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Healthcare eligibility and availability and healthcare reform: Are we addressing rural women's barriers to accessing care?

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Abstract

Background—Rural populations in the US face numerous barriers to healthcare access. The Patient Protection and Affordable Care Act (PPACA) was developed in part to reduce healthcare access barriers. We report rural women's access barriers and the PPACA elements that address these barriers as well as potential gaps.

Methods—For this qualitative study, we analyzed two datasets using a common framework. We used content analysis to understand rural, focus group participants' access barriers prior to PPACA implementation. Subsequently, we analyzed the PPACA text.

Results—Participants described healthcare access barriers in two domains: availability and eligibility. The PPACA proposes solutions within each domain, including healthcare workforce training, Medicaid expansion, and employer-based health care provisions. However, in rural settings, access barriers likely persist.

Discussion—While elements of the PPACA address some healthcare access barriers, additional research and policy development are needed to comprehensively and equitably address persistent access barriers for rural women.

Keywords

Health care reform; health services accessibility; rural communities; Affordable Care Act; Women

The implementation of the Patient Protection and Affordable Care Act of 2010 (PPACA) initiated a dramatic change in the healthcare insurance landscape in the US.¹ The PPACA was developed with the intention of expanding healthcare coverage and access—a reform that was much needed and previously attempted within the US.² Solutions resulting from this law may not, however, have responded to the voices of all constituents experiencing the burden of limited healthcare access and use. This may be particularly the case for rural individuals, who experience disproportionate health problems and outcomes relative to urban counterparts.^{3,4} To provide preliminary evidence toward this hypothesis, we conducted a novel qualitative analysis of rural women's healthcare access prior to PPACA implementation using focus group data and PPACA content.

We frame our analysis based on four domains of healthcare access defined by Norris and Aiken: availability, eligibility, amenability, and compatibility.⁵ *Availability* refers to the geographic proximity of providers and facilities in relation to an individual, as well as personal convenience related to accessing care. *Eligibility* relates to the economic qualifications, primarily income, of the health consumer relative to the eligibility criteria, namely insurance coverage, of the service agency; however, our definition expands eligibility to include additional characteristics related to qualifying for health care coverage, such as age, employment, disability status, gender, pregnancy/parenting status, and immigration status, as well as affordability of insurance coverage. *Amenability* refers to individuals' knowledge of available care, benefits, and services, willingness to use available services, and knowledge of personal health status and needs. *Compatibility* relates to the provision of culturally competent and sensitive care that is responsive to a patient's values (e.g., religious) and preferences (e.g., shared decision-making practices).

The PPACA was developed to address all four of these domains.¹ For example, regarding availability, initiatives were developed to support the healthcare workforce. Regarding eligibility, the formation of health insurance “exchanges” established a mechanism for individuals to purchase health insurance from private insurers, and to obtain income-based cost assistance to improve affordability. Regarding amenability, health insurance “navigators” were made available to assist with health insurance enrollment. Regarding compatibility, healthcare workforce initiatives included promotion of a diverse workforce and cultural competence training for providers.

Research prior to the passage of the PPACA has demonstrated the healthcare access challenges faced by rural populations in relation to each of these domains. For example, availability has been limited by the distribution of hospitals, primary and specialty physicians, and other healthcare providers in rural areas as compared to metropolitan areas.^{6–9} The dearth of providers has contributed to transportation challenges associated with accessing care.^{10–12} Often for economic reasons, rural residents also faced eligibility challenges. They reported higher rates of uninsured than urban residents, particularly among nonelderly persons with incomes less than 200% of the federal poverty level.⁸ In small rural

counties not adjacent to urban areas, residents had lower rates of employer-based coverage than in urban areas.^{13,14} Lower rates of employer-based coverage were a result of higher rates of either self-employment, and among those who were not self-employed, higher rates of not being offered coverage through an employer due to part-time employment or working for a small employer that does not offer insurance to employees.¹³ Rural areas also had higher rates of underinsurance compared to urban areas.¹⁵ This less comprehensive coverage was in part due to poor coverage quality offered by small employers in rural areas. Amenability also affected rural healthcare access; compared to metropolitan residence, rural residence was significantly associated with healthcare avoidance when individuals suspect they should visit a provider.¹⁶ Regarding compatibility, disabled individuals, immigrant populations, and HIV positive individuals faced challenges in finding providers that understood their needs, often due the limited numbers of local providers.^{17–19} However, prior research is often either epidemiological research that does not consider the context and experiences of participants, or it is specific to particular health diagnoses or outcomes and does not consider the experiences of those who may not regularly access regular healthcare for chronic health conditions or routine preventive care.

Research on rural healthcare access since PPACA implementation is limited, but preliminary studies suggest ongoing access challenges in both healthcare availability and eligibility in rural settings. Regarding availability, one PPACA mechanism is the establishment of Accountable Care Organizations (ACOs). ACOs are groups of healthcare providers and healthcare agencies that voluntarily work together to provide coordinated care to Medicare patients—particularly those with chronic illness—for the purpose of improving quality of care (e.g., avoiding service duplication, preventing medical errors), reducing healthcare spending, and improving population health.^{20,21} ACOs can contribute to availability by improving timely access to primary and specialty care via improved coordination of care;²² however, early research suggests that rural clinics are less likely to be part of ACOs.²³ Regarding eligibility, post-PPACA implementation data indicate rural counties have 32% fewer insurance issuers and 20% fewer plans as compared to urban counties, and available insurance plan premiums for rural populations tend to be more expensive.²⁴ Such differences may underlie disparities in coverage, wherein residents of large metropolitan areas are more likely to be enrolled in the health insurance marketplaces created through the PPACA as compared to residents of non-metropolitan and rural areas.^{25,26} However, additional research is needed to understand the impacts of the PPACA on rural healthcare access.

The current study addresses these issues via an innovative analysis of constituent voices and policy. We first identify healthcare access issues described by women living in a rural community prior to PPACA implementation. Second, we report elements of the PPACA that would have addressed such barriers to assess the extent to which rural populations' experiences were represented in law. Finally, we discuss potential gaps in the PPACA that may contribute to persistent access to care barriers in rural populations. We hypothesized that the PPACA would be insufficient to address all of the barriers to accessing health care as perceived by the rural women in our study population.

I Methods

Accessed Data

The current study accessed two data sources: 1) transcripts from focus groups that were conducted with rural women in the southernmost seven counties of Illinois prior to PPACA implementation and 2) PPACA text.

Focus group setting and data—This research describes the analysis of focus groups that were one component of a comprehensive community health assessment focused on women's health in the rural, southernmost seven (S7) counties of Illinois. In 2011, the estimated S7 population was 65,073 over approximately 2,000 square miles.²⁷ The estimated poverty rate across the S7 counties was 18.7% compared to 13.1% in Illinois overall. According to the Behavioral Risk Factor Surveillance System survey, in 2010, 81% of S7 residents reported having health care coverage of any type compared with 86% in Illinois overall.²⁸ Additionally, 18% of residents reported foregoing health care in the previous 12 months due to cost compared with 13% in Illinois. According to the 2013 Rural-Urban Continuum Codes, which classify counties as metropolitan or non-metropolitan by degree of urbanization based on population size and proximity to an urban area, six of the S7 counties were considered nonmetropolitan.²⁹ The University of Illinois at Chicago Institutional Review Board approved the research.

Focus groups with rural, S7 women were conducted to help identify, understand, and prioritize community health needs from the perspectives of women. A full description of focus group recruitment and implementation is described elsewhere.³⁰ Briefly, in February and March 2011, researchers and community partners collaborated to conduct 14 focus groups (n=110 participants) with community women from across the S7 counties (Table 1). Participants were recruited using flyers in community locations, announcements in community and church newsletters, and newspaper advertisements, with the goal of recruiting a broad range of women with regard to age, race, community of residence, and socioeconomic status. Focus groups were held in community locations such as health centers and churches. Focus groups were conducted by trained facilitators who used an eight-question, semi-structured focus group guide to elicit perspectives on multiple topics. The questions pertaining to this analysis included "What does health mean to you?," "What do you think are important characteristics or features of a healthy community?," "What do you think are the most significant health needs or health problems in your community?," and "Does everyone in your community have access to health care services that they need? If not, which groups do not have access and why?"

PPACA text—The certified full text of the PPACA was downloaded from the web.¹ The primary objective of accessing this document was for the current study, wherein solutions from the PPACA would be compared with constituents' perspectives represented in the focus group data.

Data Analysis

Our data analysis approach relied on a method of content analysis in which the voices of research participants were integrated with policy analysis, with the aim of understanding the context in which policy change occurs and to understand policy implementation in consideration of pre-existing constituent needs.³¹ To accomplish this goal, we adapted a previously developed codebook,³² and used it to both code and analyze the focus groups and PPACA text. The codebook was developed by two researchers (LC, KZ) using inductive content analysis to identify and examine patterns and themes in the data. We next adapted our codebook using a largely deductive approach focused on the four healthcare access domains of availability, eligibility, amenability, and compatibility.^{5,33}

For this analysis, our foci concerned identification of 1) issues that were specific to or highly prevalent within rural settings from the focus group data based on the healthcare access domains; and 2) solutions within PPACA text that could be used to resolve these issues. We used ATLAS.ti, version 7 qualitative data analysis software (Scientific Software Development GmbH, Berlin, Germany) to achieve this goal. First, two authors (KZ, LC) independently analyzed the focus group data to identify representative text pertaining to the four healthcare access domains. The researchers met multiple times to share notes, identify relevant emergent patterns and discuss interpretations, including areas of disagreement, and to reach consensus. Specifically, they examined healthcare access and healthcare insurance access, the role of the environment (i.e., physical, economic), and demographic factors (i.e., age, marital status, socioeconomic status, gender). They concluded with a list of unmet healthcare access needs and contributing factors identified by rural participants. Second, two authors (KZ, EP) independently analyzed the PPACA document, guided by this list. Text was coded if information concerned a policy solution related to at least one topic on the list. These authors met regularly to review coding strategies, maintain inter-rater reliability, share notes, and discuss interpretations, including areas of disagreement, and to reach consensus. Once coding was complete, the author team as a whole met to discuss and synthesize emergent patterns across data sources.

II Results

Emergent themes largely focused on two healthcare access domains of availability and eligibility. Participants typically discussed amenability in conjunction with availability (i.e., expressing a willingness to use services *if they were available*). Thus, we do not describe amenability as a separate category. Compatibility was not a common theme in the focus group data. We describe the results of pre-PPACA healthcare access needs of rural participants according to these two domains, followed by the components of the PPACA that address these needs, and finally specific needs that may persist for rural populations in the era of PPACA implementation.

Availability in Rural Settings: “We just don’t have much like you have in the larger cities”

Rural Voices Pre-PPACA—Similar to previous research cited above, major availability issues in rural settings were reported and largely discussed as an insufficient number of healthcare providers—particularly specialty providers—and a lack of healthcare systems

that are within a feasible geographic proximity to individuals. Indeed, some respondents noted the need to travel significant distances, using mass transit, and even crossing state lines to obtain healthcare:

Participant 1: Like we don't have any OB/GYN doctors here at all.

Moderator: Okay, so where is the closest one?

Participant 2: Mine's in Herrin...and I'm sure Marion has a lot...

Participant 3: The farther away it is, the less likely you are to go, just because you don't feel like making the trip.

(Johnson County Group A)

[Note: Herrin, IL and Marion IL are approximately 30 miles and 25 miles from Johnson County, respectively.]

Participant 1: ...You have to go sometimes three hours to St. Louis.

Participant 2: ...for them to get to go... 'cause they don't have a vehicle of their own, they have to get the Rides Bus. And you have to schedule that, you know, days in advance... I just think we need more specialists here for, for the community that does need those things.

(Pope/Hardin County Group C)

The lack of nearby healthcare providers and the need to travel to healthcare appointments contributes to the associated costs of accessing care, such as the need for a vehicle and money to purchase gasoline:

I think a lot of it's money. They don't have the money where they don't buy [their medications], or they don't have money to put gas in the car so they don't go to their tests ... (Pope/Hardin County Group A)

...that all works back to gas prices, if people can't come for their appointment...if they can't pay for gas to get to their appointments. (Massac County Group A)

Others were concerned not only about availability to healthcare providers, but specifically their ability to access consistent, high-quality care across large geographic areas with small populations, as emphasized by these participants:

I think a good healthy community would have a good support system...good local healthcare where you don't have to drive 30 miles to find someone that you trust. Or that, you know, is gonna be there next week. Or there's the same face when you walk in the door as it was the last time you went there, it's not somebody new every other time. (Pulaski County Group B)

Well, it's a low, dispersed population... There's not enough people here to attract a specialist. They wouldn't be able to make enough money.... I wonder if they'd, like, be able to come once a month, or once a week or something like that, if that would do any good? (Pope/Hardin County Group C)

Others highlighted how geography not only disconnected patients from healthcare systems, but also resulted in a geographically separated and fragmented healthcare system, as exemplified by these respondents:

We need better emergency facilities... I was cut, and I had to wait a while before I could get an ambulance to take me to where I could get sewed up. (Alexander County Group C)

Participant 1: There are not enough doctors in this rural area, you know.

Participant 2: You're gonna be waiting... If your doctor says you need to go see this specialist, then I'm gonna warn you, it's gonna be 6–8 weeks and up to 6 months depending on his list.

(Johnson County Group A)

PPACA Solutions—The PPACA uses multiple mechanisms to address healthcare provider shortages and ensure high quality care providers in rural and medically underserved areas. First, to support existing healthcare systems and providers, temporary bonus payments were authorized for primary care providers and surgeons in medically underserved areas (Sec. 5501), and temporary adjustments were authorized for low-discharge hospitals in rural areas (Sec. 3125). Second, funding was allocated for state workforce development grants (Sec. 5102); loan programs for providers to work in medically underserved areas, including rural (e.g., 5203, 5205); and healthcare workforce training with the goal of increasing the number of health professionals who serve in rural areas (e.g., Sec. 10501). Finally, there are strategies that may increase inter-organizational coordination of care for rural populations, including ensuring Exchange plans have adequate provider networks (Sec. 1311), and grant funding to support community-based collaborative care networks designed to provide coordinated care to low-income populations (Sec. 10333).

Persistent Issues—Little in the PPACA discusses expansion of consistent, high-quality specialty care services in rural and medically underserved areas. Additionally, the PPACA does not discuss resources to enable the significant travel and transportation that is necessary to access healthcare in rural setting. Finally, while the PPACA supports programs to train a healthcare workforce for rural settings, retention of rural providers that are recruited to areas is not discussed.

Eligibility in Rural Settings: “Falling through the cracks”

Rural Voices Pre-PPACA—Eligibility issues in rural settings largely manifested as a complex interplay of concentrated poverty and sparse, geographically dispersed resources. For example, many participants emphasized the lack of job opportunities with healthcare coverage. They further noted that resources are often allocated to larger, more populated areas of the state and are not available for un- and underinsured individuals in rural settings:

There are people that have...low-paying jobs that don't have any insurance... I know somebody that needs her gall bladder out... She's working all her job will allow. And her job is one that only allows you to work part time so that they won't have to pay any benefits... It's a sociologic problem as well as a medical problem,

and I don't know how to solve it. I worry and I'm frustrated about it. And I have to wonder, why do they have to be insured to get healthcare? (Massac County Group B)

...the state of Illinois does not stop in Carbondale... When you have monies, you know, coming in from the government or whatever, and it looks like it just stops at Carbondale... You got the rest of the state here, you know, come on down...

Because there are people that are in need here. (Alexander County Group A)

Such barriers to traditional strategies to obtain healthcare coverage resulted in considering non-traditional methods to obtain coverage through governmental assistance programs, as illustrated by these participants:

And then to help my health, I need money for my healthcare. Because it seems to me, you can't—unless you have a child, you can't get help with your healthcare. You can't get a medical card. They want me to file disability. I don't want to file for disability. I want get better, and I want to work. (Massac County Group A)

And if you're single, you can't get any help unless you have a baby... You don't want to have a kid just to get [Medicaid]. (Alexander County Group A)

As a result of the lack of economic opportunities and limited healthcare safety net options, participants discussed having to choose between spending money on healthcare or medication and other necessities, such as food and utilities.

But as far as getting my medicine, go to the drugstore to get my medicine? \$40. Who's keeping \$40 and \$50 for some medicine? I'd rather go buy something to eat, please. (Alexander County Group B)

We've got people in here that can't afford to buy... medicine, and also the food. (Union County Group B)

Participants also acknowledged the persistent challenges that extant, often chronically under-resourced organizations may face, particularly if they have to rely on grant funding. The volatile nature of relying on government and grant funding to support healthcare services was viewed as problematic, as the services may go away when the budgets are cut or grants end. This is exemplified by participants who discussed the services at Rural Health, a local clinic that offers services to all regardless of ability to pay, followed by a mental health facility and the local health department:

It's a lot of work to get grants and it's hard to get grants [for sliding scale clinics], and that's how Rural Health is funded is a lot of grants. (Massac County Group A)

Pope County is the closest [mental health facility] and sometimes it's 4 or 5 weeks before you can get into an appointment, unless you're trying to kill yourself...The [budget] cuts mess with your funding; they don't have the workers' pay. (Pope/Hardin County Group B)

Well, funds were cut for like the health department, so people that were going there, where do they go now? (Pope/Hardin County Group C)

Some participants also discussed the passage of the PPACA, including their lack of trust that healthcare access would improve in their communities as a result of the legislation.

I was for single payer, Medicare for everyone... I see people every day that have terrible health problems—that have no resources and no way to get them. (Massac County Group B)

It takes everything that you have to pay for healthcare. That's why I don't understand why they [opponents of the PPACA] fought against the government control of healthcare. Because most of the physicians and the insurance companies are getting the bulk of the money, and that's the reason why healthcare is going up so much. Because it's out of control, and somebody do need to control it. I wish they would control it. Not in a bad way, but in a good way for people...the majority of the people. Now, the rich people can afford it. They can get any kind of healthcare that they want to. And the ones that's in government, they can get that government healthcare. But what about us? (Alexander County Group A)

PPACA Solutions—There are a number of solutions within the PPACA to increase eligibility for individual US citizens, including mandating coverage for all citizens and legal residents of the US (Sec. 1501); requiring insurers to accept everyone (Sec. 1201); enabling the uninsured to obtain health insurance through state-based health insurance exchanges (Sec. 1311); and for those with incomes between 100–400% of the Federal Poverty Level (FPL), offering health insurance on a sliding-fee scale based on income (Sec. 1401). Additionally, states have the option to expand Medicaid for those with incomes up to 133% (FPL) for children, pregnant women, and non-disabled adults both with and without dependent children. This expansion may ameliorate adverse consequences of using non-traditional methods to obtain such coverage. The PPACA further allows states to create a basic health plan for low-income, uninsured individuals at 133–200% FPL who do not qualify for Medicaid (Sec. 1331).

The PPACA also provides several potential policy solutions to increase communities' economic resources and capacity. Related to the adverse effects of sparse economic opportunities for healthcare coverage, the PPACA seeks to expand employer-based health insurance availability by incentivizing health insurance coverage for small businesses (25 employees) through tax credits (Sec. 1421) and enabling small businesses with up to 100 employees the ability to purchase insurance through state Exchanges (Sec. 1311). With regard to increasing the capacity of under-resourced organizations, the PPACA offers some interesting pilot and demonstration grant opportunities that may help to support low-volume providers in rural communities (e.g., Sec. 3123, Sec. 3126, and Sec. 4101).

Persistent Issues—Simultaneously, several eligibility barriers may persist. First, through the PPACA, the primary means by which individuals and families are expected to obtain insurance is through employers—a major issue, as described above, in rural settings. While the PPACA seeks to set limits on out-of-pocket costs for those with incomes up to 400% FPL (Sec. 1401), little text is devoted to ensuring out-of-pocket costs (e.g., deductibles, copayments) are affordable and manageable for low-income individuals. In addition, PPACA

solutions to capacity building at the community level are comparable to those pre-PPACA (i.e., temporal grant funding that requires sufficient infrastructure to be competitive).

III. Discussion

In this paper, we have integrated an analysis of focus groups with a sample of rural women and the text of the PPACA to identify the ways in which the PPACA proposes to address identified healthcare access challenges in rural populations. Based on our sample population—an example of a racially diverse and largely low-income women in the rural Midwestern US—our study indicates that, while availability and eligibility may have been foci in the PPACA, as a function of geography, economic factors, and small population size, rural populations may continue to face barriers to accessing consistent, quality, local healthcare.

Having a sufficient healthcare workforce is associated with better health outcomes and reduced mortality.³⁴ The PPACA proposes to increase availability by expanding the healthcare workforce, largely through recruitment and training of primary care providers; however, initiatives to retain providers in rural settings are lacking in the PPACA. Currently, healthcare providers are less likely to be recruited or retained in rural settings.^{6,35,36} Specifically, few training programs for medical providers take place in rural settings,³⁷ early-career providers may be dissuaded from practicing in settings where they do not wish to raise a family,^{6,36,38} and rural providers may be more likely to leave their practices due to dissatisfaction with their careers.³⁹ These challenges suggest that provider recruitment and retention efforts must extend beyond the healthcare environment through community-integrated efforts to support a rural healthcare workforce.⁴⁰

Because of the PPACA's focus on increasing primary care providers, barriers to specialty care access may also persist. The dearth of specialists may especially impact disadvantaged rural populations such as the elderly, chronically ill, and disabled individuals if they have difficulty accessing care.^{41,42} PPACA efforts such as ACOs are designed to improve coordination of care; however, due to lack of providers, ACOs development may lag in rural settings.²³ Healthcare access and coordination of care may be further strained by rural hospital closures, as 47 rural hospitals closed between 2010 and 2014, largely due to lack of financial sustainability and decreasing patient populations.⁴³ To mitigate these challenges, future programming and policy should promote creative solutions to improve availability of providers. These may include facilitating partnerships between rural providers and larger healthcare systems to create ACOs, in an effort to improve coordination of care and access to specialty care providers.⁴⁴ Other solutions include establishing mobile specialty provider programs, where rural healthcare sites that cannot support a full-time specialty provider collaborate with a visiting physician to provide space for specialty-care practice on a regular basis,⁴⁶ and implementing care through telehealth, where various technologies (e.g., phone, video, electronic transmission of diagnostic images) are used to provide health care, health information, or health education from a distance.⁴⁷

The PPACA expands eligibility to acquire health insurance, largely through optional state-based Medicaid expansion, incentivizing employer-based health insurance, and the establishment of state-based exchanges. However, as of 2015, 20 states had not expanded

Medicaid.²⁵ Evidence suggests lack of expansion may disproportionately impact rural populations.⁴⁸ Specifically, in 2014, when 24 states had not yet expanded Medicaid, nearly two-thirds of uninsured rural residents resided in these non-expansion states. Like pre-PPACA, employment remains a primary means by which non-elderly US residents obtain healthcare.⁴⁹ Thus, among rural residents, who are less likely to obtain employer-based health insurance for employment reasons including employer size, lower wages, and higher rates self-employment,¹³ coverage gaps may persist. Once the mandate for employer-based coverage is in full effect, further research is needed to understand whether employer-based coverage has increased in rural areas.

To meet the needs of those not covered by employer-based insurance, the PPACA implementation has allowed states to have autonomy over Medicaid expansion and health insurance exchange opportunities that allow individuals to purchase health insurance, which a choice of coverage levels and price points. For participating states, the PPACA provides cost assistance for those with incomes between 100% and 400% of the FPL¹—comprising approximately half of rural Americans compared to 43% of urban.⁴⁸ However, rural residents who must purchase insurance through the exchanges may still face challenges. Early data show that at a population level as rurality increases, health insurance exchange enrollment decreases;²⁶ however, reasons for these differences are still be explored. One explanation is the “coverage gap” in rural states that did not participate in Medicaid expansion.⁴⁸ These states are more likely to be rural, and low-income residents are unable to obtain cost assistance to purchase health insurance. Additionally, 2016 data indicates that rural residents enrolled in health insurance exchanges have fewer Marketplace options and they experience higher premiums than urban residents.⁵⁰ State-specific variation in PPACA implementation, as well as variations in state and local economies will likely contribute to uneven access to healthcare, with significant barriers among those who experience challenges in both availability and eligibility, such as low-income rural populations. Additional research is needed to understand how individual, community, and state-level factors together affect PPACA enrollment levels.

This study has a number of limitations. First, while the focus groups were conducted after the PPACA had been passed, they occurred prior to the implementation of most components of the PPACA. They were also conducted as part of a larger community health assessment, and access to healthcare was just one area explored in the focus groups. Thus, the focus groups did not ask participants about specific components of the PPACA, nor did perspectives of participants capture post-PPACA impressions of healthcare access. The study would have been improved with further probing around participants’ access to healthcare concerns, and by collecting personal health insurance status data from participants. While we do not have permission to conduct follow-up with the participants in this study, this research would also be enhanced with a follow-up study with women from the same rural community. Additionally, the focus groups were conducted with women in rural, southernmost Illinois who volunteered to attend the focus groups. Thus, the results may not be generalizable to all S7 women, or to other rural populations in the US, including Tribal and undocumented populations. Rural men may also have unique perspectives regarding healthcare access that may not be included in the data.

This study of rural women's perspectives on healthcare access highlights geographic availability and affordability as major barriers to accessing healthcare, which may be only partially addressed by elements of the PPACA, however further research is needed to adequately understand and address access to healthcare comprehensively and equitably in rural populations. Specifically, follow-up research is needed to understand whether rural women's perceptions of access have changed as a result of the PPACA, and which barriers to care persist. Additionally, the amenability domain was only discussed in relation to eligibility, but with the PPACA, insurance purchased through the exchanges offers an option for which everyone is eligible. Thus, further research is needed to assess whether persistent barriers affect willingness to purchase insurance through the exchange. Similarly, compatibility domain was not an emergent theme in our focus groups; further research should explore the extent to which compatibility is relevant for rural women's access to care. Further research is also needed to examine how primary, specialty, and allied healthcare availability in rural settings has changed since the implementation of the PPACA, including promising strategies demonstrating recruitment and retention success; and whether specific components of the PPACA targeting rural populations have been effective in increasing access to care.

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Abbreviations

ACO	Accountable Care Organization
FPL	Federal Poverty Level
PPACA	Patient Protection and Affordable Care Act of 2010
S7	Southernmost seven counties of Illinois

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Table 1

Focus Group Participant Characteristics (N=110)

Characteristic	n (%)
Race	
African-American	31 (28.2)
White	79 (71.8)
Ethnicity	
Hispanic	2 (1.8)
Age	
18–30	26 (23.6)
31–50	24 (21.8)
51–70	27 (24.6)
70+	33 (30.0)
County of Residence	
Alexander	27 (24.5)
Johnson	9 (8.2)
Massac	9 (8.2)
Pope/Hardin	31 (28.2)
Pulaski	18 (16.4)
Union	16 (14.5)