Becoming Less Usual:
Understanding the Decline in the Number of People with a Usual Source of Care

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Policy Points

- Managed care may represent a promising pathway for increasing the number of people with a usual source of care and helping to reduce racial/ethnic and wealth disparities.
- The benefits of having a usual source of care may result from greater engagement with the health care system and better relationships with providers.

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ABSTRACT

Having a usual source of care (USC) — a health professional or care location where one can go if sick or in need of medical advice — is a key component of achieving better health outcomes and having a more positive experience with the health care system. Using data from the nationally representative Health and Retirement Study (HRS), this study examines recent trends (2014-2020) in the use of a USC among those age 50 and older, with a focus on racial/ethnic disparities and other socio-demographic characteristics, including type of health insurance coverage. The analysis found that people with a USC tend to be wealthier, White, and generally healthier than those without a USC. Between 2014 and 2020 there has been a decline in the use of a USC across all groups except for those enrolled in managed care. Results showed that people tend to either gain or lose a USC with major life changes, and that being a person of color was associated with higher odds of losing a USC as were decreases in income. Finally, although individuals with a USC used more health care services overall, there was no evidence that they utilized high-cost hospital services more than those without a USC.

INTRODUCTION

A usual source of care (USC) is a medical provider or health care location (such as a doctor's office, clinic, or health center) that an individual will *usually* go to if they are sick or in need of guidance related to their health.[1] Having a routine and reliable care source can be particularly important in middle-age to older adulthood when the risk of illness and complexity of health care needs tend to increase. In fact, prior research has documented that having a USC is a key component of achieving not only better health outcomes among older adults, but also a more positive overall experience with the health care system.[2] Specifically, older adults who report having a USC are more likely to utilize preventative care, have fewer high-risk health measures (e.g., high blood sugar, high blood pressure, low kidney function, high inflammation, etc.), feel that their care preferences are being taken into account by their providers, and rate their health care as more satisfactory than older adults without a USC.[3,4] Further, older adults with a USC score significantly lower than their counterparts on the What Matters Index, a measure that predicts the likelihood of needing future costly medical care (the higher the score, the more likely the use of costly care).[3]

USC also plays a critical part in reducing health care disparities associated with racism and patient wealth in later life. People of color and those with lower wealth are more likely to be in poorer health and at higher risk of chronic conditions, less likely to utilize preventive care, and more likely to report that they don't feel listened to by their providers.[3] However, health outcomes and preventive care usage improve when these individuals have a USC. In addition, having a USC significantly diminishes the association between being a person of color and/or a person of lower wealth and reporting that your care preferences are not being taken into account.[3] Nevertheless, people of color and lower wealth are still far less likely than their White and wealthier counterparts to report having a USC. [2,3]

Despite its well-documented benefits, USC has generally declined over the last few years among all demographic groups. The Primary Care Collaborative's 2022 Evidence Report showed a 60% increase from 2014 to 2019 in the percentage of those 65 and older who reported *not having* a USC — from 5.9% to 9.7%.[5] Decreases in USC over time among people of color were particularly troubling since these individuals were less like to report a USC than their White counterparts initially. With primary care clinician shortages across the US and the growth in alternative options for routine care (e.g., urgent care, retail clinic, telehealth)[5], it is important to continue monitoring USC trends and impacts over time. In addition, there is a need for greater insight into the factors associated with gaining or losing a USC, such as the role of gaining or losing health insurance. Such information will enable a better understanding of how to facilitate the acquisition and maintenance of a USC.

This study used 2014 to 2020 panel data from the nationally representative Health and Retirement Study (HRS)[6] to examine the most recent trends in USC among those 50 and older, with a focus on racial/ethnic disparities and differences related to type of health insurance (i.e., managed care versus fee-for-service). This analysis also explored the impact of USC on health care utilization as well as identified the predictors of gaining or losing a USC over time.

STUDY FINDINGS

People with Usual Source of Care More Likely to Be Wealthier, White

In comparing the 2020 characteristics of those who reported having a USC to those who reported no USC (Table 1), the results were in line with findings in the existing research. Individuals who had a USC were wealthier (both in terms of income and net wealth), in better health, and more satisfied with their health care than those who did not have a USC. Notably, those with a USC reported more engagement with the health care system to address health care needs, resulting in higher utilization of certain services and leading to somewhat higher out-of-pocket medical costs. Racial/ethnic disparities were present such that non-Hispanic Black, non-Hispanic other, and Hispanic individuals were significantly less likely to have a USC than non-Hispanic Whites; Hispanics were the least likely to have a USC. Smokers were also less likely to have a USC. Those who were married and those age 65 and older were more likely to have a USC than their respective unmarried and younger counterparts. Those with Medicare and managed care (Medicare Advantage) were more likely to report having a USC than those with other types of insurance.

Table 1: 2020 Sample Characteristics by Usual Source of Care Status (USC)

2020 Sample Characteristics	Has USC (N=12,384)	No USC (N=2,776)	Total Sample (N=15,160)
Age (Mean)	68.7*	67.4*	68.5
50 to 64	40.2%*	49.1%*	41.7%
65 to 74	30.7%*	24.3%*	29.4%
75 to 84	21.1%*	17.7%*	20.6%
85+	8.0%*	8.9%*	8.3%
Sex			
Female	59.9%*	55.0%*	59.1%
Male	40.1%*	45.0%*	40.9%
Race/Ethnicity			
Non-Hispanic White	60.9%*	39.6%*	57.0%
Non-Hispanic Black	20.3%*	26.6%*	21.5%
Non-Hispanic Other	4.7%*	5.5%*	4.8%
Hispanic	14.1%*	28.3%*	16.7%
Education Years (Mean)	13.6	12.2	13.4
Marital Status			
Married/Partnered	55.5%*	44.2%*	52.9%
Widowed	17.8%*	20.8%*	18.8%
Divorced/Separated	19.9%*	23.8%*	20.7%
Never Married	6.8%*	11.2%*	7.6%
Financial Characteristics			
Household Income (Mean)	$82,867 *	$57,719 *	$78,262
$0 to $29,999	32.0%*	50.2%*	35.8%
$30,000 to $74,999K	33.9%*	28.7%*	32.8%
$75,000 and over	34.1%*	21.0%*	31.4%
Net Wealth Mean	$873,339*	$575,273 *	$818,791
Below Federal Poverty Level	10.8%*	21.6%*	13.0%
Receives Government Assistance Benefits	14.3%*	17.3%*	14.9%
Retired	53.2%*	45.2%*	51.5%
Out-of-Pocket Medical Expenditures (Mean)	$3,186 *	$2,617 *	$3,082

Health			
Self-rated Poor/Fair Health	27.1%*	35.2%*	28.7%
Depression	20.9%	23.7%	21.5%
Chronic Conditions (Mean)	2.5	2.7	2.6
Impaired Cognition	1.5%*	3.2%*	1.9%
Activities of Daily Living Limitations (ADLs)(Mean)	1.3	1.4	1.3
Instrumental Activities of Daily Living Limitations (IADLs)(Mean)	2.5	2.7	2.6
Body Mass Index (Mean)	29.0	28.9	29.0
Current Smoker	10.6%*	16.4%*	11.7%
Exercise Moderate/Vigorous more than once/week	69.5%*	62.9%*	68.1%
Healthcare Utilization			
Had a Hospital Stay (in last 2yrs)	22.2%	20.8%	21.8%
Number of Days in Hospital (if had a stay in last 2yrs)(Mean)	1.5	2.0	1.6
Had a Nursing Home Stay (last 2yrs)	2.6%	3.8%	2.9%
Number of Days in Nursing Home (if had a stay in last 2yrs)(Mean)	5.4*	14.5*	7.1
Number of Doctor Visits (in last 2yrs)(Mean)	8.9*	5.9*	8.3
Utilized Home Healthcare (in last 2yrs)	8.8%	7.9%	8.8%
Utilized Specialized Health Facility (in last 2yrs)	17.6%*	11.4%*	16.5%
Had Outpatient Surgery (in last 2yrs)	19.2%*	12.9%*	18.0%
Currently Taking Regular Prescription Drugs	86.0%*	70.2%*	83.2%
Health Insurance			
Medicare	53.4%*	39.4%*	50.1%
Medicaid	4.6%*	6.4%*	5.1%
Dual Eligible	7.7%*	12.5%*	8.6%
Veteran Health Plan	1.8%	1.2%	1.7%
Private Insurance	32.5%*	40.5%*	34.5%
Managed Care	52.0%*	48.2%*	51.3%
Fee-for-Service	48.0%*	51.8%*	48.7%

Census Region of Residence			
Northeast	16.1%*	14.7%*	15.7%
Midwest	20.6%	18.3%	20.4%
South	41.6%*	45.2%*	42.2%
West	21.6%	21.8%	21.7%
Health Care Satisfaction Rating			
Very Satisfied	55.0%*	44.1%*	53.0%
Somewhat Satisfied	29.7%	30.5%	29.8%
Neutral	11.0%*	18.0%*	12.3%
Somewhat Dissatisfied	3.0%	3.9%	3.2%
Very Dissatisfied	1.3%*	3.6%*	1.7%

* Significant t-test difference at $p < 0.05$ between usual source of care and no usual source of care groups.

Declines in Usual Source of Care Seen from 2014-2020 Except for Those with Managed Care

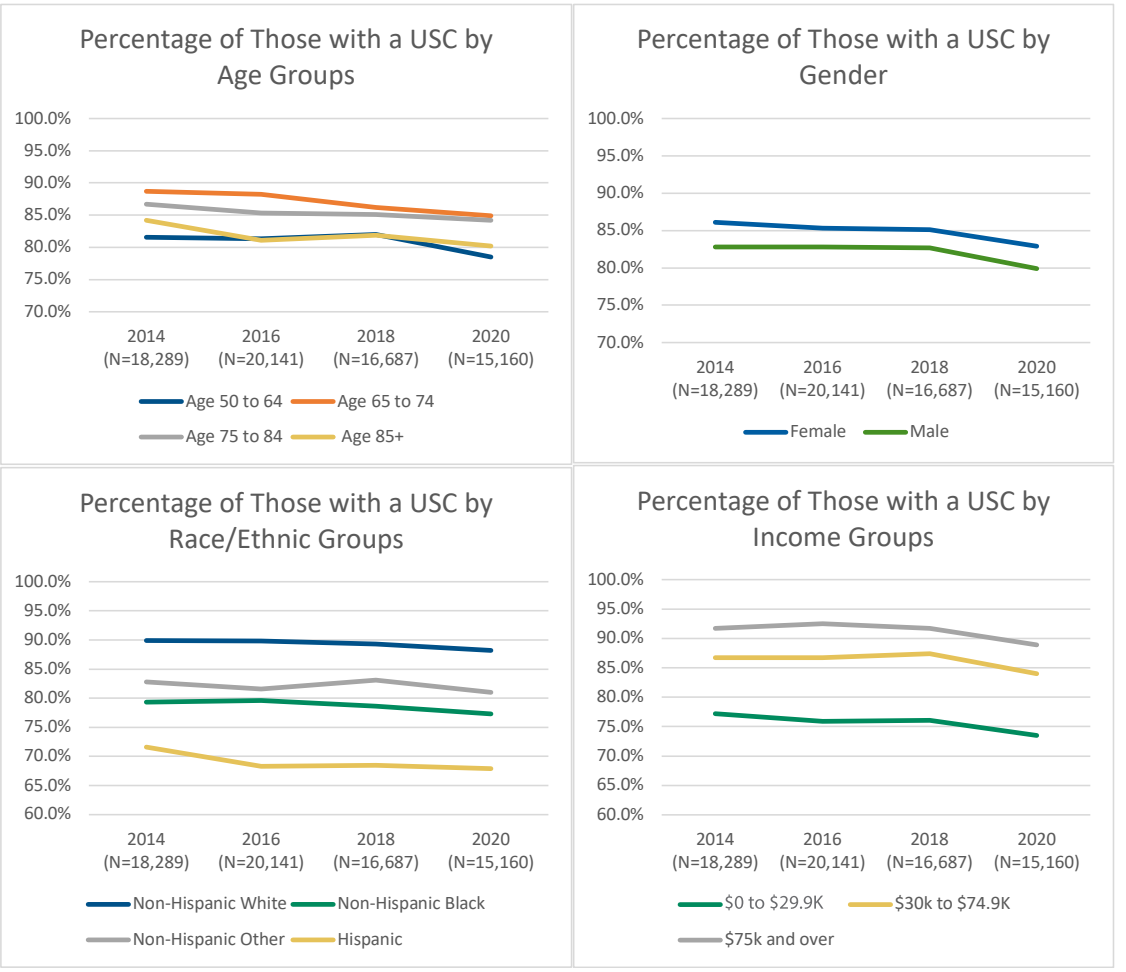
Trends between 2014 and 2020 showed that the percentage of those who reported having a USC decreased by 3 percentage points over the six-year study period from roughly 85% to 82% (Table 2). The period of greatest decline in USC — 76% of the total decline — occurred from 2018 to 2020 and indicates that the COVID-19 pandemic impacted USC status among middle-aged and older adults. In fact, the percentages of those who reported having a USC declined across all demographic groups over the study period, with the biggest decreases consistently observed between 2018 and 2020 (Figure 1). The largest declines in USC during the period were among those 85 and older (4 percentage point decline) and Hispanics (3.7 percentage point decline). In addition to the demographic groups shown in Figure 1, declines in USC were also noted regardless of health status and poverty status. The only exception to this trend of decreasing percentages of USC over time was among those who were enrolled in a managed care plan for health insurance. There was a slight-but-steady increase in the percentage of individuals reporting a USC (1.3 percentage point) for those with managed care plans from 2014 to 2020 despite the pandemic. Comparatively, there was a USC decrease of 2.8 percentage points among those enrolled in fee-for-service plans during the same time period.

Table 2: Usual Source of Care Status Among Those Age 50+ from 2014 to 2020

HRS Sample Age 50+	2014 (N=18,289)	2016 (N=20,141)	2018 (N=16,687)	2020 (N=15,160)
Has a Usual Source of Care	84.8%	84.3%	84.1%	81.8%
No Usual Source of Care	15.2%	15.7%	15.9%	18.2%

A further descriptive comparison of individuals who maintained, lost, gained, or never had a USC from 2014 to 2020 showed that the group of people that never had a USC over the study period was the worst off across all financial and health measures and mostly composed of people of color (with the highest composition being Hispanics). Conversely, the group that maintained a USC over the same period was substantially wealthier, in markedly better health with higher health care satisfaction, and was composed of over two-thirds non-Hispanic White individuals. Those who maintained a USC over time were also the most likely to be enrolled in a managed care plan. The demographic profiles of those who either gained or lost a USC during the study period looked remarkably similar, with their health and financial status falling in the middle-ground between individuals who maintained a USC or never had one. People aged 85 and older and those who were in slightly poorer health were more likely to gain a USC than lose one over the study period whereas people reporting depression were more likely to lose a USC than to gain one.

Figure 1: People Reporting a Usual Source of Care By Demographic Characteristic



Role of Race/Ethnicity, Managed Care, Key Life Changes

Consistent with the other study findings, being a person of color was associated with significantly higher odds of losing a USC as were decreases in income. Enrolling in managed care was associated with higher odds of gaining a USC whereas enrolling in fee-for-service was associated with greater odds of losing a USC. Further, as individuals got sicker and had more chronic conditions and limitations, their odds of acquiring a USC got higher. Key life changes also predicted whether a person lost or gained a USC. Job and health insurance changes were only associated with higher odds of gaining a USC; however, moving residences, becoming widowed, and becoming depressed predicted higher odds for both gaining and losing a USC. These findings suggest that there are opportunities, particularly during vulnerable times, for policymakers or insurers to provided support to ensure that individuals either maintain or connect with a usual source of care.

Higher Health Care Utilization Among Those with a Usual Source of Care

Controlling for demographics and health status, the analysis found that having a USC was significantly associated with higher use of specialized care facilities, outpatient surgery, prescription drugs, and greater doctor visits. Although USC status was not significantly related to having a hospital or nursing home stay, those with a USC spent significantly fewer nights in a hospital or nursing home when utilizing those services. Overall, the findings revealed higher health care utilization among those who reported having a USC compared to those with no USC; however, individuals with a USC were also generally in better health as reported above. The implication is that people are getting the care that they require and not utilizing more costly inpatient services, and that this is closely related to having a USC. Note that the current data do not allow for an analysis of overall costs so although utilization of these services is higher, we do not have a definitive sense of the relationship between having a USC and longitudinal health care costs.

DISCUSSION

Findings from this study contribute to the growing body of research showing that having a USC contributes to improved health outcomes and elevates patients' overall experience with the health care system, particularly as one ages. Individuals who have a USC are consistently in better health and more satisfied with their care,[2,3] but the percentage of those who report having a USC has been declining.[5] This is true across all demographic groups, but older adults age 85 and over as well as Hispanics have experienced the largest declines. Additionally, disparities stemming from systemic racism and wealth inequities are major factors in whether or not a person has a USC; White and wealthier individuals are far more likely to have a USC than are their people of color or those with less wealth. The exception to this trend is individuals enrolled in managed care, which underscores the role it is playing when it comes to USC. Managed care not only has higher and increasing percentages of those with a USC than

fee-for-service over time, but prior research has shown that managed care is also serving a more diverse population with fewer financial resources than fee-for-service.[3] Therefore, managed care may represent a promising pathway for increasing the share of people with a USC and serve an important role in helping to reduce racial/ethnic and wealth disparities in health care satisfaction, person-centeredness, and utilization. Of course, managed care plans also need to concern themselves with maintaining beneficiary choice and ensuring access to a range of provider options as well as establishing clear standards and performance measures to monitor the quality of care provided.

Although amplifying managed care plans and ensuring insurance providers simply check that beneficiaries have a USC may sound like an easy solution, the reality is more complex. Research shows that the benefits of having a USC come from both greater engagement with the health care system and from better relationships with providers.[2,3,4] Although those with a USC have higher health care utilization overall, they are also in better health and report feeling that their care preferences are taken into account by their providers more often than those with no USC.[2,3] In other words, those with a USC using more health care services are likely accessing physician services designed to prevent and cure health problems, promote maintenance of health and well-being, or provide information about health status and prognosis; there is no evidence that they utilize high-cost emergency department services and other inpatient services with greater frequency than those without a USC. The research implies that their health is better monitored with greater preventive care usage[4] and that they build more satisfactory relationships with their providers through this higher engagement with the system.[3] Thus, while promoting the importance of having a USC, it is critical to simultaneously encourage and support the reciprocal relationship between patients and providers that appears to be at the core of the benefits derived from having a USC. Those contracting with managed care plans need to assure that the proper incentives or processes are in place to do this.

The analysis in this study further identified potential windows of opportunity for the health care system and for those who administer health benefits to help individuals establish and maintain a USC. Specifically, life changes that many people experience over the life course, such as changes in physical and mental health, marital status, residence location, and jobs, are potentially vulnerable times when a USC may be lost or acquired. Providing better support and communication to patients during these life changes may be a key aspect of achieving greater and more stable USC usage over time. For example, having a protocol in place for the USC to reach out to a patient when a negative life change occurs may serve to strengthen the relationship and assure more continuity. While providers do not always know about such changes in life circumstances, when they do, making proactive communication may prevent loss of a USC. Or in the case of insurance change or loss, providing information about how to maintain a USC or what insurance options enable them to keep a USC can be helpful. Finally, as people encounter worsening health (usually as they get older), they are more likely to have

or acquire a USC, but they (and the health care system) will have likely paid an unnecessarily high price before a USC comes into the picture. Because the benefits of having a USC are not limited to those in poor health, it seems prudent to develop policy solutions that encourage younger adults to connect to a USC before their health deteriorates, when routine and preventative care can be most impactful in improving long-term health outcomes. This could include providing incentives such as reductions in copays or deductibles when longitudinal relationships are established and maintained, providing a bonus payment when a USC is gained and maintained, or waiving pre-authorization requirements for certain services. Of course, even in the presence of incentives, if there are workforce shortages of primary care physicians, for example, the positive access to health care services that results from having a USC will not occur. All of these benefits depend on having a workforce that is large enough for individuals to be able to obtain a USC.

FURTHER RESEARCH

While the analyses in this and other studies show the clear connection between having a USC and a variety of positive health outcomes, further research is needed to test whether having a USC actually costs the health system less, or whether the potential improvements in health status justify the potential added health system costs of a USC. A key question is whether access to more primary care through having a USC actually leads to reductions in more costly health care utilization (e.g. inpatient and emergency department use) so that on net, the policy goal of encouraging more use of a USC is supported through lower overall health system costs. If this turns out to be the case, then such research could be used as a basis for building a broader business and evidence base to inform the development of policy solutions for assuring that everyone has a USC throughout their adult life course.

HOW WE CONDUCTED THIS STUDY

This study first compared the most updated 2020 characteristics of HRS participants who reported having a USC with their counterparts with no USC (N= 15,160). Then data from the 2014 to 2020 waves of the HRS was used to observe patterns in USC over the six-year study period for all participants continuously, or up until the point of their death/non-participation in the study. Finally, regression modeling was employed using the HRS sample that participated continuously from 2014 to 2020 to examine the association between USC and health care utilization as well as to identify predictors of gaining or losing a USC while controlling for demographics and health status.

Methods

This study used data from the 2014 through 2020 waves of the Health and Retirement Study (HRS), a biennial, nationally representative longitudinal survey of community-dwelling adults (50 years and older) in the United States. Cross-wave weights provided by the HRS were applied for all analyses in order to account for any bias in sample selection and missing data. We first established the individuals who self-reported having a usual source of care (USC) for each wave (2014-2020). Having a USC was defined as those who responded yes to the following survey question: "Is there a place that you usually go to when you are sick or need advice about your health?" Based on a further follow-up question that asked what that USC place was, those who responded that their USC was an emergency room or urgent care were not considered as having a USC. Descriptive analysis was then utilized to compare the most updated 2020 characteristics of HRS participants who reported having a USC to their counterparts with no USC (N= 15,160). Between group t-tests were employed for bivariate analysis which tested for any significant differences in 2020 between participants who reported having a USC and those who reported no USC.

Next, data from the 2014 to 2020 waves of the HRS were examined to observe patterns in USC over the six-year study period for all participants continuously or up until the point of their death/non-participation in the study (2014 N= 18,289; 2016 N= 20,141; 2018 N= 16,687; 2020 N= 15,160). Specifically, we looked at the percentage of participants who reported having a USC in each wave by key subgroups: age, sex, race/ethnicity, income, poverty status, self-reported health status, and managed care versus fee-for-service insurance type (within the Medicare/Medicaid programs and/or as a private insurance type). A second descriptive and bivariate analysis (t-test) was then performed to compare the characteristic differences among the following groups from 2014 to 2020: participants who maintained a USC for the entire study period, participants who lost a USC during the study period, participants who gained a USC during the study period, participants who never had a USC during the entire study period.

Cross-sectional and longitudinal regression modeling was employed using the HRS sample that participated continuously from 2014 to 2020 (N=12,113) to explore the association between USC and health care utilization as well to identify predictors of gaining or losing a USC while controlling for demographics and health status. Cross-sectional logistic and ordinary least squares (OLS) regressions were used to analyze the association between having a USC and the following health care utilization measures (using the 2020 data): hospitalization (any stay and number of days of stay), nursing home usage (any stay and number of days of stay), special care facility usage, home care usage, number of doctor visits, outpatient surgery, and prescription drug usage. Controls in the cross-sectional models were as follows: age, sex, education years, household income, marital status, poverty status, retirement status, self-report health status (poor/fair versus excellent/good), chronic conditions count, cognitive impairment status, depression, ADLs count, IADLs count, managed care status, and census region of residence.

Longitudinal logistics regressions were performed which analyzed the associations between changes in characteristics from 2014 to 2020 on whether a person lost/gained a USC over the same period. The measured changes in characteristics examined in the models were as follows: marital status changes, retirement, job change, income increase/decrease, self-rated health change, chronic conditions change, ADLs change, IADLs change, cognitive impairment change, depression change, health insurance plan change (e.g. private to Medicare, Medicaid to Dual Eligible, etc.), switched to managed care, switched to fee-for-service, and moved residences. Demographic controls were as follows: age, sex, race/ethnicity, and education years.

NOTES

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ABOUT THE AUTHORS

Jane Tavares, PhD, is a senior research fellow at the LeadingAge LTSS Center @UMass Boston and an associate lecturer in the Department of Gerontology at the University of Massachusetts Boston. She has extensive experience working with large-scale representative panel data, such as the Health and Retirement Study. Her research explores how social relationships and social factors are associated with various aspects of health. More recently, Dr. Tavares has undertaken research examining social inequities in the US health care system related to person-centered care and eligibility/access to government benefit programs. She has also conducted demographic research to identify US older adults who are most financially vulnerable and to explore related longitudinal predictors and risk factors for financial vulnerability in later life. Dr. Tavares is the former managing editor of the peer-reviewed journal *Research on Aging.*

Marc A. Cohen, PhD, is a professor of gerontology at UMass Boston and co-director of the LeadingAge LTSS Center @UMass Boston. He is also a research director at the Center for Community Engagement in Health Innovation at Community Catalyst. Prior to joining UMass in the fall of 2016, Cohen served as the chief research and development officer and former president and co-founder of LifePlans, Inc., a long-term care research and risk management company.

Over his career, Dr. Cohen has conducted extensive research on public policy issues affecting the financing and delivery of long-term care services (LTSS). He has testified before Congress, served on Governor Patrick's Task Force on LTSS Financing for Massachusetts, was a steering committee member of the Long-Term Care Financing Collaborative, and served as a Chair for a National Academy of Social Insurance Study panel, Designing State-Based Social Insurance for LTSS. More recently he has been examining ways to improve person-centered care, add services to senior housing, and address issues related to caring for individuals dually eligible for Medicaid and Medicare. Dr. Cohen received his PhD from the Heller School at Brandeis University and his master's degree from the Kennedy School of Government at Harvard University.

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