

Rural/Frontier Women's Access to Health Services

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National Rural Health Association

Access to health care services is one important determinant of health status, along with educational level, socio-economic factors, and many others. This policy brief outlines the emerging needs of rural women with regard to health care and mental health services and some of the major barriers faced by rural women. It also provides policy recommendations to improve the access to health care services available to rural and frontier women.

Rural populations in the United States tend to be poorer and sicker than the overall population, and rural women are no exception. In addition, rural people have lower rates of employer-sponsored insurance coverage, and lower rates of insurance overall, and less access to specialist care. In many rural and especially frontier areas, primary care services may be difficult to access, because of a lack of providers, barriers due to geographic distance or terrain or a lack of transportation.

It is hard to quantify the number of women in rural areas living with a disability, but it has been estimated that there are 11 to 15 million people with some disability in the United States and approximately half that number with a significant disability live in rural areas.¹

High numbers of minorities, particularly African Americans, have traditionally been found in the rural southern region of the United States. There have been documented disparities in minority health status in the United States. Rural minority women face these same disparities in addition to the challenges listed above for rural populations overall.² Despite the health care provided by the federal government through the Indian Health Service, Native American and Alaska Native women also continue to experience poorer health outcomes than women overall. Research has suggested that poor socioeconomic conditions, lack of education and cultural barriers contribute to lower health outcomes for this population.³ Many Native American and Alaska Native women live in rural or frontier areas.

These challenges faced by rural populations have a unique impact on rural women. All women in rural and frontier areas are affected by the lack of primary and specialty care. In addition, the lack of specialty care has a particular impact on women of child-bearing age and those having gynecological problems. The lack of oral care in rural areas puts rural women at an increased risk for periodontal disease, which has been linked as a factor contributing to preterm birth.⁴ Rural areas also tend to have higher rates of chronic disease, including heart disease, diabetes and cancer. The risk of death from diabetes is more common in women ages 45 – 64.⁵

The shortage of women's health care specialists, coupled with the widespread lack of preventive care services impact rural women's ability to access reproductive health services. Rural women cope with unplanned pregnancies, high rates of poor perinatal outcomes, high incidence of cervical cancer mortality, and low rates of preventive screenings, such as Pap tests and mammograms. When rural women receive abnormal test results, they face difficulties adhering to a prescribed treatment plan because of the lack of specialists and advanced technology (ultrasound, radiation) in rural communities.

MATERNAL AND CHILD HEALTH/PERINATAL CARE:

Rural women face many hurdles during their reproductive years. Surveys have shown that maternal, infant, and child health rank as a top ten concern by rural health experts.⁶ With reduced access to health services, rural women tend to delay prenatal care or receive none at all.⁷ Latina women residing in nonmetropolitan counties are at the highest risk for receiving inadequate prenatal care.⁸ Rural women are also more likely to smoke during their pregnancy.⁹ The Federal Block Grant program authorized under Title V of the Social Security Act is one avenue to increase education provided to rural women about prenatal care and other important health topics regarding infants and children. This program provides core public health functions such as resource development, capacity and systems building, public information and education, knowledge development, outreach and program linkage, technical assistance to communities, and provider training.

Studies show that family physicians remain a crucial component of the provision of rural obstetric care, but the increase in medical malpractice costs has led many providers and local hospitals to discontinue OB services.¹⁰ Rural women living in communities with either no hospital or hospitals without adequate obstetrical services must deliver elsewhere. This often results in difficult deliveries and higher costs.¹¹ Rural African American women insured by Medicaid are more likely to experience labor complications that could have been avoided.¹² In addition to these service barriers, rural women face adverse perinatal outcomes as well. Infant mortality is especially high in rural communities in the South and West.¹³

FAMILY PLANNING SERVICES:

The availability of family planning services has been linked to a decrease in unplanned pregnancies; decreasing unplanned pregnancies leads to fewer infants born with low-birth-weights, incidences of late onset or complete lack of prenatal care, as well as fewer infant and neonatal deaths and fewer abortions.¹⁴ There has not been sufficient health research focused on rural women's use of family planning. Community health centers serve as a major source of primary care for rural residents.¹⁵ Although community health centers are required to provide family planning services, a 1997 study conducted by The Alan Guttmacher Institute found that only 60 percent actually provided the services.¹⁶ In addition, community health centers are less likely to offer a wide range of contraceptive options to patients, but the methods they do provide, such as oral contraceptives, are

less expensive.¹⁷ Rural adolescents who are using contraceptives tend to choose non-prescription methods and use them with less consistency than urban teens.¹⁸ The rural South has the highest rates of teenage births;¹⁹ these unintended adolescent births are at greater risk for poor perinatal outcomes partly due to the increased likelihood that pregnant teens will engage in risky behavior during pregnancy.²⁰

HIV/AIDS:

The rising prevalence of HIV/AIDS cases in women should be of concern to rural women. Between 1985 and 1999 the number of women HIV/AIDS cases in the U.S. tripled; 21.6 percent of the rural AIDS cases in 1999 were women. While this continues to be a problem for all rural women, minority women are particularly affected by this epidemic. In addition, the South accounts for over half of rural AIDS cases while it is home to only 35 percent of the nation's population.²¹

PREVENTIVE SERVICES:

The lack of women's health specialists and primary care providers results in low numbers of preventive services. While Pap tests, developed to screen for cervical cancer, have been available for decades, rural women continue to experience high rates of cervical cancer mortality.²² Treatment plans for abnormal Pap tests may be more difficult for rural women to follow because of availability, transportation, and cost considerations. Rural African American women have been found to be less likely to initiate regular mammogram use than rural White women.²³

DOMESTIC VIOLENCE/HEALTHY RELATIONSHIPS:

There is a need for more studies focused on domestic violence in rural communities. Feelings of isolation, lack of health insurance and continuity of care, lack of transportation, as well as heightened concerns about confidentiality may aggravate the problem of domestic violence in rural areas. Despite the general absence of data, that which is available suggests that domestic violence prevalence is high in rural communities.²⁴ Primary care providers are crucial to serving rural women who are facing domestic violence; it has been found that domestic violence is a primary reason for an increase in the use of health care services.²⁵ Coupled with the lack of data-based studies of rural domestic violence is the lack of development of models for improvement of screening and care and dissemination of these models.

ELDERLY/AGING ISSUES:

In 2001, the National Center for Health Statistics found that there were more rural women than men over age 44. In addition, the number of women aged 65 and older is projected to increase by 55 percent in non-metropolitan areas by 2020.²⁶

Rural women lack many of the human services available to their urban and suburban counterparts. They are more likely to be older, widowed, and poorer. The care, well-being, independence and quality of life of older women are impaired by such issues as lack of nearby younger family

members, difficulty accessing transportation, lack of knowledge of available services, and distances to services in rural communities.

Diseases such as age-related macular degeneration occur most frequently in adult and aging women. Specifically, rural areas lack many social and health services to care for older women provided by primary care physicians trained in gerontology and geriatrics, geriatricians and other specialists, social workers, nurse managers and caseworkers. This situation is compounded by the economic state of many rural communities, which often are unable to fund adequate services. In-home social services (adult day care, respite care, meals on wheels) are much less likely to be available in rural areas.²⁷

The Medicare population is demographically diverse and includes significant numbers of individuals who are financially and medically vulnerable, especially in rural areas. Beneficiaries are predominantly white (79 percent) and female (56 percent). Those over age 85 account for 12 percent of Medicare beneficiaries. Nearly four in 10 elderly have incomes below 200 percent of poverty with higher rates among Hispanics and African Americans. In recent years, cost increases have led to increases in Medigap premiums, resulting in higher out-of-pocket spending by beneficiaries.

Medicare beneficiaries account for 14 percent of the total U.S. population and a wide ranging share of state populations, from 7 percent in Alaska to 19 percent in West Virginia. Although people with Medicare are generally concentrated in urban areas, 24 percent of beneficiaries live in rural areas. Rural beneficiaries account for more than 70 percent of the Medicare population in South Dakota, Idaho, Mississippi, Vermont, and Montana. Barriers to accessing health care services often encountered in less populous areas can create challenges for Medicare beneficiaries in rural counties.²⁸ In addition to paying for health care services for the elderly through Medicare, the federal government also provides outreach and education through the Administration on Aging. These resources are an important avenue for reaching elders in rural and frontier communities.

MENTAL HEALTH:

Many rural women succeed in rearing healthy and very productive families and maintaining loving homes despite the challenges of low income, limited education and health care access. These women and their families generally reflect solid value structures and principles that contribute to their overall well-being which can be attributed to a significant measure of resilience.

The American Psychological Association (APA) has cited the lack of research in the area of rural women's mental health. However, the APA has conducted a review of the available literature and drawn some conclusions about rural women's mental health.

One study of a rural Central Virginia community health center providing primary health care to the medically underserved found 41 percent of women were found to be suffering from depression, compared to the typical urban prevalence rates of 13-20 percent. Several factors were related to higher rates of depression, including being younger, unemployed, and poorly educated.²⁹

In addition to responsibilities for parenting, housework and farm work, the job of caring for aging parents and ailing relatives is an added responsibility for many rural women. Social services are less accessible than in urban or suburban communities, and respite care may be hard to access or nonexistent.

Suicide rates have been found to be higher in rural than urban areas, with rural women in the western states committing suicide three times more than those living in metropolitan settings.

According to the APA, in rural areas the barriers to people seeking mental health care may be similar to those in urban areas: the perceived stigma associated with mental illness, lack of understanding about mental illnesses and their treatments, lack of information about where to go for treatment, and the inability to pay for care.³⁰ However, in rural areas, the lack of anonymity in rural areas adds an additional barrier where “everyone knows everyone.”

Geographical distances, lack of transportation, cost of mental health care services and lack of insurance, and maldistribution of providers can be additional barriers to rural women accessing mental health care.

POLICY RECOMMENDATIONS

Research is needed to describe the overall health status and access to health care services, including primary care, oral, vision and eye health services, available to women in rural and frontier areas.

In addition, research is needed in the following specific areas:

- Research should be supported by federal as well as private funding sources to obtain data on rural women’s access to and use of family planning.
- Research should be supported by federal as well as private funding sources to obtain data on rural domestic violence and rural women’s mental health.
- The NRHA supports funding from the National Institutes of Health for development of pilot programs to assure access to low vision services for rural women.
- More research is needed to articulate and contribute to the knowledge base of how some rural women’s values and resilience directly affect their health and mental health outcomes, when other rural women in similar circumstances have poorer outcomes in these areas.

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- The Department of Health and Human Services, through the Centers for Disease Control and Prevention (CDC), should facilitate the development of models for improvement of screening and care of domestic violence appropriate for rural populations and dissemination of these models.
- The Bureau of Primary Health Care should encourage rural community health centers to offer comprehensive family planning services.
- The Administration on Aging, DHHS, should conduct outreach to rural and frontier women and should make targeted funding available for programs that serve rural populations.
- The Office of Women's Health, DHHS, should designate a liaison for rural and frontier women's issues.
- The NRHA supports CDC funding and collaboration between the divisions of reproductive health, oral health and diabetes translation through the following initiatives, which should include a focus on access for rural and frontier women:
 - A) Healthy birth outcomes**
 - Identify and assess the impact of maternal exposures on birth outcomes:
 - Identify new methods to monitor risk factors, implement interventions before and during pregnancy, expand primary prevention programs for birth defects.
 - B) Preconception Care**
 - Establish and evaluate a research-to-practice effort to promote pre-pregnancy care which utilizes primary care providers in areas such as maternal health history, screening for disease during routine eye examinations (including identification of early inflammatory markers of disease), assessment for complications of existing illness such as diabetes (gestational) and counseling related to smoking, alcohol use, obesity and promotion of folic acid use.
- The NRHA reiterates its previous recommendation that reforms to the medical liability system should result in lower, affordable premiums for providers, including obstetricians.
- The Substance Abuse and Mental Health Services Administration should include rural women's mental health issues in its National Rural Mental Health Plan under development.
- The Federal block grant program authorized under Title V of the Social Security Act should provide adequate funds to rural populations.

ENDNOTES

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