



Rural America: Look

BY JOHN A. GALE, M.S.

The term “rural” evokes a variety of images for many Americans. For some, it suggests scenes of farms, sleigh rides and small-town Americana as depicted by Currier and Ives and Norman Rockwell. Others view rural America in terms of geography: the rugged Rocky Mountains, the wind-swept Midwestern plains or the forests of northern New England and the Pacific Northwest. Still others conceptualize rural America in terms of its deficits, including social isolation, long travel distances, low population densities, high rates of poverty, limited economic and educational opportunities, greater health disparities and fewer resources.



Beyond the Images

Rural America is all of these things and more. It encompasses diverse populations, cultures, landscapes and economic environments. Despite this diversity, we often view rural populations and environments as homogenous entities. In reality, there are as many or more differences across rural areas as there are between urban and rural. Understanding these differences and their impact on rural communities is critical to the provision of rural health services. In this article, I explore the rural health care environment and discuss approaches to conceptualizing rurality; rural demography, health disparities and economic issues; challenges facing rural delivery systems; unique rural provider types;

and resources to support rural providers and communities.

CLASSIFYING AND CONCEPTUALIZING 'RURAL'

Given the diversity of rural America, researchers have developed alternate approaches to classifying rurality based on the needs of specific studies and federal programs. These multiple classification systems reflect the fact that “rural” and “urban” are multidimensional concepts with indistinct boundaries.¹ These systems call to mind the tale of three blind men describing an elephant based on the body part (tail, leg or trunk) within their reach. Much like their answers (a rope, tree trunk or fire hose), each classification system focuses on specific aspects of rurality and may not be the wholly “correct” definition of rural for all situations. As such, it is important to select the classification system that is appropriate to individual study or program needs.

Urban-rural classification systems differ based on how the boundaries of urban entities are defined and the minimum population size (ranging from 2,500 to 50,000 people) necessary to be considered urban. Municipal or jurisdictional borders, population settlement patterns or economic influence patterns (measured by commuting patterns between heavily populated core areas and adjacent counties) define boundaries. Rural population estimates using alternative combinations of population thresholds and boundary definitions range from 7 percent to 49 percent of the total U.S. population. The choice of urban-rural classification system used to drive funding or eligibility decisions for federal or state programs can have important implications for communities that may qualify as “rural” under one system but not another.

Although these systems are valuable for rural health research and for targeting rural funding and programs, they mean little to residents of rural communities. Their definition of “rural” is defined by their experiences, context and perceptions, and it includes such factors as travel dis-

tances, local population size and proximity to a larger urban area with greater access to services, jobs and other resources.

RURAL DEMOGRAPHY

■ **Population Growth:** Through much of the 20th century, rural areas experienced a loss in population as residents migrated to cities and suburban areas.² However, from the 1970s through the current period, rural areas experienced periodic growth spurts during which their population gains exceeded those of urban areas. Based on the most commonly used urban-rural classification systems, between 17 percent and 20 percent of the U.S. population live in rural areas that comprise 75 percent to 80 percent of the U.S. landmass.

These growth patterns were not consistent across the country. Rural areas experiencing the highest population growth were characterized by some combination of picturesque landscapes, mild climates and proximity to growing urban areas. Rural areas with slow or declining growth included remote counties and farming and mining areas.

■ **The Rural Economy:** Traditionally, the economies of rural communities were dependent on farming, fishing, forestry, mining and other extractive industries. This is no longer true, as the employment in these industries has declined in rural areas.³ More recently, rural employment growth has been in counties defined as retirement or recreation destinations, with much of the growth

in service sector jobs.

Rural economies are dominated by small businesses and self-employment, many of which offer seasonal jobs and are less likely to offer health insurance.⁴ As a result, rural residents are more likely to be uninsured or underinsured and more dependent on a dwindling individual insurance market. Underinsurance is as significant a problem for rural residents as uninsured. Twice as many residents of rural counties that are not adjacent to an urban area are underinsured compared to residents of urban or rural adjacent counties. High deductibles and lesser coverage levels associated with underinsurance shift a greater por-





tion of health care costs to underinsured individuals, rendering them essentially uninsured for routine health care needs. These individuals are responsible for almost 22 percent more of their health care costs than their urban or rural-adjacent counterparts.

Residents of rural counties experience earnings disparities compared to urban residents. On average, individuals living in rural areas earn 25.5 percent less than those in urban areas, yet living costs in rural areas are only 16 percent less. More rural residents hold more than one job compared to urban residents, and a higher percentage of part-time workers are seeking full-time work.

■ **Immigration, Ethnic and Racial Diversity:** Rural America is becoming increasingly ethnically and racially diverse. Varying regional migration patterns impose different demands on local health care services and providers in terms of cultural sensitivity, access and service needs. Although the population of rural America is predominantly white (82 percent), the higher growth rates of Hispanic, blacks and other groups suggest that the trend towards greater ethnic and racial diversity is likely to continue.

■ **General Rural Demographic Patterns:** Rural populations are aging more rapidly than urban populations. Almost 19 percent of rural populations are over 65, compared to 12 percent of urban populations.⁵ This trend is attributable to outflows of younger people, changing birth patterns and retirement patterns that favor rural communities. It is also driving a shift in the gender composition of rural communities as women live, on average, four years longer than men do. As a result, almost 75 percent of the 75 and older rural population in 2000 was female, and the overall proportion of females in the rural population is increasing.

Rural residents generally have lower education levels. Among rural adults ages 21-64, 31.4 percent had more than a high-school education compared to 53 percent in metro counties.⁶ Rural women tend to marry, have children at a younger age and have more children than urban women. Divorce rates tend to be lower in rural areas.

Rural people are disproportionately represented in the military and among America's veterans. In 2004, greater than 44 percent of military recruits came from rural areas.⁷ Residents of rural communities tend to return to those communities upon discharge from military service with many suffering from post-traumatic stress disorder, traumatic brain injuries and mental health

and substance abuse issues. They are less likely to have access to U.S. Department of Veterans Affairs health care services and more likely to tax rural delivery systems.

■ **Rural Health Disparities:** In 1999, Congress directed the Agency for Healthcare Research and Quality to produce an annual report tracking

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“prevailing disparities in health care delivery” that are related to racial and socio-economic factors for priority populations that included residents of rural areas.⁸ The agency found that rural residents suffer from higher rates of chronic and acute illnesses and have lower access to health services, along with higher rates of uninsurance and underinsurance. Other articles in this issue of *Health Progress* note other rural disparities, including limited health care resources and higher rates of poverty, motor vehicle deaths and substance abuse.

CHALLENGES FACING RURAL DELIVERY SYSTEMS

Rural delivery systems are built on fragile webs of small hospitals, clinics, nursing homes and public health agencies, many of which experience significant financial stress due to low patient volumes, reimbursement policies not suited to their operating characteristics, high dependence on Medicare and Medicaid and high rates of uninsurance and underinsurance. Given their financial difficulties, many rural providers have difficulty investing in critical physical plant and health information technology upgrades.

Rural delivery systems are plagued by chronic shortages of health care providers. In 2005, 55 primary care physicians per 100,000 residents practiced in rural areas compared to 72 per 100,000 in urban areas.⁹ The number drops to 36 per 100,000 in isolated small rural areas. There are half as many specialists per 100,000 rural residents and one third as many psychiatrists. Only 10 percent of America's physicians practice in rural areas. There are also shortages of dentists, pharmacists, mental health professionals, registered nurses and ancillary medical personnel.

One alarming trend is the growing shortage of general surgeons in rural delivery systems.¹⁰ Less

than 5 percent of physicians practicing in rural communities are general surgeons. Without the backup of a general surgeon, rural delivery systems are unable to provide needed routine health care services.

The problem will worsen, for the medical workforce in rural areas is aging rapidly and many are approaching retirement. Almost 30 percent of rural registered nurses are over 55 and the median age of rural physicians is 48. Among physicians that graduated from medical school between 1988 and 1997, only 11 percent practice in rural areas. The number of recent medical students planning to practice in rural areas is only 3 percent. Ongoing challenges to building an adequate rural workforce include the declining number of medical students choosing primary care as a specialty.

FEDERAL RURAL PROVIDER DESIGNATIONS

In response to concerns about the viability of rural primary care providers in the 1970s and small rural hospitals in the 1990s, Congress passed legislation creating two unique rural provider types — rural health clinics and critical access hospitals. Both programs provide qualifying providers with Medicare cost-based reimbursement (and Medicaid cost-based reimbursement for rural health clinics), a payment mechanism better suited to the patient volumes experienced by rural providers. (See article on Critical Access Hospitals, page 26.)

The 1977 Rural Health Clinic Services Act increased the availability of rural primary care services by providing designated clinics with cost-based Medicare and Medicaid reimbursement for a set of core services and expanding Medicare and Medicaid coverage for services provided by nurse practitioners and physician assistants. Subsequent amendments added nurse midwives, doctoral-level psychologists and clinical social workers to the list of rural health clinic core providers. Currently, 3,761 such clinics provide services in 45 states.¹¹

CONTRIBUTIONS TO ECONOMIC HEALTH

Viable health care delivery systems are critical to the economic health of rural communities. Rural hospitals are among the largest employers in rural communities.¹² An average primary care physician generates \$1.5 million in revenue, \$900,000 in payroll and creates 23 jobs.¹³ In addition to their direct economic activity, health care providers

contribute to local economies through the “multiplier effect.” The multiplier effect quantifies the portion of salary and spending leveraged in the community and the impact of those dollars through increased production, expenditures and employment. High quality health care is also important to rural economic development, as it en-

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hances the ability of rural communities to recruit and retain business and industry. Finally, in the absence of local services, rural residents travel to larger communities for care and make purchases in those communities that would otherwise have been made locally.

RURAL HEALTH RESOURCES

The rural health community is supported by a national and state infrastructure of resources, services and technical assistance. The Office of Rural Health Policy coordinates rural health activities within the Department of Health and Human Services and administers grant programs to build local and state health care capacity. Additionally, national organizations such as the National Rural Health Association, National Association of Rural Health Clinics, National Association for Rural Mental Health and National Organizations of State Offices of Rural Health, among others, support rural providers with networking and educational opportunities and advocacy for rural health issues. The 50 state offices of rural health help rural communities build health care delivery systems by collecting and disseminating information, coordinating statewide rural health resources and activities, providing technical assistance, encouraging recruitment and retention of health professionals and strengthening state, local and federal partnerships. The Rural Assistance Center, funded by the Office of Rural Health Policy, is a web-based information resource that serves as a comprehensive rural health and human services information portal.

OPPORTUNITIES AHEAD

This article provides an overview of the challenges involved with caring for and improving the



health of rural residents. The issues faced by rural providers and patients differ greatly from those of their urban counterparts. They also differ across rural communities. Rural Americans experience health disparities not found in many urban areas. Economic factors, cultural and social differences, educational shortcomings, lack of recognition by legislators and the isolation of living in remote rural areas impede rural Americans in their efforts to lead normal, healthy lives. These challenges also provide opportunities for Catholic hospitals and health systems to make a significant difference in access to rural health services and in the lives and health of vulnerable rural residents.

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NOTES

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