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Health and Health Care in Rural America

by Lorraine Garkovich and Rosalind P. Harris

A report from a March 1994 congressional briefing on "The Rural Perspective on National Health Reform Legislation" asserts that "the single most important concern for rural America is *not* at the core" of the national debate on health reform. The key issue for rural America is "the supply of providers and the infrastructure of the rural health care system." The subsequent analysis of five national health reform legislative proposals concluded that individually, none would satisfy the need for an adequate supply of providers or contribute to the improvement of the services infrastructure. A final conclusion of the briefing was that, while some of the proposals do address some rural health issues, the net effect of all the provisions in each bill could mitigate any beneficial impact on the rural health care system.

Can a case be made for special attention to the health concerns of rural America? How do the health status and health care services of rural America compare with those of urban areas?

Health status of rural people

One in four Americans, some 62 million people, live in rural areas. In fifteen states (Alaska, Arkansas, Idaho, Iowa, Kentucky, Maine, Mississippi, Montana, Nebraska, New Mexico, North Dakota, South Dakota, Vermont, West Virginia, Wyoming), more than half of the population resides in nonmetropolitan areas. The mortality rate for nonmetropolitan residents is lower than that for metropolitan residents (8.87 versus 9.21 per thousand). But rural residents have higher rates of mortality due to motor vehicle (0.31 versus 0.21 per thousand) and other accidents (0.29 versus 0.22 per thousand). Three important rural occupations—agriculture, mining, and forestry—have some of the highest work-related injury and fatality rates, and white nonmetro infants are more likely to die within the first year of life than their metro counterparts (8.8 versus 8.6 per thousand live births).

Rural Americans, in contrast to their urban neighbors, experience a higher incidence of five chronic health conditions (heart disease, hypertension, emphysema, kidney disease, epilepsy, arthritis, sensory impairments). Together, these contribute to the higher proportion of all rural as opposed to urban Americans (14.9 versus 12.6 percent) whose chronic conditions limit their activities. Similarly, chronic conditions limit the rural elderly more than the urban elderly (41 versus 36.2 percent).

A recent state-wide survey in Wisconsin found a slightly higher incidence of arthritis, cancer, and high blood pressure for farm residents than all state residents. Moreover, farm residents "had significantly higher proportions of adults reporting limitations in walking, climbing, bending, and performing vigorous exercise or work."

Insurance: access to health care

The ticket to health care for most Americans is health insurance. A 1993 Current Population Survey shows that nearly equal proportions of rural and urban residents (84 versus 83 percent) were covered by some type of health insurance in 1991. However, rural residents were less likely to have employer-provided health insurance (60.1 versus 63.4 percent), and were more likely to compensate for this by purchasing private, individual insurance policies (9.5 versus 7.6 percent).

The 1994 Wisconsin survey found similar disparities. Farm respondents were slightly less likely to have employer-provided health insurance com-

pared to nonfarm residents (10 versus 12 percent), and substantially more likely to obtain individual insurance through a private insurance company (32.4 versus 7.5 percent). Moreover, the Wisconsin survey found that farm residents' insurance coverage was less extensive than that available to other state residents. Farm residents were less likely to have full hospitalization coverage (76.2 versus 82.5 percent), coverage for doctor visits (48.3 versus 67.7 percent), or preventive health services (36.8 versus 52.3 percent). Similarly, the Illinois Rural Life Panel survey reports that one in eight of the youngest rural residents (those under the age of thirty) were uninsured.

Health insurance through small rural businesses

What accounts for the lower rate of employer-provided health insurance in rural areas? Small firms are more common employers in rural areas, and small businesses are much less likely to provide health insurance coverage than are larger firms. Nearly two-thirds of small business owners state they want to provide some or better health insurance for their employees, but high premiums prevent their participation.

Insurance industry underwriting practices have moved from "community" to "experience" rating of premiums. Insurers base health insurance premiums on employee group risk factors, and a small number of employees means that one serious illness can skew the firm's risk rating upward. The current estimate is that small businesses pay up to 35 percent more than larger firms for the same benefits.

Rural unemployment limits access to health care

Since the recession of the early 1980s, rural areas have posted higher rates of unemployment than urban areas. In 1991, the nonmetro unemployment rate stood at 8.7 percent compared to 6.8 percent in metro areas. But this masks the numbers who have given up looking for work (discouraged workers) and those who work part-time but want full-time jobs (the sub-employed), who together comprise the underemployed. Adjusting the official unemployment figures upward for discouraged workers and those sub-employed raises the rural rate to 12.3 percent and the urban rate to 9.7 percent. Some argue that those who earn low wages (earnings less than 1.25 times the poverty threshold) should be added to these groups to show a more complete picture of the economic distress experienced by rural workers.

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Part-time workers and low-wage workers are not eligible for unemployment compensation or most other social support programs, such as Medicaid. Yet typically their jobs do not provide health insurance as a benefit, and their earnings may not be sufficient to pay the costs of private coverage. Some 85 percent of the uninsured live in families headed by an adult with some level of employment.

If their jobs do not provide insurance or they are unemployed, many families turn to private insurance policies. Individual or family insurance policies typically provide less coverage at a higher cost than employer-provided policies. Private insurance policies typically require higher deductibles, cover fewer conditions and medical treatments, and shift more of the medical costs to the consumer through co-payments.

Rural household incomes

Whether or not you can afford the out-of-pocket costs of private health insurance depends on your household income and the cost of the policy. Since 1985, median rural household income has averaged about 25 percent less than urban median income ($23,709 versus $31,823).

The price of private, individual family health insurance policies is difficult to estimate because of differences in coverage, deductibles, and

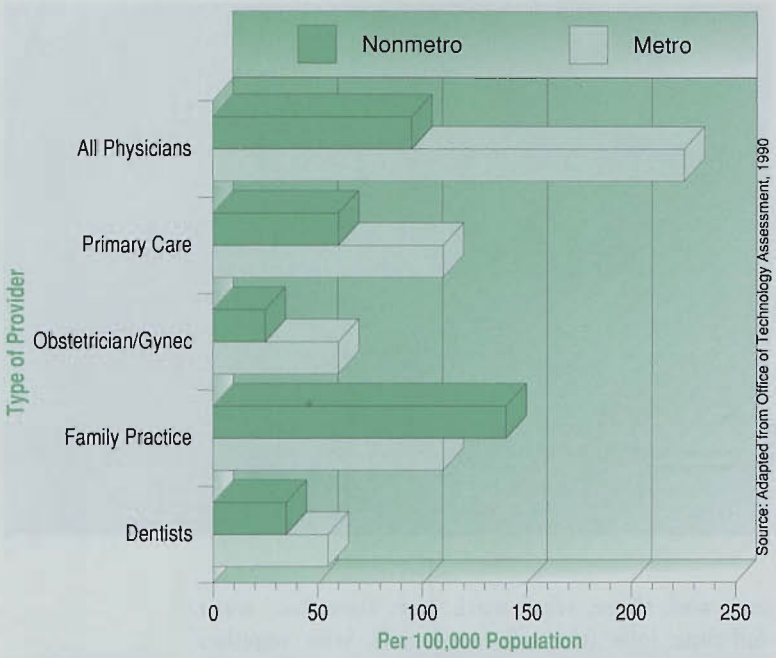

Figure 1. Types of health providers by residential area: 1988

co-payments. A 1989 study of Kentucky farm families found premium costs ranging from $380 to $600 a month, about one-fifth of the families' income. The Wisconsin survey found the farm population much more likely than the general population (25 percent versus 5 percent) to cite costs as the key barrier to health care. The Illinois Rural Life Panel survey found one in seven of rural residents with incomes under $15,000 were uninsured. Forty percent of the rural Illinois respondents indicated that the cost of seeing a doctor was a serious problem, and nearly 60 percent stated that the cost of hospitalization was a serious problem.

Rural poverty and Medicaid

Rural households and families are also more likely than their urban counterparts (16.3 percent versus 12.7 percent) to be in poverty, a situation that has persisted since at least 1959. Yet despite the higher incidence of poverty, the rural poor have less access to safety net programs. According to the USDA's Economic Research Service, the rural poor are "concentrated in states that pay lower Aid to Families with Dependent Children benefits than the national average, do not supplement Federal Supplemental Security Income payments for the aged, blind, and disabled, and run restrictive General Assistance programs, if any." Since most states require participation in these social support programs as a pre-condition for eligibility for Medicaid, this requirement limits the access of the rural poor, especially children under the age of seventeen, to Medicaid benefits. Rural poor children are less likely than their urban counterparts (9.1 percent versus 11.5 percent) to have Medicaid coverage.

Medically underserved areas

Rural counties are three times more likely to be classified as "medically underserved" than are urban areas. That is, in comparison to their population, infant mortality rate, proportion of population over sixty-five years old, and percentage of population in poverty, rural areas have a greater shortage of primary care physicians. In one-half the states, more than 75 percent of all rural counties are classified as "health professional shortage areas." These are areas where the population-to-physician ratios exceed federal standards or where specific population groups do not have access to health care providers. In 1988, of the 1,931 federally designated health professional shortage areas for primary care, two-thirds were in rural areas.

Rural areas have only half the number of physicians per capita as metro areas, and the more rural the county, the lower the physicians per capita ratio (figure 1). Primary care physicians—family and general practitioners, general pediatricians, general internists, and obstetrician/gynecologists—are the entry point for health care, providing a broad range of basic preventive, diagnostic, and supporting care. Nonmetro areas have a primary care physician-to-population ratio that is 40 percent lower than in metro areas. The rural South has the lowest primary care physician-to-population ratio of any region. In 1988, there were sixty-one obstetric care providers per 100,000 women in urban areas, but only twenty-five per 100,000 rural women. Over half a million rural women live in counties that do not have a physician trained to provide obstetric care.

The limited choice in health practitioners, the closing of rural hospitals, and the greater time required to reach health services have potentially life-threatening implications for rural residents.

Access to health care providers and services

Most urban areas provide a full range of health services. But not rural communities. According to the National Rural Health Association, the typical rural health system includes a small hospital, a few solo practitioners or a small group practice, a com-

munity health center, a county health department offering a variety of basic services, and occasionally a mental health service center. But rarely are all these found in any one rural community. Twenty-seven percent of those responding to the Illinois Rural Life Panel indicated that access to primary care was a serious or moderately serious problem, and more than 40 percent declared access to specialty health care services as a moderately serious to serious problem.

Nonmetro areas do have a higher proportion of family practice physicians than do metro counties (figure 1). This reflects two factors. First, osteopathic physicians tend to set up practices in rural areas, where they represent more than one in six of all physicians. Second, the high proportion of family practice physicians in rural areas is a function of the lack of other medical specialties (figure 2). Some 40 percent of all nonmetro counties have no general surgeons or physicians with specialties in internal medicine, and 60 to 70 percent have no physicians with specialties in obstetrics/gynecology, pediatrics, radiology, anesthesiology, or psychiatry. In contrast, less than 20 percent of metro counties lack these specialties, except radiology.

The National Rural Health Association states rural hospitals are especially "vulnerable" to financial instability and closure due to increased competition from larger urban hospitals and changing reimbursement and regulatory policies. Recent studies suggest that increasing numbers of rural residents, particularly those well-to-do, seek care in urban hospitals. Also, the dramatic restructuring of regulatory and reimbursement policies that took place in the 1980s restricted the opportunities of rural hospitals to recover losses on Medicare and Medicaid clients with payment "subsidies" from other clients. Between 1984 and 1988, then, nonmetro areas experienced twice the rate of hospital closures as metro areas.

When local areas lack medical services, residents must travel to more distant communities. A 1983 National Health Interview Survey indicates that on average, nonmetro residents must spend twenty-five minutes travel time to visit any physician compared to twenty minutes travel time for metro residents. To reach a general practitioner, rural residents travel only a minute longer, on average. But the trip to visit an ophthalmologist takes sixteen minutes longer and to see a neurologist, thirty minutes longer. A recent national weighted sample of urban and rural residents confirms this disparity in access. On average, rural residents must travel nearly twice the distance of urban residents to see a doctor for general health purposes (11.6 versus 6.3 miles) or to receive emergency care (12.0 versus 6.6 miles). But nearly one in six rural residents

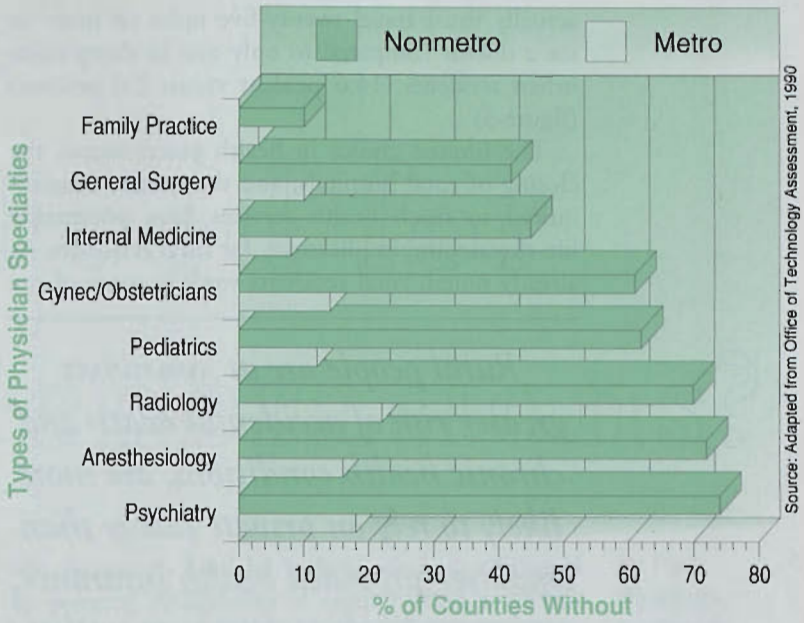

Figure 2. Proportion of counties without selected physician specialities: 1988

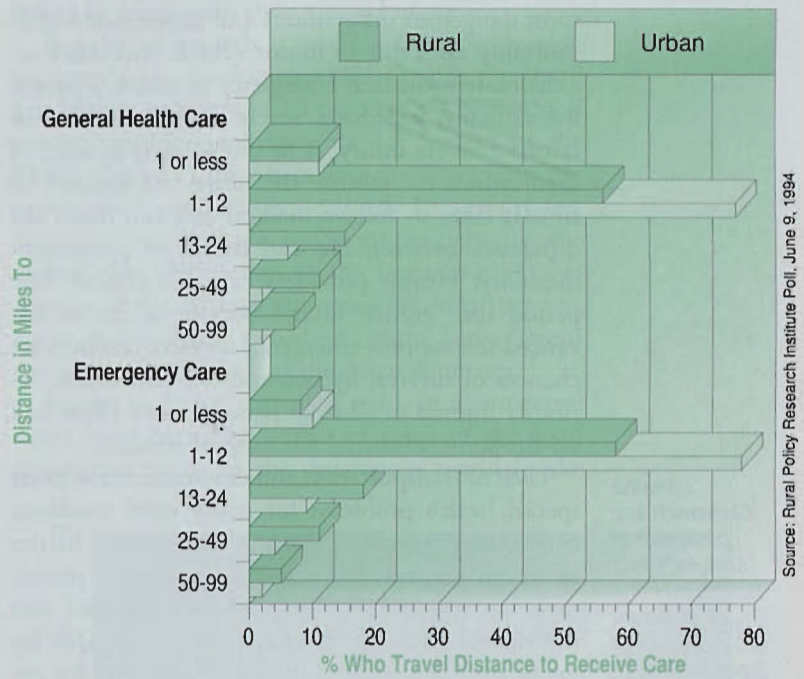

Figure 3. Distance to type of health service: 1994

actually must travel twenty-five miles or more to see a doctor compared to only one in thirty-three urban residents (14.6 percent versus 2.6 percent) (figure 3).

The limited choice in health practitioners, the closing of rural hospitals, and the greater time required to reach health services have potentially life-threatening implications for rural residents. As already noted, rural residents work at some of the most dangerous occupations and experience higher mortality rates due to motor vehicle and other accidents. In a medical emergency in which a person has difficulty breathing, severe blood loss, has sustained a severe injury, is in shock, or is in need of medications to stabilize the heart, the amount of time it takes to receive medical care can mean the difference between life and death, or permanent disability. Health providers call this critical time period the "golden hour," because access to advanced life support emergency services can increase chances of survival by two-and-one-half times. Seriously injured or ill rural persons more often lack on-the-scene advanced life support services.

Rural people are at somewhat greater risk of accidental death and chronic health conditions, are more likely to rely on private rather than employer-provided health insurance, and more likely to simply go without health care services.

Lack of transportation and communication cause special health problems for many rural residents. Most Americans don't think of distance as a barrier to health services. Most simply pick up a phone, make an appointment, hop in their car, and visit the doctor. But the process is not so simple for many rural Americans. In rural Kentucky, for example, 15 percent, or nearly one in six of the rural counties' households do not have telephones. Twelve percent of the state's households do not have cars, and nearly 20 percent lack cars in many rural counties. In contrast to urban areas, bus and taxi services seldom exist. A clinic just twenty-five minutes driving time away might as well be three hours away. This is especially challenging if you are one of the thousands of rural Americans with a chronic illness who needs continuous monitoring or health care.

Rural health challenges

Rural people are at somewhat greater risk of accidental death and chronic health conditions, are more likely to rely on private rather than employer-provided health insurance, and more likely to simply go without health care services. The rural health infrastructure faces a serious shortage of providers and facilities, and access is often difficult for many rural citizens. The 1994 national poll showed a consequence of this situation. Rural residents are significantly less likely to indicate complete satisfaction with the quality of the health care available to them than urban residents (37 percent versus 49 percent). As the debate over health reform continues, the impact of specific proposals on the rural health care system and the economic access of rural citizens to health services must be considered. ■

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■ For more information

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