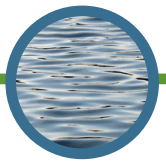


Rural Data for Action

A Comparative Analysis of Health Data for the New England Region

Second Edition
October 2014

Overview of Findings

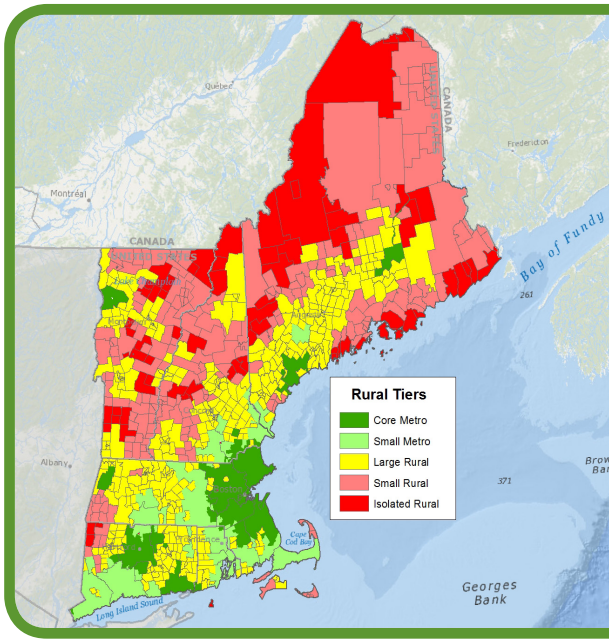
Mission: "The New England Rural Health RoundTable is a forum for promoting healthy rural communities and solutions to the unique health challenges facing rural New England."

The New England Rural Health RoundTable is pleased to share this summary of findings from our newly updated comparative analysis of health and health-related statistics in rural areas of the region. While rural New England communities are idyllic in many ways, they also face a unique set of challenges related to demographic and economic factors, physical distance, sparse population, and resource availability, which combine most acutely in terms of health care. Establishing and maintaining health resources in rural areas is an ongoing struggle, and solutions that may work in more urban settings are often not practical in a rural context. The unique health needs of rural areas of the region are also easily overlooked, as inherently small population numbers are quickly overwhelmed when combined with data from metro areas.

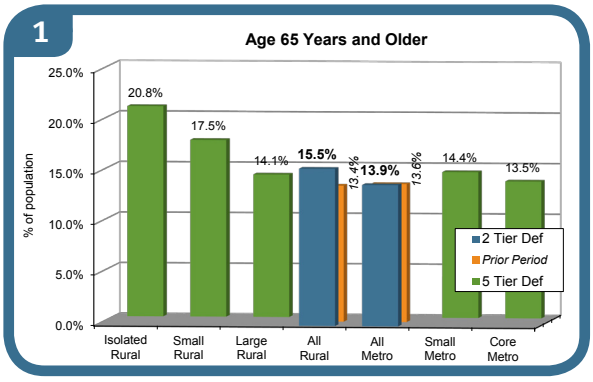
As our mission statement notes, identifying and addressing the unique health challenges facing rural New England is the reason for our existence, and is the impetus behind the development of this report. In addition to highlighting key differences and patterns related to rurality, this update also illustrates regional trends from the last decade, which was characterized by a crosscurrent of significant forces both promoting and hindering health care access. This analysis is intended to serve as both a planning tool and a benchmark against which to measure and monitor the implementation of the Affordable Care Act (ACA) and other developments that will shape health care in rural areas of the region going forward. The complete report and data tables will be available on our web site.

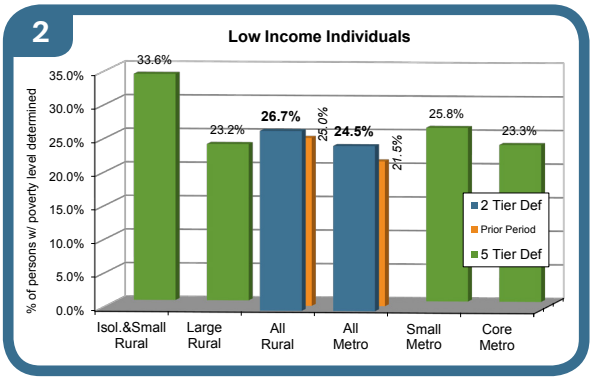
The results of this analysis, taken broadly, paint a picture of rural health in the region that is similar to the results from the analysis nearly a decade ago, which described it as, **"a functioning yet fragile system struggling to overcome a variety of underlying challenges".** The overall self-assessed health status of the rural population remains generally comparable to that of the metro population of the region, and considerably better than the national average, though the overall portion in 'fair/poor health' increased in all areas. Age-adjusted mortality also remains generally comparable between rural and metro areas, though the rate declined regionally and fell somewhat less in rural areas.

While it appears that the rural health delivery system is functioning to uphold the overall health status of the population measured broadly, this masks some notable differences and troubling trends in key demographic, access, and outcome indicators. **The differences observed often follow a pattern strongly associated with increasing rurality.**

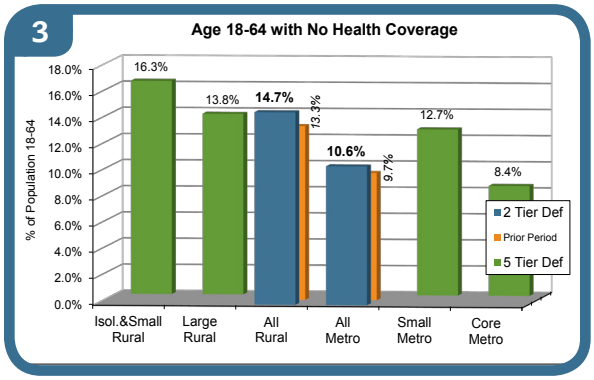


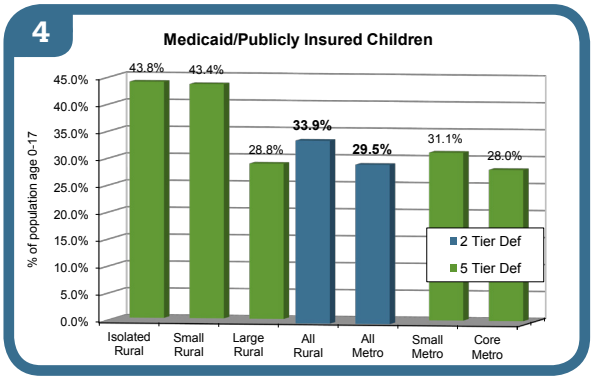
The rural population is different from the metro population along key demographic measures related to health status and access to care. The rural population is older and aging at a faster rate than in metro areas, with greater gains in the portion of elderly residents (1) and greater declines in youth. Average incomes have risen notably, but this has not benefited those at the lower end of the income scale, as the percentage of people living in poverty, and with low income has increased and is particularly high in the more remote rural areas. (2)



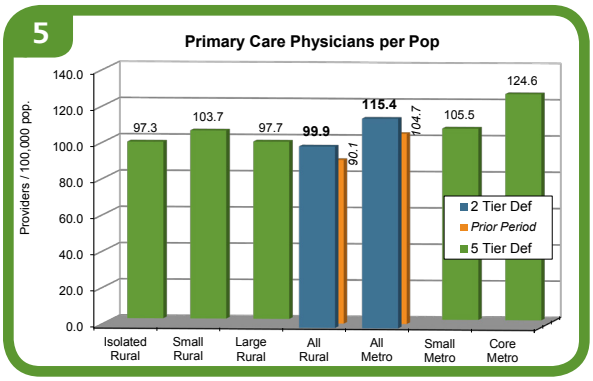


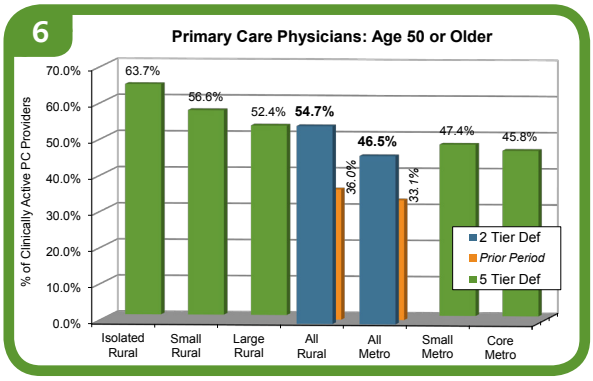
In spite of the passage of insurance reform in one of the region's largest states, the overall level of uninsurance has increased across the region, remaining higher and rising faster in rural areas (3), which are also notably more dependent on Medicaid for coverage. (4)

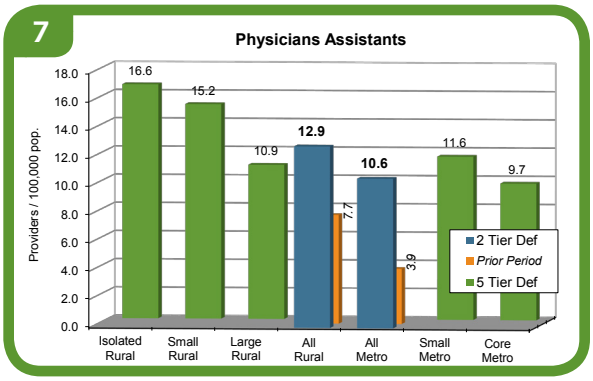




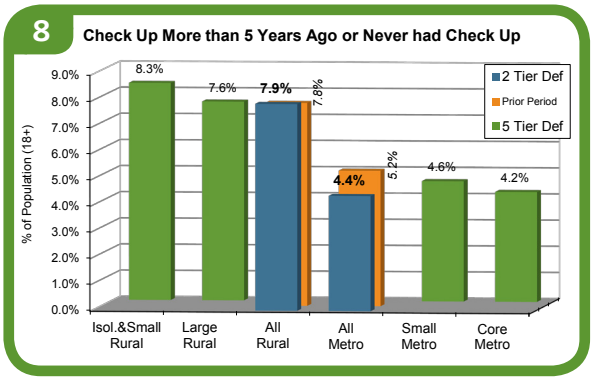
Discrepancies regarding the availability and mix of primary care providers, and related access indicators, persist and are likely to expand. Primary medical care provider levels are up regionally, but remain lower in rural areas (5), and the age of the physician workforce suggests that this gap could widen in coming years. (6)





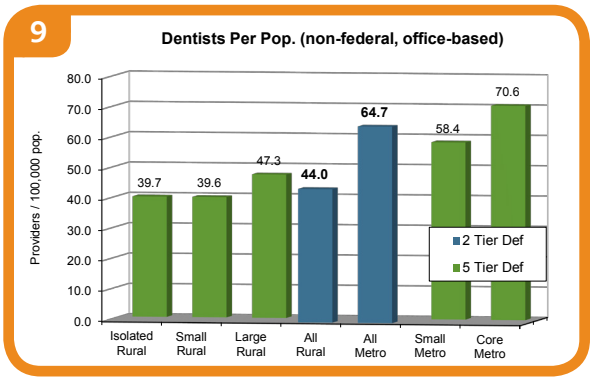


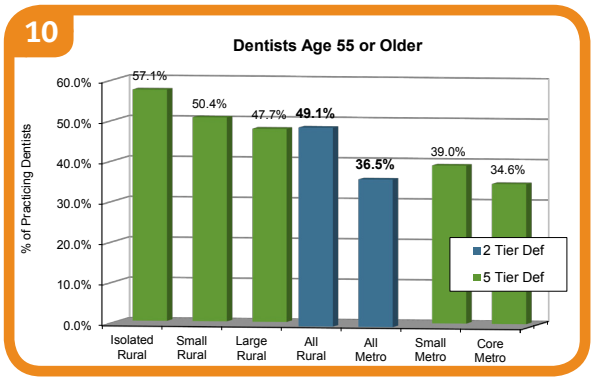
Rural areas continue to be more dependent on non-physician providers for primary care, which may help offset losses of physicians in the future, but the level of growth in physician assistants was faster in the metro areas. (7)



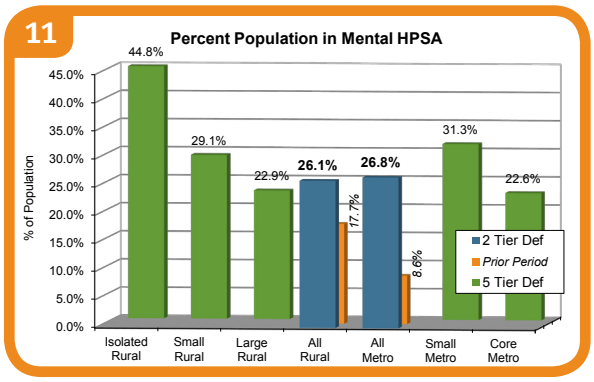
Rural residents are far more likely to have gone without a checkup or routine preventive tests within the past 5 years (8), and expectant women continue to smoke at a much higher rate in rural areas. Chronic disease rates, which had been largely equivalent between rural and metro areas, have begun to diverge due to faster rates of increase in rural areas.

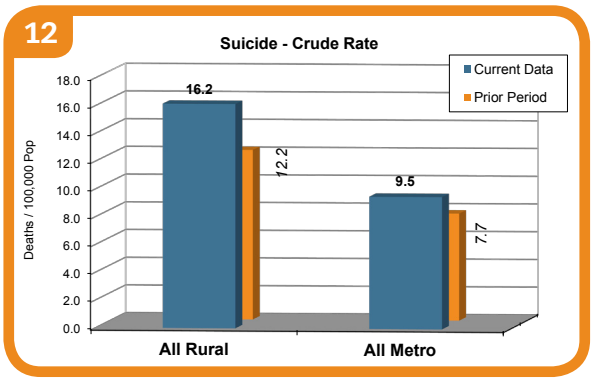
The picture is significantly worse for dental and mental/behavioral health access and outcomes in rural areas. Dentist availability per capita is notably lower in rural areas. (9) Rural dentists are also considerably older (10) and more likely to work part time, further expanding the gap, both currently and likely in the future. Dental Health Professional Shortage Area (DHPSA) designations cover nearly half of the population in the more remote rural areas. The result is reflected in lower portions of rural residents reporting a dental visit in the past year.



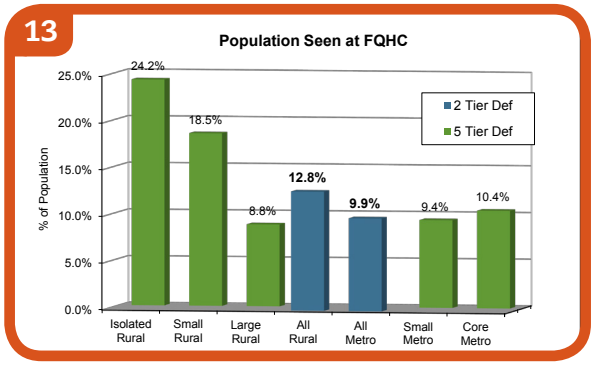


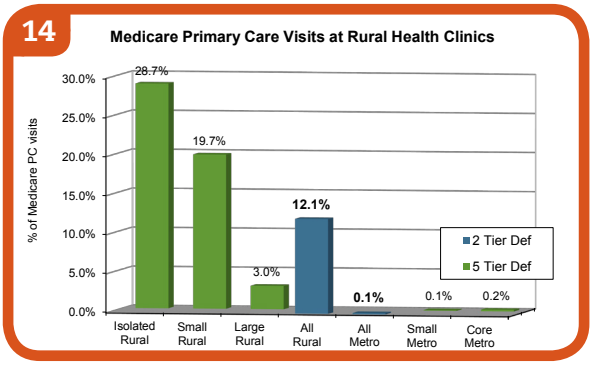
Mental/behavioral health findings include nearly half of the population in isolated rural areas covered by a Mental Health Professional Shortage Area (MHPSA) designation (11), and a dramatically higher and rising suicide rate in rural areas overall (12), despite comparable portions of the population reporting having mental health problems. This finding may be partially associated with the higher and increasing rate of firearm deaths in rural communities. Alcohol and substance use and dependency rates are somewhat lower in rural areas of the region, but the rates in New England are considerably higher than the national rates overall.



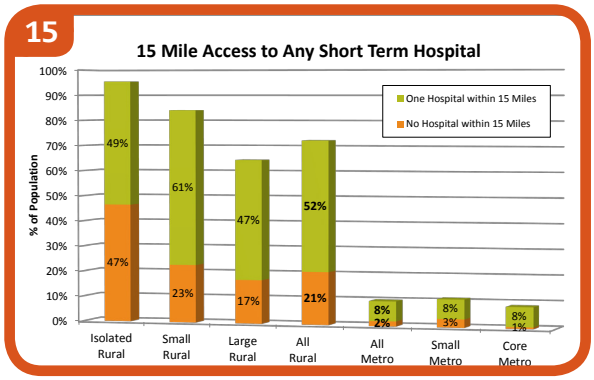


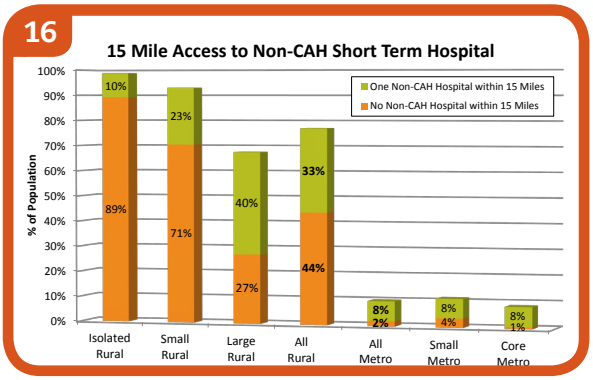
Rural access is heavily dependent on the support of federal programs, without which rural results might look much worse. In the small and isolated rural areas more than a third of the total population and nearly three quarters of the low income population are seen at Federally Qualified Health Centers (FQHC) each year. (13) The majority of all primary care for the elderly in isolated rural areas takes place at a Rural Health Clinic (14) or an FQHC.



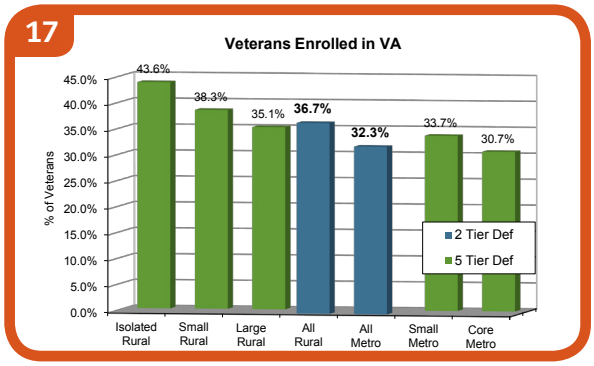


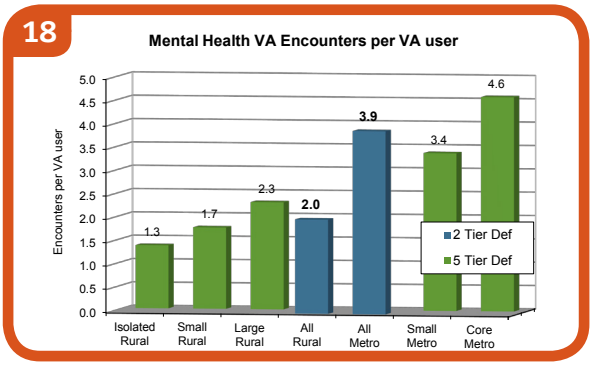
Rural populations are much more likely to live 15+ miles from the nearest hospital, or to be reliant on a single hospital within that distance. (15) Maintaining even this level of access depends heavily on hospitals which are supported by Critical Access Hospital (CAH) status (16), which has come under threat recently.





Rural communities are home to a greater proportion of military veterans. Data obtained from the Veterans Health Administration (VA) suggests that rural veterans are more likely to rely on the VA for care (17), but may have greater trouble accessing these services effectively, as reflected in lower individual utilization rates for mental/behavioral health care (18) and a range of other VA services.





These results point toward issues that must remain the focus of efforts aimed at assuring rural access and improving rural health in the region. The New England Rural Health RoundTable will continue to monitor progress, share information, advocate for change, and bring rural communities and stakeholders together to assure continued progress.