Rural Health Issues for the Older Population

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The rural elderly assess their health as poorer than that of the urban elderly. The range of health care providers and services in rural communities is narrower than in urban areas, and the rural elderly may experience structural barriers to accessing doctors, hospitals, or advanced medical services. For example, the per capita supply of physicians in nonmetro areas is considerably lower than in metro areas. Rural communities differ in their ability to meet the growing need for health care and other services of an aging population.

Americans are living longer, and as the population ages, major public attention turns to the declining health and consequent loss of independence in old age. With an aging population and an increasing number of persons at risk of disability and chronic conditions, the need for medical, rehabilitative, and social services will increase. Because older persons are primary users of health care services, the growth of this age group implies an increased burden on the Nation's health resources. Population aging has wide-ranging implications for health care, housing, and transportation, as well as social and health policy.

Rural areas generally have a higher proportion of older persons in their total population than urban areas; as of 2001, persons 65 and older constituted 20 percent of the U.S. nonmetro (or rural) population and 15 percent of the metro (or urban) population. The rural elderly assess their health as poorer than urban elders, and may thus have a greater need for health care services. Moreover, the range of health care services for the older population in rural communities is narrower than in urban areas. Fewer treatment alternatives are available, and fewer health care providers practice in rural areas. The older rural population is also more likely to be poor than the urban elderly, which introduces a financial barrier to obtaining adequate health care services.

Across rural America, some counties have grown by attracting older persons (retirement counties), while other nonmetro counties have aged through the outmovement of young adults. The different dynamics in the growth of the older population result in disparities between communities in terms of resources to meet the medical, social service, economic, housing, and long-term care needs of their populations. Sparsely populated rural communities are often far from specialized medical care and other health care services, which are concentrated in metro centers.

The problems affecting health care in rural America, such as greater travel times to obtain care and higher out-of-pocket health expenditures, often require solutions that differ from those appropriate in urban areas. This article examines rural-urban differences in health status, health resources, and access to health care services. The continued growth of the older population, especially in rural areas, will greatly affect resources such as medical care facilities, nursing homes, Medicare/Medicaid, and Social Security funds.

More Rural Than Urban Elderly Report Fair or Poor Health

Most people age 60 and older assessed their health as good to excellent in 2001, with metro elders reporting better health than nonmetro elders (fig. 1). Nearly 37 percent of nonmetro elders reported their health as fair or poor, compared with 32 percent of metro elders. Self-assessed health is a critical measure because it is associated with mortality, quality of life, and other important indicators of health status such as physical exams.

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With advancing age, self-assessments of health consistently decline. At age 60 to 64 years, 40 percent of nonmetro elders reported excellent or very good health; by age 85 and older, only 21 percent did so. As people live longer, many are active and healthy well past retirement. Those in their 80s, however, may have to cope with chronic disabilities and declines in physical functioning.

Difficulties in performing personal care tasks and home management tasks are referred to as "functional limitations." Activities of Daily Living (ADLs) measure ability to perform physical tasks such as eating, bathing, dressing, toileting, and getting in or out of a bed or chair. A higher proportion of elders in nonmetro counties reported a functional limitation than in metro counties—40.5 percent in adjacent nonmetro areas and 37.6 percent in nonadjacent nonmetro areas versus 34.3 percent in metro areas (Coburn and Bolda). In terms of restricted activity due to illness, residence made no difference in the number of days the elderly restricted their usual activities (about 31 days per year) or stayed in bed (about 14 days) (Van Nostrand).

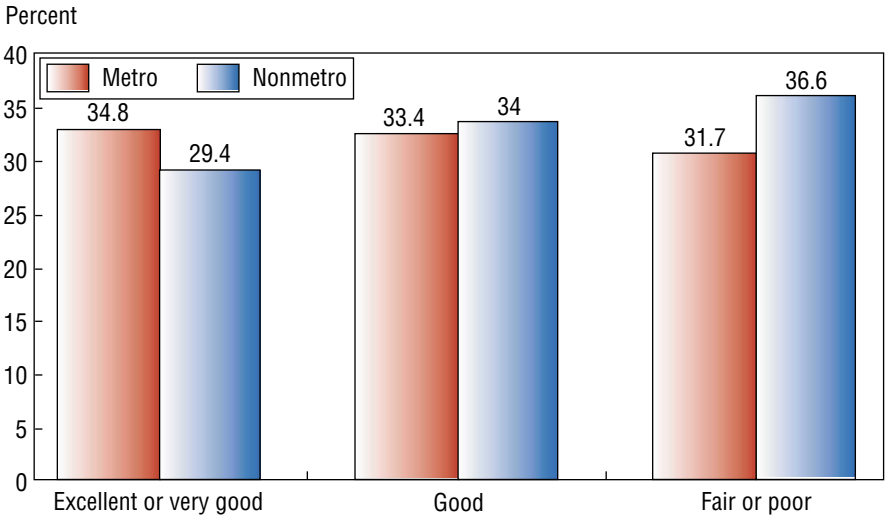
Higher socioeconomic status, measured by education and income levels, is strongly associated with more positive self-assessments of health and fewer functional limitations. Poorer health is found among the oldest old (age 85 and older), women, minorities, and those with fewer sources of social support. A significant proportion of the older population suffers from chronic conditions that affect their physical functioning and ability to live independently.

Residential location appears to affect health status indirectly. Nonmetro elders are more likely to have characteristics associated with poorer health because they tend to be less educated and financially worse off than the metro elderly, and lower socioeconomic status is strongly associated with poor health. Nonmetro elders are also more likely to have certain chronic conditions (for example, arthritis and hypertension) that darken self-assessed health status and impair the ability to perform various activities of daily living. Hence, the rural elderly may have a greater need for health care services than their urban counterparts. Furthermore, rural communities often lack

Figure 1

Health status of persons 60 years and older, by residence, 2001

A larger share of nonmetro elders reported fair or poor health than did urban elders

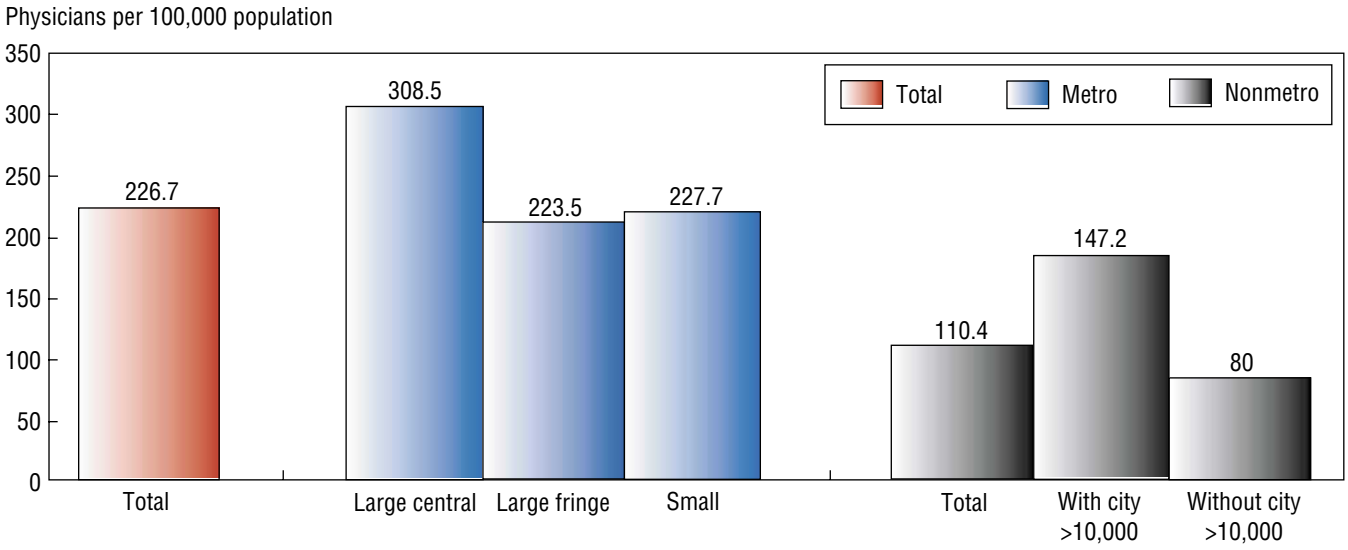


Source: March 2001 Current Population Survey (CPS) data file.

Figure 2

Number of physicians per 100,000 residents, by residence, 1998

Rural areas have a lower physician-to-population ratio



Source: National Center for Health Statistics, CDC. *Health, United States*, 2001.

comprehensive medical services and access to public transportation, which could compound the already poorer health of their older residents.

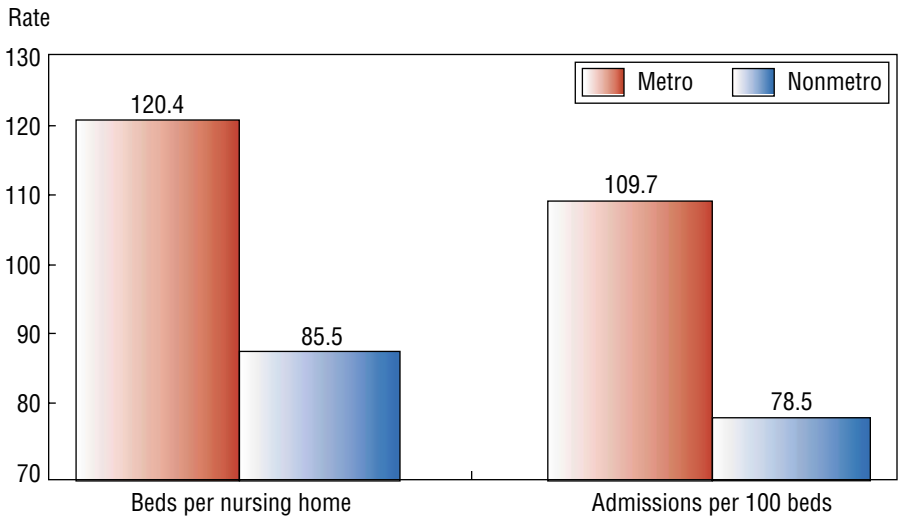
Rural Areas Have Fewer Physicians and Smaller Hospitals

Physicians. The rural elderly may experience structural barriers to accessing doctors, hospitals, or other medical services. In all regions, the per capita supply of physicians in nonmetro areas is considerably lower than in metro areas. In metro areas, there were 308.5 physicians per 100,000 population in large central counties in 1998, 223.5 in large fringe counties, and 227.7 in small metro counties (fig. 2). In contrast, nonmetro counties overall had 110.4 physicians per 100,000 population. Within nonmetro counties, physician-to-population ratios were related to county population size. Nonmetro counties without a city of 10,000 population had substantially fewer physicians per 100,000 people (80) than those counties with a city of 10,000 or more (147.2). The number of physicians practicing in nonmetro areas in relation to population has increased during the 1980s and 1990s, but more slowly than in metro areas (Ricketts et al.).

Figure 3

Nursing home beds and admissions, by residence, 1996-97

Nonmetro nursing homes are smaller than metro nursing homes



Source: Gabrel.

The comparison of all physicians is somewhat distorted due to the inclusion of specialists who are concentrated in urban centers. Even so, the per capita supply of primary care physicians in nonmetro areas is lower than in metro areas. In 1998, just 14 percent of primary care physicians in the U.S. practiced in nonmetro areas (Ricketts et al.), substantially lower than the nonmetro share (20 percent) of the total population. In remote rural areas that have a shortage of physicians or other primary health care providers, older persons may have to travel farther to obtain primary care and thus may visit physicians less frequently.

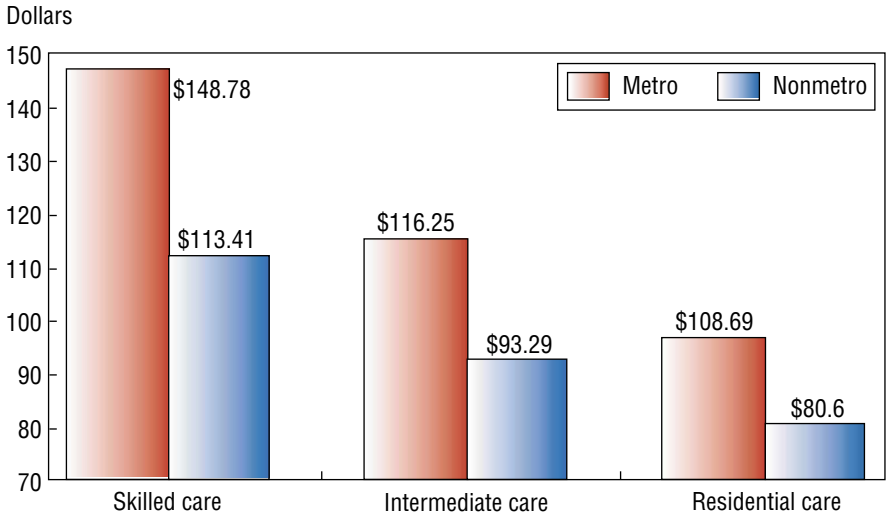
Hospitals. Rural hospitals are often small facilities that treat a low volume of patients. Many rural Medicare beneficiaries are treated in urban hospitals, primarily for specialized care that is not available locally. In 1998, 33 percent of rural Medicare beneficiaries were treated in urban hospitals (Buczko). Rural patients with severe conditions requiring complex surgical procedures are frequently referred or transferred to nearby urban hospitals. Those conditions most often responsible for rural beneficiaries' use of urban hospitals are related to coronary and other specialized surgical care.

In 1998, rates of hospitalization per 1,000 persons age 65 and older were 347.2 in rural areas and 274.1 in urban areas. Rural hospitals represent about half of all hospitals and about one-fourth of all inpatient beds in the United States. They are often small facilities (fewer than 100 beds) with small staffs. In urban areas, only 26 percent of hospitals have fewer than 100 beds, while in rural areas 81 percent of hospitals have under 100 beds. Many of these small hospitals depend on Medicare patients. Because of low patient volume, rural hospitals are more financially vulnerable than urban hospitals.

Figure 4

Average daily charge for private-pay nursing home residents, by level of care of facility and residence, 1997

Nonmetro nursing home residents pay less for nursing home care than do their urban counterparts



Source: Gabrel.

The 1990s brought several changes to the organization of rural health care, such as managed care, hospital mergers, and the development of multi-hospital systems. Many rural hospitals joined multihospital networks, alliances, or systems to increase their viability and better cope with the growth of managed care. However, the growth of managed care in rural areas and the development of rural hospital systems have lagged in comparison with urban areas. Because of this, rural residents may have been increasingly drawn to urban areas for inpatient care in the 1990s. Although this necessitates traveling farther to obtain health care, rural residents gain in obtaining specialized and more comprehensive medical services.

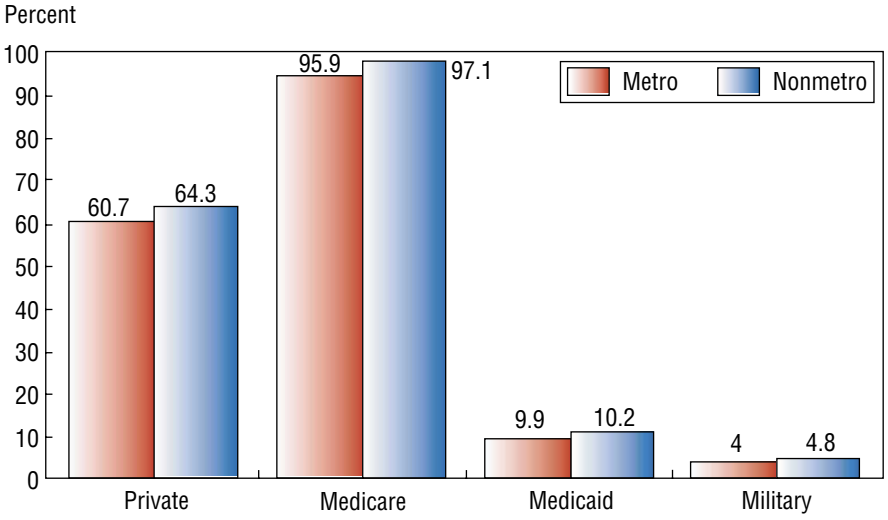
Nursing Homes. Only a small portion of the elderly population resides in nursing homes—in 2000, 4.5 percent of those 65 and older (Census Bureau). However, as this population grows, an increased need for nursing home care is inevitable. When the leading edge of the baby boom generation reaches age 65 in 2010, the need for nursing homes will increase even more.

The 1997 National Nursing Home Survey indicates that there were 10,500 nursing homes (61.5 percent) in metro areas and 6,600 nursing homes (38.5 percent) in nonmetro areas. Metro nursing homes are larger (120 beds per

Figure 5

Health insurance coverage of persons 65 and older, by type of coverage and residence, 2001

Nonmetro persons 65 and older were more likely to have private health insurance coverage than were metro persons



Source: March 2001 Current Population Survey (CPS) data file.

nursing home) than nonmetro homes (85.5 beds). The number of nursing home residents 65 and older was 1,006,500 in metro areas and 458,500 in nonmetro areas. Thus, a disproportionate share was in nonmetro areas in 1997 (31.3 percent), as only 24 percent of the population 65 and older resided in nonmetro areas. Nursing homes in metro areas had higher admissions (109.7 per 100 beds) than nonmetro areas (78.5) (fig. 3), suggesting that because nonmetro homes are smaller, they are less able to accommodate demand.

Of the total number of nursing homes in metro areas in 1997, 81 percent were certified by Medicare and Medicaid; in nonmetro areas, 71 percent were certified. Daily charges are higher in homes certified by Medicare. In 1997, the average daily charge in Medicare-certified homes was $234.72 in metro areas and $183.19 in nonmetro areas. The level of nursing home care also affects the average daily charge of private-pay nursing home residents. Charges were highest in skilled-care (versus residential) facilities (fig. 4), with charges higher for metro areas ($148.78) than nonmetro areas ($113.41). Nursing homes located in nonmetro areas are less likely than those in metro areas to have certified skilled nursing beds or special care units.

Rural and urban elderly differ in the mix of long-term care services they use. Home health care services serve as an alternative to institutionalization. The rural long-term care system is characterized by a larger supply (per elder) of nursing home beds than in urban areas and fewer community-based home health services and residential care options. This may contribute to the higher rate of nursing home use among the rural elderly and the lower rate of home health and other community-based inhome services.

Health Insurance. Most elderly persons have some form or combination of health insurance coverage. Less than 1 percent of the 65-and-older population have no health insurance coverage. In 2001, 96 percent of the metro elderly were covered by Medicare and 97 percent of the nonmetro elderly were covered. About 10 percent of all elderly persons had Medicaid coverage. A slightly higher share of the nonmetro elderly had private insurance (64 percent) in 2001 than the metro elderly (61 percent) (fig. 5). This includes "Medigap" policies that fund various services not covered by Medicare such as prescription drugs.

Rural Access to Health Services Is More Difficult

Structural barriers to health care access include a lack of specific medical services in the local area, fewer health professionals, and difficulty in reaching facilities. Other access barriers are financial and include the lack of affordable and available transportation, limited income, and less insurance coverage. Income has a strong effect on access to health care resources. Low income has a more pervasive relationship to self-reported access, satisfaction, and use of health care services than does rural residence per se (Stearns et al.).

Access to health care varies between urban and rural areas as well as within rural areas. The older residents of nonadjacent and remote nonmetro counties have the greatest difficulties. Medicare beneficiaries in nonmetro counties that are adjacent to metro areas and have their own city of at least 10,000 population report higher levels of satisfaction and fewer access problems than do residents of metro counties (Stearns et al.).

Preventive vaccination rates in nonmetro areas are on par with or better than rates in metro areas. However, preventive cancer screening for women and dental care are less accessible in rural than urban areas (Stearns et al.).

Across rural America, some counties have grown by attracting older persons (retirement counties) while other nonmetro counties have aged through the outmovement of young adults. Rural retirement counties are presently defined as those with an increase of 15 percent or more in population age 60 and older from inmigration between 1980 and 1990 (Reeder). Retirement communities benefit from an increased population and tax base and are better able to provide needed services. Older persons who move to retirement areas are generally better educated than the average older person and more aware of programs and services available to them. They also tend to be in better health than average and bring higher than average income to the retirement area. On the other hand, rural areas with a high proportion of older persons but without an influx of retirees have a declining population and tax base, which may result in unanswered needs of the elderly in terms of income, health care, housing, and transportation.

There are numerous barriers and challenges to reducing the differences in health and long-term care access and use for rural older persons. First, the current financing of long-term care generally, and in rural areas particularly, limits the availability of services in rural areas. As the rural elderly are less able to pay for long-term care services out of their own pockets than the urban elderly, they are more dependent on Medicare, Medicaid, and other public programs to meet their long-term care needs. The Balanced Budget Act of 1997 reduced Medicare post-acute care expenditures, and continuing pressures on public programs may limit access to critical services for rural older persons (see "Implications of Medicare Restructuring for Rural Areas" in this issue). Moreover, the smaller economies of scale, higher costs of developing and providing services, and lower supply of critical health personnel handicap the development of adequate long-term care services in rural communities.

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A related challenge will be to develop better models for delivering health and long-term care services in rural areas. This is especially important in light of limited financing for long-term care and the competition for health personnel. The development of partnerships and service networks among rural and urban health and long-term care providers may be one solution. The expansion of newer financing and delivery systems in rural areas could provide the necessary incentives for service expansion and integration among acute and long-term care providers.

Conclusion

Several aspects of the aging U.S. population are of major public concern and will affect future programs and services for the elderly. Growing numbers of older persons, especially those age 85 and older, will lead to increased needs in terms of health services, finances, housing, and social and psychological support. Declining health and poverty in old age are serious concerns, especially for subgroups such as the oldest old and the most rural elderly. The oldest component of the older population is the most likely to need health care and physical support, and may also need special programs to alleviate their financial situation.

Rural communities are more limited in public sector capacity than urban areas and are usually economically concentrated in a few industrial sectors. Within rural America, there is wide diversity. Rural retirement areas are benefiting from growth, as inmigrating retirees boost the tax base and help sustain local businesses. Alternatively, farming- and mining-dependent rural areas have been losing working-age persons and experiencing declining populations and tax bases. The remaining older population in these areas has increased demands for medical and social services and long-term care. While Medicare provides significant health insurance at relatively little or no cost, it offers very limited coverage of long-term care services—whether in the community or in a nursing home—and much of the cost is borne by older people and their families. The need for long-term

care will most likely increase with the growth of the oldest old.

Based on trends in the 1990s, nonmetro retirement counties are expected to continue their rapid growth. Retirement counties constitute only 9 percent of all nonmetro counties, but they accounted for 25 percent of the population growth during the 1990s. With the aging of the population, nonmetro retirement counties will most likely continue to outpace other nonmetro counties in population growth. Many retirement areas benefit from an influx of highly educated older persons, since they tend to have higher incomes as well. Older persons in good health and highly educated will be in a position to better avail themselves of available programs and services. Although remote rural areas have not experienced as large an increase in their older populations, these areas are less equipped to provide services and programs to meet the needs of the elderly. Furthermore, the most rural counties are also the most likely to have higher rates of elderly poverty, putting them at an even greater disadvantage in providing needed services.

The restructuring of the Medicare program and payment policies will have significant implications for the sustainability of rural health systems. In addition to ensuring that Medicare policies support rural people and health care systems, attention needs to focus on the long-term care needs of rural populations. The rural elderly are less able to pay for long-term care services out of their own pockets and are therefore more dependent on public programs. Yet currently, public funding of long-term care cannot meet the growing demand for such care. If significant shortfalls in Medicare funding occur, the underserved rural communities and populations could easily fall through the cracks. RA

For Further Reading . . .

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