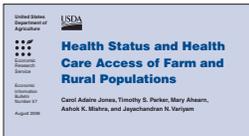


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Health Status and Health Care Access of Farm and Rural Populations

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Health is a critical component of household well-being, and reforming the U.S. health care system is high on the national policy agenda. Health care access and health status are a particular concern in rural areas, where the population is older, has lower education and income levels, and is more likely to be living in medically underserved areas than is the case in urban areas.

What Is the Issue?

U.S. health policy debates have focused on expanding health insurance coverage, improving health care quality and value, and achieving greater efficiencies and sustainable financing. Information on current geographic and demographic disparities in both health outcomes and access to high-quality and cost-effective health care can aid in the design and implementation of effective policy solutions. This report focuses on the health status and health care access of members of the Nation's rural households and farm-operator households in comparison with those of urban and nonfarm households.

What Did the Study Find?

Health status. Rural (nonmetro) residents have higher rates of age-adjusted mortality, disability, and chronic disease than their urban (metro) counterparts, though mortality and disability rates vary more by region than by metro status. The recently identified gap between metro and nonmetro mortality rates opened in 1990 and has widened continually since then. Farming has one of the highest occupational fatality rates of all occupations, and farm children also have high fatal accident rates. In addition, farmers are at high risk for work-related lung diseases, noise-induced hearing loss, skin diseases, and certain cancers associated with chemical use and prolonged sun exposure.

Socioeconomic status and behavioral health risks. The nonmetro population is older, is less likely to be from a minority group, and has lower education and income levels than the metro population. (Higher socioeconomic status, including education, income, and nonminority status, tends to be positively associated with health status.) However, within nonmetro areas, farm operators are more likely to have college degrees and greater economic resources and are less likely to be from a minority group than their nonfarm counterparts. Farmers whose major occupation is farming are less likely to smoke than nonfarmers, whereas nonmetro adults overall are more likely to smoke, to be obese, and to be physically inactive than metro adults.

Health insurance coverage and health care expenditures. Among nonmetro and metro populations, about 15 percent of all individuals had no health insurance coverage during 2007—this includes about 17 percent of the nonelderly population and 2 percent of the elderly population. (The

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elderly share is low because Medicare coverage starts at age 65.) The rates of uninsurance are considerably higher in the South and West (21 percent and 19 percent, respectively) than in the Northeast and Midwest (both are 13 percent). The study found no statistically significant disparities in coverage or in level of health expenditures by metro status; however, because nonmetro incomes are lower than metro incomes, nonmetro nonelderly populations pay a greater share of household income for health care than their metro counterparts.

Among all farm-operator households, 14 percent of all members did not have health insurance during 2007—this includes 15 percent of nonelderly and 7 percent of elderly household members. Lack of coverage is higher for members of households in which farming was the primary occupation of the operator (20 percent and 6 percent for nonelderly and elderly, respectively). The study did not find statistically significant disparities in coverage of nonelderly farm household members by metro status, and the regional variations are much smaller than those among the general population (lack of coverage is slightly elevated in the West relative to the South and the Midwest).

Nonmetro households are more likely than metro households to report that health care costs limit their medical care. In contrast, households of farmers who cite farming as a primary occupation are less likely to report that health care costs limit their medical care than households of nonfarmers.

Health care resources—quantity and quality. The accessibility of health care resources generally declines as population density declines and geographic isolation increases. In smaller and more remote counties where small patient volumes will not support full-service hospitals, the rural health care model focuses on providing primary care and emergency care locally, and referring patients to (often distant) regional health care centers for specialized care. As a result, rural residents in more remote areas incur higher financial and travel-time costs than urban residents for specialized treatment. As an alternative, they may substitute local generalists for specialists, or reduce their usage of health care.

Nonmetro hospitals, particularly the smaller, more remote Critical Access Hospitals, performed less well on average for process-of-care quality indicators for treatment of some conditions, though for other conditions their performance was comparable with metro hospital performance. Adoption rates for health information technology—widely touted to improve coordination of services and thereby improve quality and reduce costs—remain low at this point among all providers. Though high-speed connectivity to the Internet is becoming less of a stumbling block in nonmetro areas than it once was, nonmetro hospitals report lower adoption rates for electronic health record systems than their metro counterparts. Proposed national policy initiatives to improve health care quality and contain costs raise opportunities for rural health care. These initiatives, however, may also pose challenges for health care providers serving farmers and rural residents unless policies take into account distinctive features of the rural context. With smaller patient volumes, rural hospitals and other rural providers tend to provide a different portfolio of health care services and have a higher cost structure and lower levels of financial and human capital relative to urban providers.

How Was the Study Conducted?

This study used household-level data for various measures of health status, risk behavior, insurance coverage, and care expenditures, as well as for nonoccupational health risks and health care usage rates. (All health status and nonoccupational health risk variables are age-adjusted.) For farm households, USDA's Agricultural Resource Management Survey was the primary source of data on sociodemographic characteristics, insurance coverage, and health expenses. For all U.S. households, the U.S. Census Bureau's American Community Survey was the source for demographic information, and the Census Bureau's Current Population Survey was the source for economic and health insurance coverage information. The Medical Expenditure Panel Survey, developed by the U.S. Department of Health and Human Services (HHS), Agency for Healthcare Research and Quality, was the source for health expenditure data for all U.S. households. The National Health Interview Survey, developed by the HHS's National Center for Health Statistics, was the source of measures of health status, behavior, and use of health care for nonmetro households and for farm households (identified by having a household member who indicates farming as an occupation, a subset of all farm households identified by USDA). Measures of health resources were drawn from the Area Resource File, a county-level file developed by HHS's Health Resources and Services Administration, which contains health-related data from a wide variety of sources.