RURAL HEALTH: THE STARTLING STATISTICS

The second paragraph of Vision 2020, which we unveiled in June at the CHA Assembly, commits us to "... improve the health of individuals and communities." That's what came to mind as I thought about the special section devoted to health care in rural communities in this issue of *Health Progress*.

ELAINE BAUER

The statistics are startling: 75 percent of the United States' land mass is nonmetropolitan (rural) and home to 20 percent of the population. Yet that means 1 in every 5 Americans experiences significant disparities in health and health care delivery due to geographic isolation, socioeconomic status, health risk behaviors and limited job opportunities.

More rural health statistics you will see echoed in these pages[2]:

- Rural residents are less likely to have employer-based health care coverage or prescription drug coverage (17.8 percent are uninsured versus 15.3 percent of urban residents)
- The rural poor are less likely to be covered by Medicaid benefits
- Rural adults are more likely to report having diabetes than are urban adults — with rates of diabetes markedly higher among rural American Indian and black adults
- Rural residents are more likely to be obese than are urban residents
- Fewer than 10 percent of physicians practice in rural communities
- Rural women are less likely than urban women to be in compliance with mammogram screening guidelines or to have had a Pap smear done within the past three years
- Alcohol abuse is a significant problem among rural youth
- Suicide rates among rural males are higher than among men in urban areas
- One-third of all motor vehicle accidents occur in rural areas; two-thirds of all motor vehicle deaths occur on rural roads
- In rural areas, the majority of emergency medical services first responders are volunteers

For much of the 20th century, most rural communities experienced population loss as millions of rural residents left for the opportunities that city life provided. The volume of out-migration varied from decade to decade, but the direction of the flow did not. This trend ended in the 1970s when rural population gains exceeded those in urban areas. The predominance of rural vs. urban population growth vacillated each decade through the rest of the century; in 2001, population growth in rural areas picked up again. This growth occurred primarily in large areas of the Mountain West, the Pacific Northwest, the Upper Great Lakes, the Southern Highlands and Piedmont, Florida and the eastern half of Texas.[3] The Hispanic population in nonmetropolitan areas grew at the fastest pace of any racial or ethnic group in the post-2000 period.

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Recent research suggests immigration to nonmetropolitan areas is on the upswing. Between 2000 and 2004, immigration accounted for 31 percent of the overall population increase in nonmetropolitan areas.[4]

There are many challenges to providing health care services in sparsely populated rural communities — recruiting physicians and other health care professionals, the high cost of technology and facilities juxtaposed against a lower income, un- and underinsured population with few community-supported resources, just to name a few.

Dozens of Catholic hospitals are among more than 1,300 U.S. hospitals that have received Critical Access Hospital designation from the Centers for Medicare and Medicaid Services.[5] This special

designation for small, short-stay, rural and "isolated" hospitals enables them to receive cost-based reimbursement — improving the likelihood that they can survive.

The National Rural Health Association has collected a variety of "Models that Work" — examples of initiatives that have improved the quality of care provided in rural communities and have addressed rural population health needs.[6] They are heavily dependent on collaboration and use increasingly reliable and available technologies that help many make geographic proximity a non-issue. Catholic health providers can use these models to stimulate thinking about how to serve rural populations.

Catholic social tradition calls us to respond to the most vulnerable among us. As the population of rural America is expected to grow in the coming years, we should challenge ourselves to think proactively and strategically about how Catholic health care providers can work to eliminate some of these health disparities and improve the health of individuals who live in rural communities.

ELAINE BAUER M.A., FACHE is vice president, strategic initiatives, Catholic Health Association, Washington, D.C. Write to her at ebauer@chausa.org.

NOTES

1. www.chausa.org/vision2020.
2. Kevin J. Bennett, Bankole Olatosi and Janice C. Probst, *Health Disparities: A Rural-Urban Chartbook* (Columbia, S.C.: South Carolina Research Center, 2008). http://rhr.sph.sc.edu/index.php.
3. Kenneth Johnson, *Demographic Trends in Rural and Small Town America*, (Durham, N.H.: Carsey Institute, 2006). carseyinstitute.unh.edu/publications/Report_Demographics.pdf.
4. Johnson.
5. Catholic Health Association provider database.
6. www.ruralhealthweb.org/go/rural-health-topics/quality-issues/models-that-work

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

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Reprinted from *Health Progress*, September-October 2010