POLICY BRIEF
December 2019

UNIVERSITY OF MINNESOTA
RURAL HEALTH
RESEARCH CENTER

Rural-Urban Differences in Access to and Attitudes Toward Care for Medicare Beneficiaries

Carrie Henning-Smith, PhD, MPH, MSW
Ashley M Hernandez, MSPH
Megan Lahr, MPH

Key Findings

- Overall, rural and urban Medicare beneficiaries reported similar rates of having a usual source of care and receiving timely medical care.
- Rural Medicare beneficiaries were more likely than their urban counterparts to have delayed care due to cost; they also had longer travel times to see their usual provider.
- Compared with urban Medicare beneficiaries, rural Medicare beneficiaries were much more likely to avoid going to the doctor and to not tell anyone if they were feeling sick.

rhrc.umn.edu

Purpose

Access to timely, affordable health care is important to health outcomes and overall wellbeing. However, even among Medicare beneficiaries who all have the same minimum insurance coverage, access to care may differ by rural-urban location because of significant differences in the health care and socio-demographic landscape. This brief describes rural-urban differences in access to care for Medicare beneficiaries.

Background and Policy Context

Access to timely, appropriate, and affordable health care is important for health outcomes and overall wellbeing.[1] Access to care is partially determined by access to insurance coverage to help make such care affordable and attainable.[1] Because Medicare provides nearly-universal insurance coverage for older adults in the United States, as well as for some non-elderly adults and children with disabilities, access to care should, in theory, be guaranteed for individuals with Medicare coverage. However, there is ample evidence showing that some Medicare beneficiaries—including rural residents—still struggle to access care when they need it.[2]

Rural Medicare beneficiaries face particular hurdles in accessing care, including longer distances to health care facilities, lower median incomes, fewer private supplemental and Medicare Advantage plan options, higher disability rates (leading to greater need), and health care workforce shortages.[3–9] Given these differences, current information is needed about access to care for rural Medicare beneficiaries in order to inform policies and programs to ensure the best possible health care access and health outcomes. In 2012, the Medicare Payment Advisory Commission (MedPAC) released a report entitled, "Medicare and the Health Care Delivery System," devoting an entire chapter to the topic of how best to serve rural Medicare beneficiaries. This report included information on rural-urban differences in access to care, as well as on rural-specific programs to improve access; however, the data for that report were from 2010.[2]

Given the substantial changes to the health care landscape since then, along with a new cohort of beneficiaries aging into the Medicare program, updated information on rural Medicare beneficiary access to care is needed to inform current health policy discussions and decisions. This policy brief provides up-

dated estimates of rural-urban differences in access to care for Medicare beneficiaries across multiple dimensions.

Approach

For this analysis, we used weighted data from the 2016 Medicare Current Beneficiary Survey (MCBS) to analyze bivariate differences in access to care by rurality (rural, including micropolitan and non-core counties, vs. urban). The MCBS sample includes beneficiaries enrolled at the time of the survey, not necessarily continuously enrolled for the entire year, and it includes individuals enrolled in Part A, Part B, or both, or in Medicare Advantage, and with Medicare/Medicare Advantage as their primary or secondary payer. We included all respondents from the Community Survey, which includes both beneficiaries over age 65 and younger beneficiaries. It does not include individuals living in an institutional setting at the time of the survey.

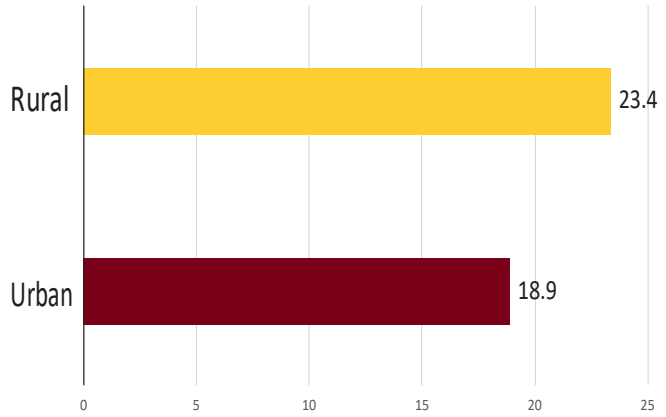
Access measures included difficulty getting to a provider, delayed care, foregone care, usual source of care (both having a usual clinic or facility where they go for care and then having a usual doctor they see at that facility), travel time to get to the provider, and beneficiary attitudes toward accessing care. Because access to care is multifaceted, it is important to measure it across different dimensions, especially those that might disproportionately impact rural residents (e.g., transportation).[10] We used chi-squared tests to determine significant differences by rural-urban location and survey weights to account for the complex sampling design.

Results

Rural and urban Medicare beneficiaries reported similar experiences accessing care (see Table 1), with the exception of having a delay in care due to cost. Rural Medicare beneficiaries were significantly more likely than their urban counterparts to have a delay in care for financial reasons (12 vs. 10%, p<0.01). Nearly one in ten beneficiaries in both locations reported having difficulty accessing needed health care, and more than one in ten reported having a health problem for which they thought they should receive care, but did not. The vast majority of all beneficiaries reported having a usual source of care, both a facility/clinic and a provider within that facility/clinic.

Rural Medicare beneficiaries reported significantly longer travel times to get to their usual provider (see Figure 1), although in practical terms, the difference between beneficiaries in rural and urban areas was approximately five minutes. (Rural beneficiaries reported 23.4 minutes on average, compared with 18.9 minutes on average for urban beneficiaries, p<0.001).

Figure 1: Average Minutes to Get to Usual Provider



Rural-urban differences in travel time significant at p<0.001.

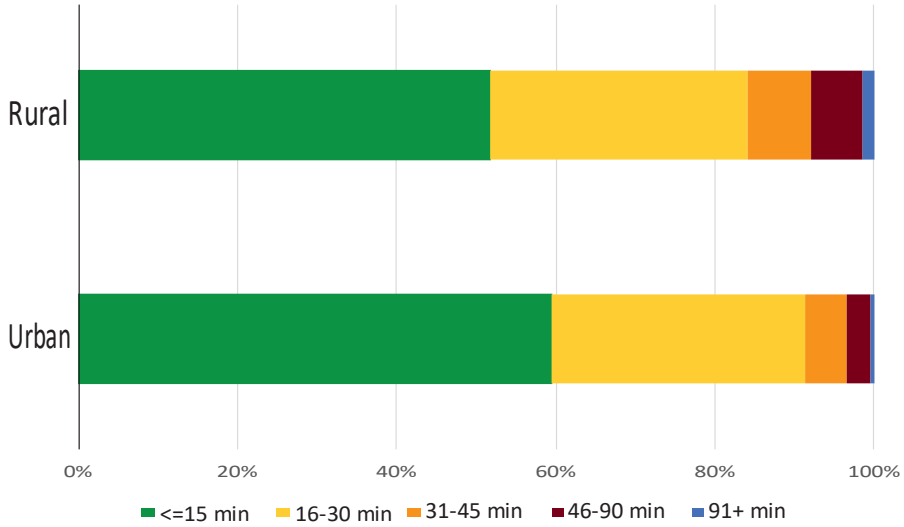
Table 1: Access Barriers

Access Issue	N	Urban	Rural	P-value
Had trouble getting needed health care in the past year	12,823	7%	8%	.789
Ever had a delay in care due to cost	12,834	10%	12%	<0.01
Had any health problem or condition about which beneficiary thought they should have seen a doctor but did not in the past year	12,777	11%	12%	.146
Usual source of care (facility/clinic) for sickness and advice about health	12,829	94%	92%	.200
Usual provider at facility/clinic	3,083	85%	86%	.719

Note: N represents the unweighted sample for each question. The N varies slightly based on the number of respondents asked each question. Percentages are calculated using survey weights to approximate nationally representative estimates.

There was also a difference in the overall distribution of travel time by rurality. Rural Medicare beneficiaries were significantly more likely to have travel times of 16-30 minutes, 31-45 minutes, 46-90 minutes, and more than 90 minutes, relative to urban beneficiaries (see Figure 2).

Figure 2: Distribution of Travel Time to Usual Provider



Rural-urban differences in travel time significant at p<0.001.

When comparing rural and urban Medicare beneficiaries on their attitudes toward seeking care, we observed sizeable and significant differences across measures (see Table 2). Rural beneficiaries were more than ten percentage points more likely to say that they "will do just about anything to avoid going to the doctor" (36 vs. 25%, <0.001); ten percentage points more likely to say that when they are sick they try to keep it to themselves (46 vs. 36%, p<0.001); and ten percentage points less likely to say that they go to the doctor as soon as they start to feel bad (30 vs. 40%, p<0.001).

Table 2: Attitudes Toward Seeking Care

Access Issue	N	Urban	Rural	P-value
Will do just about anything to avoid going to the doctor	12,785	25%	36%	<0.001
When beneficiary is sick they try to keep it to themselves	12,737	36%	46%	<0.001
Beneficiary usually goes to the doctor as soon as they start to feel bad	12,721	40%	30%	<0.001

Note: N represents the unweighted sample for each question. The N varies slightly based on the number of respondents asked each question. Percentages are calculated using survey weights to approximate nationally representative estimates.

Discussion and Implications

In this brief, we examined rural-urban differences in access to care and attitudes toward seeking care across multiple dimensions for Medicare beneficiaries. Consistent with previous research,[2] we found that rural and urban Medicare beneficiaries were similar on multiple measures of access to care, including having a usual provider and getting timely medical care when needed. However, we also found that rural Medicare beneficiaries were significantly more likely than their urban counterparts to have delayed care due to cost, and to have longer travel times to see their usual provider.

These findings should not come as a surprise. Rural residents, including Medicare beneficiaries, have lower incomes, on average, than urban,[5,8] and may be more likely to experience financial barriers to care as a result. Rural residents also frequently have longer travel times to access care, and transportation is a well-documented barrier to care for patients living in rural areas.[11] While the difference in average travel time in this study was relatively small (5 minutes) between rural and urban residents, rural residents were significantly more likely to have travel times greater than 30 minutes. Traveling to access necessary care can cause challenges in addition to transportation, including the need to take additional time off work or find assistance for caregiving responsibilities. Known workforce issues of having too few providers available in rural areas increase issues of long travel times.

Policy solutions could help mitigate access barriers caused by financial hardship, transportation, and health care workforce issues. These solutions could include addressing out-of-pocket costs in the Medicare program to lessen the financial burden of health care. To address transportation issues policy could focus on improving road quality and infrastructure as well as expanding the availability of public transportation, especially for non-emergency medical appointments. Finally, increasing the availability of advanced practice clinicians (for whom rates may not be as high), as well as increasing the availability of telehealth and other options for accessing care without traveling for long periods of time could also help solve problems related to workforce shortages and transportation.

Where we observed the largest differences between rural and urban Medicare beneficiaries, however, was in attitudes toward seeking care. Rural beneficiaries were considerably less likely to want to seek care, even when feeling sick. If they were to seek care at similar frequencies when feeling ill, we may see more noticeable disparities in other access measures by rurality. Additionally, reticence on the part of rural Medicare beneficiaries to seek care, even when it may be necessary, could lead to delays in diagnosis, even of critical issues, and to exacerbated conditions that might have been treated more easily had they been dealt with earlier.[12]

Reluctance to seek care may be characterized as stoicism and heartiness among rural residents; indeed, it may indicate true resourcefulness and independence. Still, to the extent that rural Medicare beneficiaries are not getting timely medical care when necessary as a result, attention should be given to strategies to make seeking appropriate care more appealing. If reticence to seek care is related to financial concerns, or to practical issues related to traveling to the doctor, the policy recommendations mentioned above take on particular salience. It is also possible that such attitudes stem from mistrust of the health care system or lack of information about what services are covered and for whom. In either case, additional work to connect with beneficiaries, learn about their concerns, and ensure that they have all available information is essential. Benefits counseling programs, such as those provided through Aging and Disability Resource Centers and Area Agencies on Aging are essential to helping to inform Medicare beneficiaries of their rights and should be supported. But, even more should be done to ensure that they know what services are available to them and what the health benefits of such services might be.

References

1. Sommers BD, Gawande AA, Baicker K. Health Insurance Coverage and Health — What the Recent Evidence Tells Us. N Engl J Med. 2017;377(6):586-593. doi:10.1056/NEJMsb1706645
2. Medicare Payment Advisory Commission. Serving rural Medicare beneficiaries. In: Report to the Congress: Medicare and the Health Care Delivery System. Washington, DC; 2012. http://www.medpac.gov/docs/default-source/reports/chapter-5-serving-rural-medicare-beneficiaries-june-2012-report-.pdf. Accessed April 25, 2018.
3. Chan L, Hart LG, Goodman DC. Geographic Access to Health Care for Rural Medicare Beneficiaries. J Rural Heal. 2006;22(2):140-146. doi:10.1111/j.1748-0361.2006.00022.x
4. O'Connor H, Henning-Smith C, Casey M, Moscovice I. Differences in Part D Plans Offered to Rural and Urban Medicare Beneficiares. Minneapolis, MN: University of Minnesota Rural Health Research Center; 2015. http://rhrc.umn.edu/2015/07/part-d-differences/.
5. Henning-Smith C, O'Connor H, Casey M, Moscovice I. Rural-Urban Differences in Satisfaction with Medicare Part D: Implications for Policy. J Aging Soc Policy. 2016;28(2):65-80. doi:10.1080/08959420.2016.1139421
6. MacDowell M, Glasser M, Fitts M, Nielsen K, Hunsaker M. A national view of rural health workforce issues in the USA. Rural Remote Health. 2010;10(3):1531. doi:1531 [pii]
7. Rural Health Information Hub. Disability in Rural Areas - RHIhub Toolkit. https://www.ruralhealthinfo.org/community-health/disabilities/1/rural-prevalence. Published 2017. Accessed April 7, 2017.
8. USDA. USDA ERS - Income. https://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/income/. Published 2016. Accessed April 11, 2017.
9. Pourat N, Rice T, Kominski G, Snyder RE. Socioeconomic Differences In Medicare Supplemental Coverage. Health Aff. 2000;19(5):186-196. doi:10.1377/hlthaff.19.5.186
10. Henning-Smith C, Hernandez AM, Neprash H, Lahr M. Measuring Access to Care in National Surveys: Implications for Rural Health. Minneapolis, MN; 2019. https://3pea7g1qp8f3t9ooe3z3npx1-wpengine.netdna-ssl.com/wp-content/uploads/2019/06/UMN-policy-brief-Measuring-Access_6.26_2.pdf.
11. Henning-Smith C, Evenson A, Corbett A, Kozhimannil K, Moscovice I. Rural Transportation: Challenges and Opportunities | The University of Minnesota Rural Health Research Center. Minneapolis, MN; 2018. https://rhrc.umn.edu/publication/rural-transportation-challenges-and-opportunities/. Accessed January 28, 2019.
12. Taber JM, Leyva B, Persoskie A. Why do People Avoid Medical Care? A Qualitative Study Using National Data. J Gen Intern Med. 2015;30(3):290-297. doi:10.1007/s11606-014-3089-1

RHRC
Rural Health Research & Policy Centers
Funded by the Federal Office of Rural Health Policy
www.ruralhealthresearch.org

Support for this study was provided by the Federal Office of Rural Health Policy, Health Resources and Services Administration, Cooperative Agreement U1CRH03717-13-00. The information, conclusions, and opinions expressed are those of the authors, and no endorsement by FORHP, HRSA, or HHS is intended or should be inferred.

For more information, contact Carrie Henning-Smith (henn0329@umn.edu)

University of Minnesota Rural Health Research Center
Division of Health Policy and Management, School of Public Health,
2221 University Avenue SE, #350 Minneapolis, MN, 55414