >= 61) health literacy | **Rate Ratio (95%CI)**  **1. 1.93 (1.55-2.40)**  **2. RR 2.33 (95% CI 1.75-3.1)**  **3. RR 1.42 (95% CI 0.99-2.40)** | Limited health literacy is a risk factor for potentially preventable ED visits. |
| FINANCIAL AND NON-FINANCIAL BARRIERS | | | | | | | |
| Shippee, N. D., et al.  2014  United States | Cross-sectional study | To examine the distinct associations financial and non-financial barriers to care have with patterns of ED use among a publicly insured population | Publicly insured patients (n=1,737) | **ED visits** (0, 1 or 2+ ED visits in 1 year) | **a. Financial concerns[[21]](#footnote-21)**  **b. Non-financial barriers[[22]](#footnote-22)** | **Odds ratio (95% CI)**  **a. 0.939 (0.849-1.038)**  **b. 1.210 (1.048-1.398)** | Non-financial barriers are associated with actual ED visits. |

1. Do not resuscitate [↑](#footnote-ref-1)
2. Percutaneous coronary center. [↑](#footnote-ref-2)
3. ST segment elevation myocardial infarction. [↑](#footnote-ref-3)
4. MAEs: Major adverse events, identified from ICD-9-CM codes (cerebrovascular accident, pneumonia, pulmonary embolus, acute respiratory distress syndrome, renal failure, urinary tract infection, myocardial infarction sepsis, septic shock and cardiac arrest) [↑](#footnote-ref-4)
5. FTR: the odds of in-hospital mortality after an MAE [↑](#footnote-ref-5)
6. CCG-LSOA : a block of CCG registered population residing within a neighbourhood census unit called LSOA (Lower Super Output area). [↑](#footnote-ref-6)
7. Carstairs score: An index of deprivation used in spatial epidemiology, based on four variables (Male unemployment, Lack of car ownership, Overcrowding and Low social class). [↑](#footnote-ref-7)
8. Quintile of socio-economic deprivation (Carstairs): a geographically-based deprivation score based on four census indicators (low social class, lack of car ownership, overcrowding and male unemployment). [↑](#footnote-ref-8)
9. RCOP (Reshaping Care for Older People): programme developed to address the projected increase in health service and social care use by older people in Scotland. [↑](#footnote-ref-9)
10. SIMD (Scottish Indicator of Multiple deprivation): the Scottish Government's official tool for identifying those places in Scotland suffering from multiple deprivation. By identifying concentrations of multiple deprivation, the SIMD can be used to target policies and resources at the places with greatest need. [↑](#footnote-ref-10)
11. CT/10: a coefficient that refers to the effect of a 10% increase in the percentage of the population in the Census tract (CT) who have household incomes below 200% of the federal poverty threshold. (The poverty coefficient indicates the effect of a 10% increase in the fraction of the population living in poverty) [↑](#footnote-ref-11)
12. ON-MARG: a validated census- and geography-based index that measures marginalization at the level of the census dissemination area, including economic, ethno-racial, age-based and social marginalization [↑](#footnote-ref-12)
13. A composite score originates from the following domain indices: income, employment, health, education, access to services, community safety and physical environment. [↑](#footnote-ref-13)
14. Institut national de la santé publique du Québec (INSPQ) deprivation index: an index based on six socioeconomic indicators calculated at the dissemination area (DA) level. This index has two components, material and social. The material component is based on the proportion of people without a high school diploma, the employment-to-population ratio and the average income. The social component is based on the proportion of people living alone, the proportion of separated, divorced or widowed people and the proportion of lone-parent families [↑](#footnote-ref-14)
15. Ibidem [↑](#footnote-ref-15)
16. 64.1% of all rehospitalizations are originated in the ED [↑](#footnote-ref-16)
17. Area-based SES quintile : an index of seven components based on American Community Survey (Education index, percent persons above 200% poverty line, percent persons with a blue collar job, percent persons employed, median rental, median value of owner-occupied housing unit and median household income) [↑](#footnote-ref-17)
18. Patients who visited an ED with chest pain or cardiac conditions, were released from the ED, subsequently returned to a hospital within 0 to 7 days, and were admitted with a principal diagnosis of acute myocardial infarction (AMI) [↑](#footnote-ref-18)
19. Based on the classification of the American Association for the Surgery of Trauma (AAST), which encompass 621 unique ICD-9-CM [↑](#footnote-ref-19)
20. A reading recognition test comprised of 66 health-related words arranged in ascending order of difficulty. [↑](#footnote-ref-20)
21. A set of seven self-reported financial concerns items: “insurance won’t cover care”, “the respondent will have to pay more than expected”, “he/she will have to pay more than he/she can afford”, “medications will cost too much”, “not being sure about being dropped from the public healthcare program”, “not knowing what the health plan covers and not knowing where to go with questions about coverage”. [↑](#footnote-ref-21)
22. Seven self-reported non-financial barriers including: transportation difficulties, problems making appointments, not knowing where go for care, work/family responsibilities, office/clinics not being open at suitable times, obtaining childcare and not being able to utilize one’s preferred provider. [↑](#footnote-ref-22)