

Access to Health Care by Rurality and Disability Status

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Key Findings

- Compared to adults without disabilities, adults with disabilities were more likely to report barriers to accessing health care, among nine of 11 barriers examined, regardless of location.
- Some access barriers were more likely to be reported by urban residents compared to rural residents. Compared to rural residents without disabilities, urban residents without disabilities were more likely to report five out of the 11 barriers, and urban residents with disabilities were more likely to report two of the 11 barriers compared to rural residents with disabilities.
- Among non-financial barriers, over 11% of rural people with disabilities and over 15% of urban people with disabilities delayed care due to appointment availability, and almost 16% of rural people with disabilities and 14% of urban people with disabilities delayed care due to lack of transportation.
- Among financial barriers, over 12% of both rural and urban people with disabilities delayed care due to cost and reported not being able to afford needed prescription medication.
- Approximately 18% of rural and urban people without disabilities and over 26% of rural and urban people with disabilities delayed dental care due to cost.

Purpose

Access to health care is important for health and well-being; however, both rural residents and people with disabilities experience unique barriers to accessing care. Further, less is known about access barriers at the intersection of rurality and disability status. In this policy brief, we examine rates of non-financial and financial access to care barriers by rural-urban location and disability status.

Background and Policy Context

Access to health care is important for supporting good health outcomes. Access can involve both financial as well as non-financial components of care relating to provider or facility availability, accommodation, affordability, acceptability, and accessibility (distance/travel time);¹ challenges in any of those areas can present barriers to getting care. Challenges in access to care are important to understand as a component of addressing differences in health outcomes.

Access to care may vary by sociodemographic groups.² Rural residents have poorer health outcomes than urban residents, including higher rates of underlying health problems and chronic conditions, and higher risk of the leading causes of death.³⁻⁵ Rural residents also face unique health care access barriers, including limited public transportation, longer driving distances to medical facilities, shortages of medical providers, and facility closures.⁶⁻⁸ In addition, people with disabilities face challenges with finding accessible transportation, barriers in access to quality care, as well as increased financial burdens.⁹⁻¹¹ Access to care is especially important to examine at the intersections of these groups as overall rates of disability are higher in rural areas,^{12,13} making better access to health care for people with disabilities one way to promote improved health outcomes in rural areas.

Although access to care is a population health concern, there is less research on how access varies at the intersection of rurality and disability status. This policy brief

examines various financial and non-financial barriers to health care access among rural and urban individuals by disability status.

Approach

We used data from the 2022 National Health Interview Survey (NHIS), a nationally representative survey of the civilian, non-institutionalized U.S. population, accessed through IPUMS Health Surveys.¹⁴ The sample includes all adults age 18 and older who had complete information on the disability status measure defined below (N=27,647).

We examined access to health care through several individual variables that we grouped as non-financial and financial barriers to care. Non-financial access barriers were those responding ‘yes’ to a delay in care, or not getting medical care due to any of the following: hours the facility is open, insurance acceptance, appointment availability, length of travel time to the facility, respondent’s busy schedule, or lack of transportation. Respondents could select any number of barriers that applied. We also included a variable examining whether the respondent did not have a usual place for medical care as a non-financial barrier. Financial access barriers were defined as delaying the following in the past year due to cost: medical care, mental health care, or dental care; again, respondents could choose all that applied. We additionally included a measure of respondents not getting needed prescription medication because they could not afford them.

Disability status was measured in the NHIS using the Washington Group Short Set Composite Disability Indicator,¹⁵ where respondents are defined as having a disability if they report having “a lot of difficulty” or “cannot do at all” any of the following: remembering or concentrating, washing or dressing, communicating in usual language, walking or climbing steps, hearing, or vision. We acknowledge this measure likely underestimates the size of the population with disabilities as it focuses on the two highest severity categories of difficulty of the ordinal scale instead of “any” difficulty (which would include those reporting “some” difficulty as well).¹⁶

Rural residency was defined using the 2013 NCHS Urban-Rural Classification Scheme with all non-met-

ropolitan counties categorized as rural.¹⁷ Overall, 78.7% (n=21,092) of the sample was comprised of urban individuals without a disability, 7.5% (n=2,245) was urban individuals with a disability, 12.0% (n=3,679) were rural residents without a disability, and 1.8% (n=631) were rural individuals with a disability. A higher proportion of rural residents (13.0%) had a disability compared to urban residents (8.7%, $p<0.001$).

We used chi-square tests to determine statistically significant differences in access to care between rural and urban adults by disability status overall as well as t-tests of differences in proportions between each subgroup. We used Stata 18 and employed survey weights to account for the complex sample design and to generate nationally representative estimates.

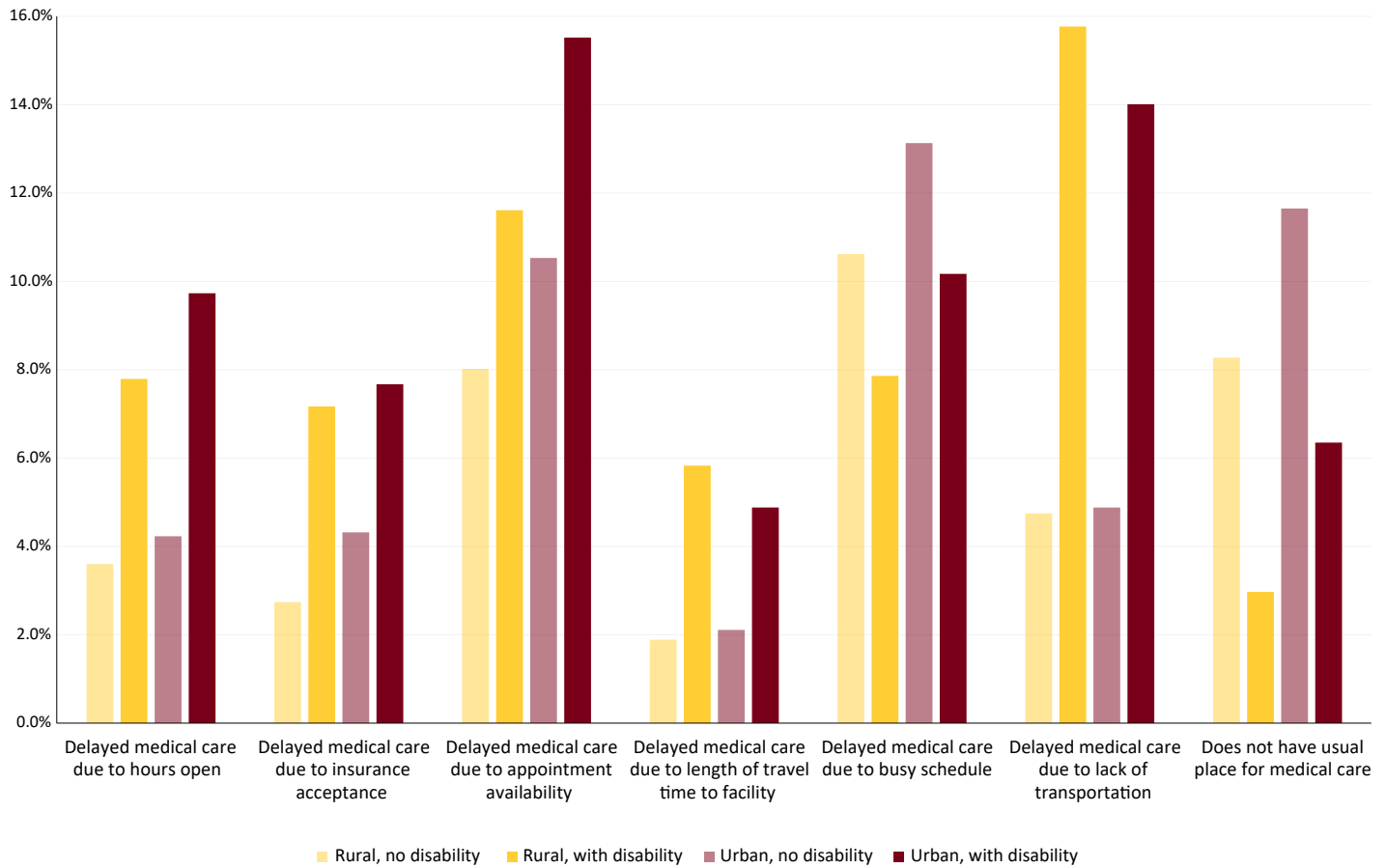
Results

Non-financial Barriers

Figure 1 shows the seven non-financial access to care barriers by rurality and disability status. Both rural and urban residents with disabilities had similar and higher proportions reporting they delay medical care due to the hours a facility is open (7.8% and 9.7% respectively) compared to rural and urban residents without disabilities (3.6% and 4.2%). Rural and urban residents with disabilities were the most likely to report delaying medical care due to insurance acceptance (7.2% and 7.7%), followed by urban residents without disabilities (4.3%), and rural residents without disabilities (2.7%). Urban people with disabilities were the most likely to report delaying medical care due to appointment availability (15.5%), followed by rural people with disabilities and urban people without disabilities at similar proportions (11.6% and 10.5%), and rural people without disabilities (8.2%). Both rural and urban residents with disabilities reported delaying medical care due to length of travel time to a facility at similar and higher rates (5.8% and 4.8%) compared to the similar rates of rural and urban residents without disabilities (1.9% and 2.1%). All reported differences were statistically significant at $p<.05$.

Urban residents without disabilities were the most likely to report delaying medical care due to their busy schedule (13.1%) followed by similar rates among rural

Figure 1. Non-financial Access to Care Barriers by Rurality and Disability Status



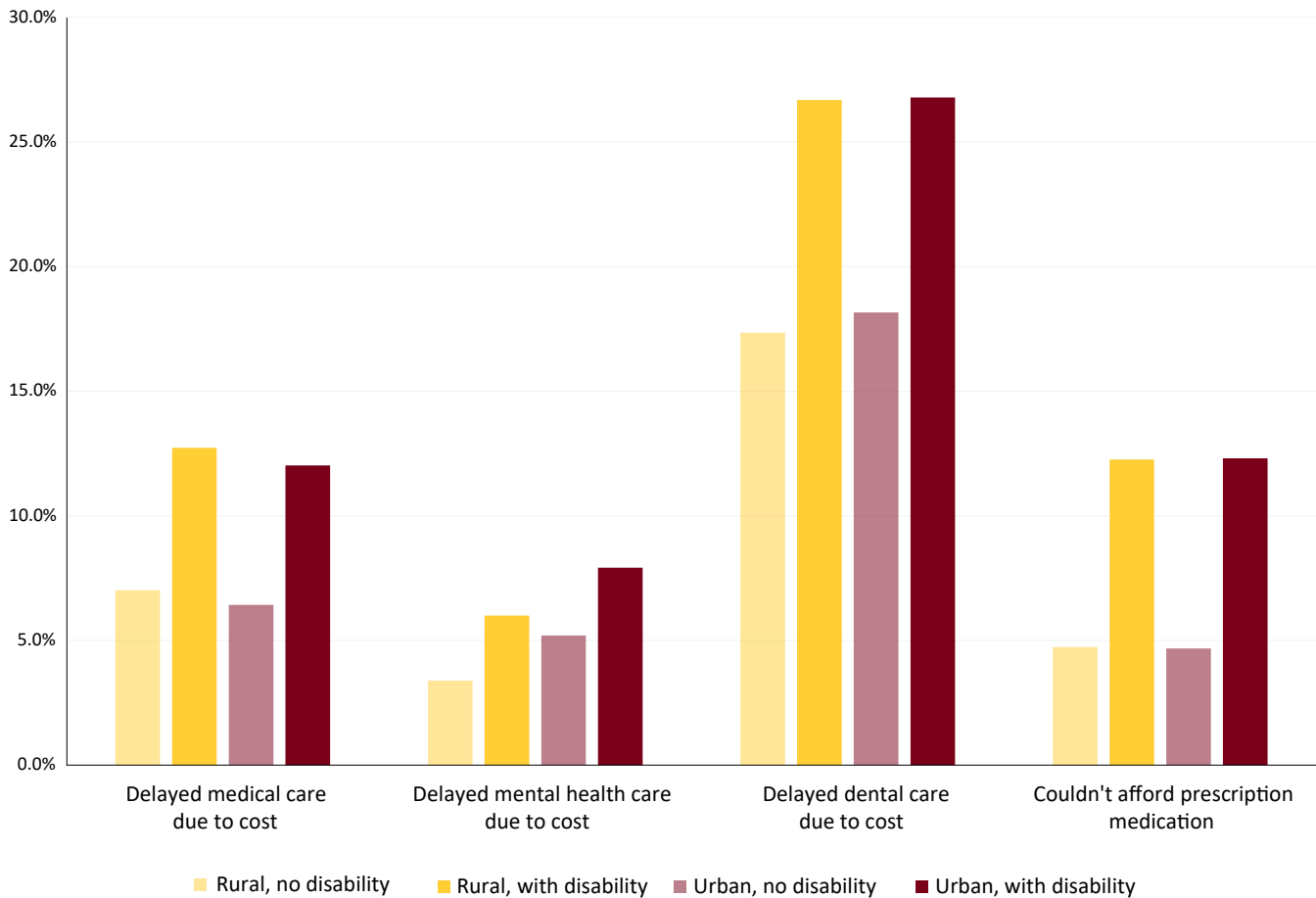
residents without disabilities (10.6%), urban residents with disabilities (10.1%), and rural residents with disabilities (7.9%). Both rural and urban residents with disabilities had similar and higher proportions of reporting delaying medical care due to lack of transportation (15.8% and 14.0%) compared to similar rates among rural and urban residents without disabilities (4.8% and 4.9%). Of those reporting not having a usual place for medical care, urban individuals without disabilities had the highest rates at 11.7% followed by rural individuals without disabilities (8.3%), urban individuals with disabilities (6.4%), and rural individuals with disabilities (3.0%). All reported differences were statistically significant at $p < .05$.

Financial Barriers

Figure 2 shows the four financial access to care barriers by rurality and disability status. Both rural and urban residents with disabilities had similar and

higher proportions reporting delaying medical care due to cost (12.7% and 12.0%) compared to rural and urban residents without a disability (7.0% and 6.4%). Both rural and urban residents with disabilities also had similar and higher proportions reporting delaying mental health care due to cost (6.0% and 7.9%) in comparison to the similar proportion of rural and urban residents without disabilities reporting this barrier (3.4% and 5.2%). Higher rates of both rural and urban individuals with disabilities reported delaying dental care due to cost (26.7% and 26.8%) followed by urban individuals without disabilities (18.2%), and rural individuals without disabilities (17.4%). Both rural and urban residents with disabilities reported higher and similar rates of not being able to afford prescription medication (both 12.3%) compared to rural and urban residents without disabilities (both 4.7%). All reported differences were statistically significant at $p < .05$.

Figure 2. Financial Access to Care Barriers by Rurality and Disability Status



Discussion and Implications

Overall, we find differences in both financial and non-financial access to health care among people with disabilities compared to people without disabilities, regardless of location. This means that, for the majority of the individual access barriers that we examined, we were more likely to find differences between people with and without disabilities rather than between rural and urban residents. But we found some exceptions with urban residents being more likely to report access barriers. These include urban residents without disabilities being more likely than rural residents without disabilities to report delaying care due to insurance acceptance, appointment availability, schedule conflicts, not having a usual place for medical care, and delaying dental care due to cost. In addition, urban residents with disabilities were more likely to report delaying care due to appointment availability and not having a

usual place for medical care compared to rural residents with disabilities.

The most commonly reported non-financial barriers overall were delaying care due to appointment availability, having a busy schedule, and due to lack of transportation. We found that over 11% of rural people with disabilities and over 15% of urban people with disabilities delayed care due to appointment availability, and almost 16% of rural people with disabilities and 14% of urban people with disabilities delayed care due to lack of transportation. Among financial barriers, over 12% of both rural and urban people with disabilities delay care due to cost and report not being able to afford needed prescription medication. In addition, approximately 18% of rural and urban people without disabilities and over 26% of rural and urban people with disabilities delayed dental care due to cost.

These findings have considerations for public

policy. Many individuals with disabilities have limited incomes, which likely impacts each of these access barriers and which requires addition to employment and income benefit policies to ensure that they are adequate to meet individuals' basic needs. It would be helpful for policies to reflect accessibility needs for people with disabilities that are tailored to location-specific needs. Our results show that transportation and travel time are more common among those with disabilities regardless of location, highlighting a need for accessible clinics/facilities close to where people with disabilities live and with expanded public or medical transportation options available. Expanded telehealth use could potentially meet some of these gaps. During the COVID-19 pandemic, the U.S. Department of Health and Human Services temporarily allowed Medicare to cover phone and video telehealth visits in both rural and urban areas and with a wider variety of clinicians.¹⁸ We acknowledge that telehealth cannot completely replace in-person specialty care, which people with disabilities are more likely to require due to having increased risk of medically complex conditions.^{19,20}

Financial access differences between those with and without disabilities were particularly evident in delaying dental care and delaying prescriptions due to cost, where delays were approximately 8 to 9 percentage points higher among those with disabilities. These results highlight the possibility of more expansive insurance coverage, especially to include and reduce out-of-pocket spending for dental and prescription costs. For instance, Medicare does not cover routine dental care.²¹ And although state Medicaid programs are required to cover dental services for those under 21 years old, services for adults are optional and vary by state.²² For instance, three states provide no adult dental coverage and eight more provide only emergency dental services. Thirty-nine states and the District of Columbia provide various levels of coverage beyond emergency dental services.²² Delaying or forgoing dental care could impact overall health and well-being as dental visits can serve as preventative care as well as screen for other disease or health concerns that manifest orally, and periodontal disease has been linked to health conditions such as heart disease, diabetes, and pregnancy outcomes.²³

Additionally, our findings that appointment availability and lack of facility operating hours were more commonly reported by those with disabilities highlight a need for expanded facility capacity, including longer hours. Increasing operating hours to evenings and weekends may reduce challenges for people with disabilities (and their potential caregivers) who are unable to take time off work or other responsibilities during the day.

Conclusion

This brief highlights both financial and non-financial barriers in access to health care by rural-urban location and disability status. Our findings show that attention could address access barriers among people with disabilities, regardless of location. However, such attention could account for the unique context of rural and urban settings. Policies to improve access to care could be directed to serve the needs of people with disabilities and tailored to both rural and urban contexts to promote improved population health

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