

Research & Policy Brief

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Health Care Access and Use Among the Rural Uninsured

Overview

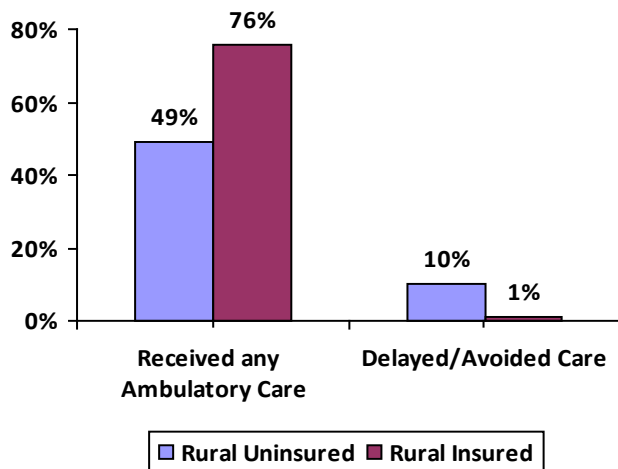
In a landmark series of reports, the Institute of Medicine's Committee on the Consequences of Uninsurance noted the policy significance of the "cascading" effects of uninsurance on patients, families, and communities.¹ Multiple studies confirm that rural residents are more likely to be uninsured than their urban counterparts.²⁻⁴ Additionally, there is ample evidence that the uninsured have poorer access to care, delay care, and obtain care at levels of greater acuity than those with health insurance.⁵ However, the impact of being uninsured versus insured in rural areas, particularly compared to urban areas, is largely unknown.

Using data from the 2002-2007 Medical Expenditure Panel Survey (MEPS), this study examines access to care and service use among non-elderly, uninsured rural and urban residents compared to each other and to their insured counterparts using a combination of bivariate and multivariate analyses. For the purposes of this study we defined uninsured as lacking any health insurance coverage for a full year. Rural and urban designations are based on the rural-urban continuum codes; for some analyses we divide rural counties into those that abut an urban county (adjacent) and those that do not (non-adjacent).

Being Uninsured Leads to Poorer Access in both Rural and Urban Areas

As anticipated, being uninsured for a full year is significantly associated with poorer access to health care services regardless of residence. In both rural and urban areas, the uninsured are less likely to have a usual source of health care (USC), defined as the place one usually goes to if sick or needing health care advice, such as a particular doctor's office, clinic, health center, or other place. Additionally, both rural and urban uninsured report more difficulty accessing care after hours, and have to travel more for care. As shown in Figure 1, compared to the rural insured, the rural uninsured are less likely to receive any ambulatory care during the year (49% versus 74%), and are much more likely delay or forgo medical care because of cost (10% versus 1%).

Figure 1: Receipt of Care by Rural Uninsured versus Rural Insured



DATA: Medical Expenditure Panel Survey, 2002-2007
Differences between rural uninsured and insured significant at $p < .05$

Fast Facts

- Uninsured residents of both rural and urban areas face serious barriers to care compared to those with health insurance coverage.
- The rural uninsured are more likely to have a usual source of care and to have used ambulatory care in the past year than the urban uninsured.
- Insured or not, rural residents have difficulty accessing after hours care and traveling to see their usual provider.

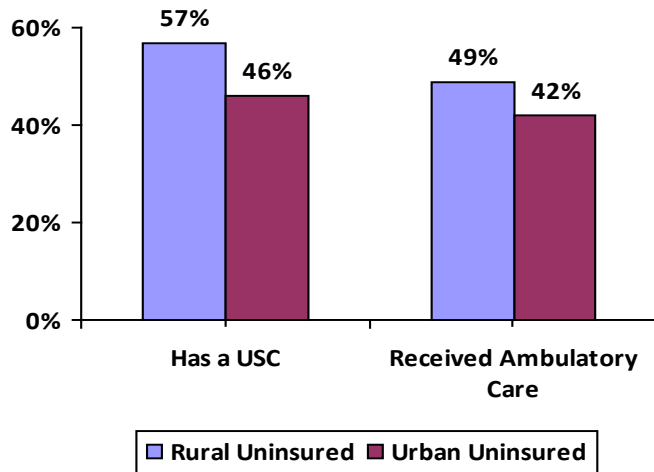
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Rural Uninsured More Likely to Have a Usual Source of Care and Use Ambulatory Services than Urban Uninsured

Although being uninsured creates access barriers, the rural uninsured are more likely than those in urban areas to have a usual source of health care (USC) and to have obtained at least one ambulatory care visit during the year (Figure 2). While these rates are lower than for their insured counterparts, the disparity in access between the uninsured and the insured is less pronounced in rural areas. For example, more uninsured rural residents (57%) report a USC than uninsured urban residents (46%), compared to approximately 85% of the rural and urban uninsured.

Similar patterns are also apparent for prescription drug use. These rural-urban access differences among the uninsured relative to their insured counterparts persist after controlling for factors known to affect health care access and health care use including age, gender, income, race/ethnicity, education, and health status.

Figure 2: Receipt of Care by Rural versus Urban Uninsured



DATA: Medical Expenditure Panel Survey, 2002-2007; Rural-urban differences and uninsured-insured differences significant at $p < .05$

Rural Residents Affected by Other Access Barriers

Regardless of insurance status, rural residents are more likely to report difficulty accessing care after hours than urban residents with the same insurance status. Insured and uninsured rural residents living near urban counties (rural adjacent) are more likely than their more remote rural and urban counterparts to travel more than 30 minutes to see their USC. They are also more likely to report their travel distances as an access problem, which could be related to urban sprawl or travel to more densely populated areas to receive care.

Discussion and Policy Implications

In general, we find that differences in access between the insured and uninsured in rural areas are smaller than those observed in urban areas. Uninsured rural residents appear to have better access to at least some basic services than do the urban uninsured, thus, uninsured-insured differences in rates of having a usual source of care, having an ambulatory care visit, and having a prescription filled are each less pronounced among rural residents than among their urban counterparts. This persists even when controlling for age and self-reported health status, suggesting that the greater likelihood of using health services in rural areas is not solely related to greater health care need.

Rural providers may impose fewer barriers on the uninsured who seek care, at least for initial access, than those in urban areas. One explanation may be the greater reliance of the

rural health system on non-physician providers (e.g. Physician Assistants or Nurse Practitioners) who may be easier for underserved populations to access. Additionally, many services obtained by the rural uninsured may be provided by the “informal safety net”—providers who offer reduced fees or free care to uninsured patients despite having no mandate or financial support to do so.⁶ This includes rural health clinics, the majority of which offer free or discounted care to patients who are un- or underinsured.⁷

Despite being more likely to have a USC and to receive some basic care, rural residents are impacted by other barriers to care. Both insured and uninsured rural residents are more likely than their urban counterparts to report difficulties reaching their usual source of care after hours, many of which may be small or solo practices for whom providing 24-hour, on-call care is more challenging. The Affordable Care Act (ACA) contains a number of provisions designed to strengthen and integrate primary care with other services; for rural providers and patients, a key policy intervention would develop novel approaches to support small practices in providing after-hours care.

While the rural uninsured may fare somewhat better in obtaining basic services than do those in urban areas, the insured-uninsured disparity in access is clear and pronounced regardless of residence. This somewhat better access likely comes at a significant cost to rural patients and providers, and potentially third-party payers through cost-shifting. If the ACA is implemented in ways that effectively extend coverage to the nearly 8 million rural residents currently lacking health insurance,⁸ both access to care for rural people and the financial viability of rural health care practice could be improved.

Endnotes

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