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Rural-urban differences in health care access vary across measures

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Research & Policy Brief

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Rural-Urban Differences in Health Care Access Vary Across Measures

Introduction

Rural uninsured rates are higher than urban,¹ and the uninsured often have difficulty obtaining needed care.² Difficulties recruiting and retaining health care providers have resulted in longstanding disparities in rural and urban physician supply.³ This combination of factors suggests that rural residents may face greater barriers to accessing health care than their urban counterparts. Analyses of data from the 2006 Medical Expenditure Panel Survey (MEPS) for non-elderly rural and urban residents partly supports this premise, yet rural residents fare better on some measures of access.

Rural Residents More Likely to Have Usual Source of Care

Having a regular provider (usual source of care, or USC) from whom one receives health care services is a common measure of health care access. Research indicates that having a USC is one of the many factors that increases the use of preventative care services and decreases risk of having unmet health needs.⁵

As shown in Figure 1, 83% of rural residents under age 65 have a USC and the proportion is higher than in urban areas (79%). The USC is most commonly a physician's office although a small percentage of both rural and urban individuals identify hospitals and/or emergency rooms as their USC (data not shown). In keeping with prior research,⁶ the uninsured are much less likely to have a USC yet uninsured rural residents are significantly more likely to report having a USC than urban (57% versus 47%).

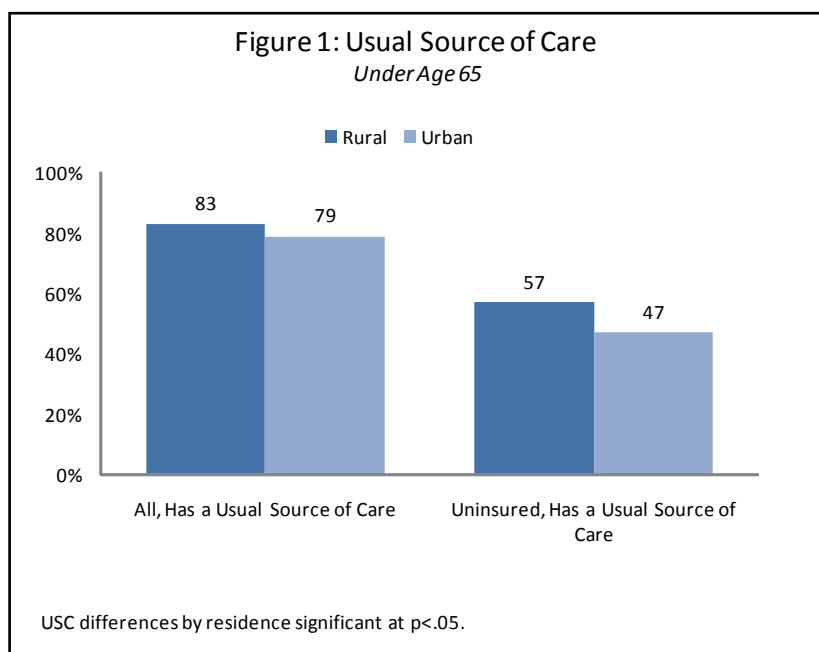
Fast Facts

- Rural residents are more likely than urban residents to have a usual source of health care (USC), particularly the rural versus urban uninsured.
- Rural residents are somewhat more likely to report long travel times to reach their USC and have greater difficulty getting care after hours.
- While rural access to care is not uniformly worse than urban access, the burden on rural providers in delivering this care may be high, especially since rural physicians are twice as likely to work in solo practices.

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Rural Residents More Likely to Have Difficulty Accessing Usual Source of Care

Evidence suggests that the travel time to a health care provider can adversely affect a person's ability to access that provider, especially among those needing specialty care.⁷ As Figure 2 demonstrates, rural residents are somewhat more likely to travel more than 30 minutes to see their USC (13% of all non-elderly residents compared to 10%).

There is no rural-urban difference in the percentage of individuals that report difficulty reaching their USC provider by telephone (about 16%). However, rural residents are much more likely to have trouble reaching their USC provider outside of normal office hours (37% versus 29% urban). This is likely related to the fact that rural physicians are twice as likely to work in solo practice as their urban counterparts (29% versus 15%),⁸ which makes providing 24-hour coverage challenging.

Some Preventive Care Services are Less Commonly Used by Rural Residents

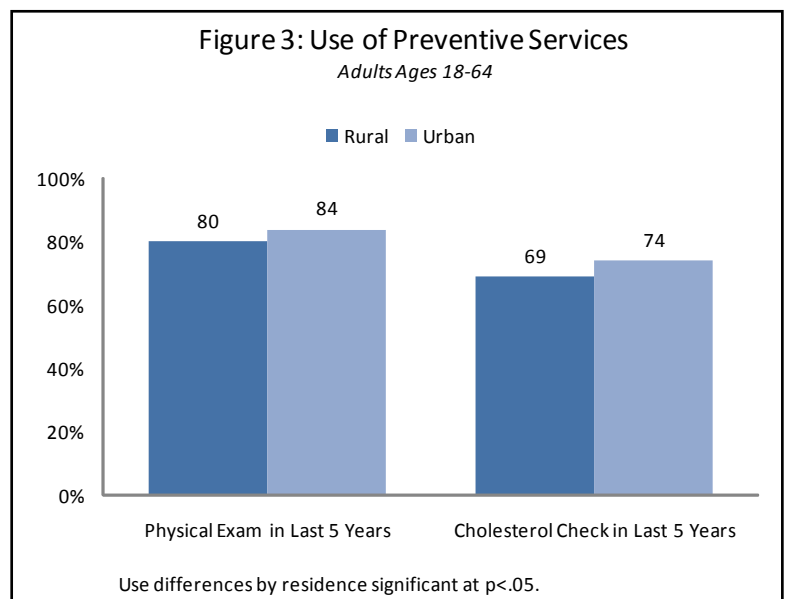
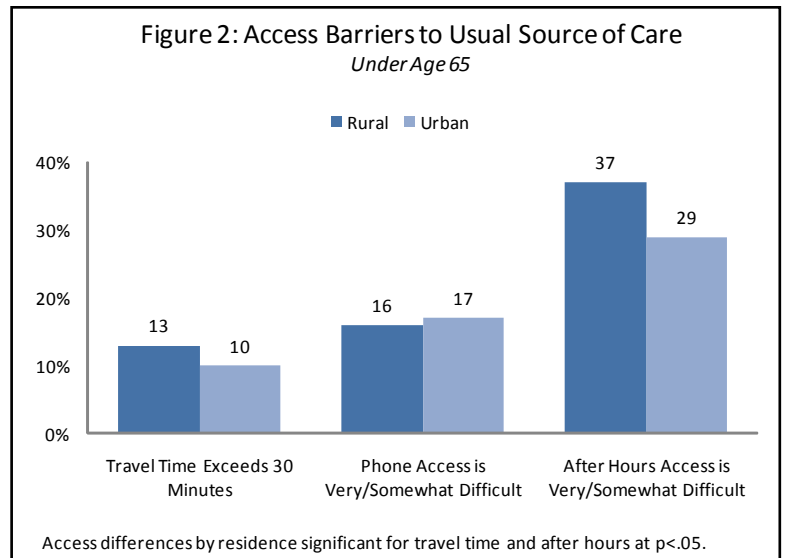
Use of preventive care services is one indicator of access to health care and is a component used in Healthcare Effectiveness Data & Information Set (HEDIS) measures of access.⁹ Despite being more likely to have a USC, rural adults are somewhat less likely to receive certain preventive care services than are urban adults. For example, only 80% of rural adults under age 65 have had a physical exam in the past five years compared to 84% of urban residents (Figure 3). Similarly, only 69% of adults in rural areas reported receiving a cholesterol check within the past five years, versus 74% in urban areas.

For other preventive care services, rural residents are as likely as their urban counterparts to receive care. In particular, rural women under age 65 report receiving pap smears, breast exams and mammograms with the same periodicity as urban women. It is unclear why rural residents fare more poorly for some types of preventive care and not others.

Policy Implications

Although rural areas have lower physician to population ratios than urban areas,¹⁰ rural residents are more likely to have a usual source of health care (USC). This may be a function of rural residents having more limited health care options and therefore being more likely to have one "usual" provider.

While having a USC is a benefit to rural residents, the burden of providing care may be high for rural providers, especially when they have few options for sharing the financial and logistical costs of treating the un/underinsured. Rural physicians work longer hours and see more patients than



urban physicians¹¹ and to the extent that this contributes to dissatisfaction with their practice, may exacerbate the problems of rural physician recruitment and retention.¹²

The demands on rural physicians, combined with their greater likelihood of being in solo practice, may explain why rural residents have much more difficulty accessing their USC after hours. It also illustrates the importance of having other health care resources, such as Critical Access Hospitals (CAHs) available to provide urgent care or telephone triage after office hours.

Although travel to a USC is somewhat longer for rural residents, the difference was smaller than might be expected. However, it is important to note that we used a single measure of rurality to encompass all rural areas, and this limits our ability to discern differences among rural communities that have very different landscapes and provider availability.¹³ Thus, some very remote rural areas may fare worse on this measure (as would some poor inner-city urban areas). Finally, while rural access to health care is not categorically worse than urban access based on current

data, trends in the rural health care workforce suggest that this could change. For example, recent evidence indicates that a greater proportion of rural than urban primary care physicians are nearing retirement age, particularly in more remote rural communities.¹⁴ Combined with the challenges of recruitment and retention in the rural health care workforce, this suggests that rural access to providers will warrant careful monitoring in the future.

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