

R E S I D E N C E : **R U R A L *a n d* U R B A N**

NATIONALLY, WE KNOW:

- Twenty percent (20%) of Americans live in rural areas, defined as places with fewer than 2,500 residents.
- Although some health disparities between rural and urban residents may be a direct result of the inherent structural differences of a rural area, some are clearly the result of a complex interaction among structural, cultural, and economic differences.
- Poverty is higher in rural areas. Fourteen percent (14%) of rural Americans lived in poverty compared to 11% of urban Americans in 1999 (Census).
- Rural residents have fewer health care providers per capita and increased transportation barriers. For example, only 9% of the nation's physicians practice in rural areas, even though 20% of the population lives there. There especially appears to be a shortage of dentists in rural areas compared to urban areas.

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"One of the biggest challenges for improving health of rural Mainers is to begin to understand the underlying cultural issues that lead to unhealthy behaviors and develop culturally appropriate initiatives to change them. These will quite likely be different from one community to the next."

"A second challenge is to begin to effect a change in the medical community toward a population perspective that acknowledges these cultural factors and takes them on, helping every primary care practitioner to accept responsibility for population health."

"A third challenge, and perhaps the most difficult, is to distribute responsibility for population health across a broader spectrum of the leadership of rural communities by means of multi-sector partnerships. The business community, schools, municipal government, and the citizenry must recognize that economic health, social health, and physical health are intimately related, and that the future welfare of each rural community depends on an integrated, collaborative effort across all the factors that make for a healthy rural community."

"The health of rural Mainers is directly connected to the health of rural Maine communities."





Critical Access Hospital Program (Maine Rural Hospital Flexibility Program)

This Federally-funded program, administered by the Maine Department of Human Services' Bureaus of Health and Medical Services, allows rural hospitals to convert to cost-based reimbursements under Medicare and Medicaid (MaineCare). In exchange, the hospital agrees to continue 24-hour emergency services and provide appropriate staff, but to limit the number of inpatient acute care beds (15 acute care beds and 10 swing beds for a total of 25 licensed beds).

This program was created in 1997 by Congress to address the problem that many of our country's rural hospitals serve a higher proportion of elders and low income people and, therefore, are often more highly dependent on Medicare and Medicaid funds.

As of August 2002, seven Maine hospitals have converted to CAH license:

- **Blue Hill Hospital**
- **Calais Regional Hospital**
- **Penobscot Valley Hospital in Lincoln**
- **St. Andrews Hospital in Boothbay Harbor**
- **CA Dean Hospital in Greenville**
- **Mount Desert Island Hospital in Bar Harbor**
- **Rumford Hospital**

- Because there are fewer specialists in rural areas, primary care providers (such as family physicians, pediatricians, internists, nurse practitioners, and physician assistants) tend to be utilized much more frequently for specialty-type care such as treating mental disorders, orthopedic, and cardiac illnesses.
- Rates of health insurance are lower in rural areas than urban.
- Access to emergency services and the availability of specialty care are challenges in rural areas.
- People living in inner-city areas often lack access to health care because of a shortage of primary care providers, cultural barriers, lack of health insurance, and lack of awareness of available health services and how to access them.
- Rural residents visit a physician less often and later in the course of an illness than their urban counterparts.
- Preventive screening rates (such as mammograms, cholesterol, blood pressure checks), physical activity rates, and safety belt usage are lower in rural than in urban areas. However, it appears that leisure-time physical activity rates are higher (by 20%) in rural areas of the Northeast than their urban counterparts.
- Tobacco addiction rates are higher in rural areas versus urban and urban fringe areas.
- Injury-related deaths are 40% higher in rural populations than urban.
- Deaths from suicide are at higher rates in rural areas than urban.
- Heart disease, cancer, and diabetes rates are higher in rural areas than urban.
- Limitation in activity due to chronic health conditions among adults is more common in rural areas than urban.



- Some of our country's highest death rates, including the highest infant mortality rates, are found in our most rural areas.
- People who live in the most rural areas (fewer than 10,000 people) and inner-city areas share several factors in common: higher rates of poverty, mortality, and poorer health status than their suburban counterparts.
(Urban and Rural Health Chartbook, National Center for Health Statistics, 2001.)

IN MAINE, WE KNOW:

- Maine ranks 38th nationally in population density.
- According to the 1990 Census, Maine, along with Vermont and West Virginia, were the states with the highest proportion of population classified as rural.
- Forty percent of Maine's population lives in three counties – Cumberland, Penobscot, and Androscoggin – which are all designated as metropolitan counties by the US Census Bureau. However, all three of these counties include a wide variety of demographics from densely populated cities (Portland, Bangor, and Lewiston-Auburn) to suburban areas to sparsely populated communities, with profiles more fitting of rural areas.
- Rural counties tend to have older populations. For instance, people 65 years and older comprise 13–14% of the population in Cumberland, Androscoggin, and Penobscot Counties, whereas they comprise 17% of the populations of Aroostook, Piscataquis, and Washington Counties.
- Rural counties in Maine tend to have higher rates of poverty and lower median incomes. For instance, Cumberland, Androscoggin, and Penobscot Counties have 8–12% of their population living in poverty and median household incomes ranging from about \$36,000 to \$41,000. By contrast, Aroostook, Piscataquis, and Washington Counties have 14–18% of their population living in poverty and median household incomes ranging from about \$25,000 to \$29,000.
- Ethnic and racial minority populations vary between rural and urban counties in Maine. For instance, black and Asian populations tend to account for most racial minority populations in Cumberland and Androscoggin Counties. Native Americans account for most of the racial minority populations of Washington and Aroostook Counties.
- Rural areas of Maine tend to have fewer health care providers per population. For instance:
 - Cumberland County has about twice the density of primary care allopathic physicians (MDs) than Oxford, Piscataquis, and Washington Counties (97 per 100,000 versus 43, 49, and 53 per 100,000 respectively).
 - Cumberland County has over twice the density of dentists than Oxford, Piscataquis, and Washington Counties (72 per 100,000 versus 32, 33, and 31 per 100,000 respectively).
 - There are 39 Health Professional Shortage Areas (HPSAs) in Maine, which account for the majority (63%) of Maine's Primary Care Analysis Areas. Most HPSAs are in rural areas.

Percent Of Population Living In Rural Areas
(Using Census Bureau Definition Of Rural Areas As Counties
Designated Nonmetropolitan)

	US	Maine
1900	60%	67%
1990	25%	55%
2000	20%	60%

Source: US Census.



CHALLENGES

- Town of residence is collected by many health data systems including the Census, PRAMS, MHDO, the Cancer Registry, Vital Records, and Infectious Disease Reports; and it may soon be collected by BRFSS (see Health Data Section beginning on page 65).
- However, defining rural and urban areas in Maine is particularly challenging. Commonly used Federal definitions do not accurately reflect Maine's population distribution patterns. Consequently, we lack the ability to accurately assess many health indicators as they relate to degrees of urbanization and rurality in Maine.
- The US Office of Management and Budget (OMB) uses a definition for urban that includes population densities as well as social and economic integration factors. Their definition of Metropolitan Areas includes the entire county that an urban area is in. Using this definition, Cumberland, Penobscot, and Androscoggin counties are considered entirely Metropolitan Areas because they include the cities of Portland, Bangor, and Lewiston/Auburn. However, many of the communities in these counties have the demographic, social, and economic characteristics of rural areas.
- Likewise, the Census Bureau has defined densely settled Urbanized Areas and the contiguous areas as Urban Clusters. Using this definition in Maine, there are only three Urban Clusters – Portland, Lewiston/Auburn, and Bangor. Essentially, the Census Bureau's definition defines all non-urban areas as rural. As a result, this definition does not reflect gradations in our population density seen in small cities such as Augusta and Waterville.
- The Bureau of Health is committed to looking at populations and data on a rural-urban continuum. By working with partners around the State, the Bureau hopes to create a definition that will reflect the gradations in population densities seen in Maine, so that health data can be evaluated to reflect the impact of geographic residence on health status.
- The Bureau has analyzed BRFSS data using the OMB definition (urban counties versus rural counties), as well as some analyses using population density data by town. No significant differences have been detected so far between rural and urban residents of the BRFSS questions analyzed using these methods. Other methods, as mentioned above, are being explored.

Nathan Nickerson, Director Public Health Division, Health and Human Services Department, City of Portland



"I think the biggest challenge and opportunity for Maine's health professionals and communities is that we are entering into a time in which two important health issues are front and center. First, there is an emerging political will to address the need for health care coverage for all residents of Maine. Second, I believe there is an unprecedented interest in developing a functional local public health infrastructure throughout the State. If we can take advantage of these opportunities, and meet these challenges, we will have taken a giant step forward toward being equipped for a healthier Maine."