

Executive Summary

The New England Region Rural Health Data Analysis is a unique examination of the health care and health related data that describe a range of demographic, access, utilization, and health outcome parameters for rural communities across the six-state region and compare these to the non-rural areas of the region. This approach is consistent with the mission of the New England Rural Health RoundTable (NERHRT), which employs a regional strategy to support and promote high quality and accessible health care for rural residents of the area and to address the challenges presented by the unique character of New England's rural communities. While available data cannot describe all aspects of the region's rural health situation, nor provide great depth of insight into underlying causes or potential solutions directly, it is a valuable and important first step in targeting attention and efforts to further explore, and ultimately to address, the most pressing problems and vulnerabilities in the system.

The study is based on a rural definition developed in consultation with rural health policy leaders representing each of the New England states. The definition balances and unifies the differing views of rurality across the region into a consistent schema that reflects the rural character of New England. The definition produces a four-tiered rural stratification, of which three tiers define varying levels of 'rurality', and the fourth reflects the non-rural areas. Notably, this approach characterizes only 2.7 million (20%) of the region's nearly 14 million residents as rural, though the rural communities in which they live account for 83% of all the land in New England. The population density in the non-rural areas of the region is nearly 20 times as high as in the combined rural tiers.

The results of the analysis provide a mixed picture of the rural health landscape in New England—a functioning yet fragile system struggling to overcome a variety of underlying challenges. On one hand, by the broadest measures of health status, it appears that rural residents of the region are not significantly sicker than their non-rural counterparts. Age adjusted overall mortality rates—perhaps the ultimate outcome measure of a health care system—are consistent across the region. Self-assessed health status is also reasonably comparable between rural and non-rural areas, as are all measures of self-reported chronic disease status.

On the other hand, the data show significant disparities between rural and non-rural areas on a variety of key factors associated with health care access problems, as well as evidence of some ongoing access issues. On many of these measures, the data also show a notable correlation with the increasing degree of rurality, where the small and isolated rural areas show greater degrees of adversity than the large rural areas. The rural population was characterized by lower income and educational attainment, and greater reliance on self-employment and in occupations unlikely to offer health benefits. Survey data demonstrates that rural residents are 37% more likely to be uninsured than their non-rural counterparts, with higher disparities in the more remote areas. Geographic access was also an issue, with public transportation generally not available, significant numbers of households with no vehicle available, and higher proportions of the population living more than 15 miles from the nearest hospital.

Rural areas were shown to be highly dependent on support from programs designed to help sustain the health care infrastructure. Nearly all hospitals in the small and isolated rural areas were participating in the Critical Access Hospital program. In general, primary care providers were reasonably available on a per-capita basis, though such availability was highly linked to the support of programs such as the rural health clinics and federally qualified health centers, which collectively delivered the great majority of the care in the more remote rural areas. Rural primary care was also highly dependent on family practice providers, with a relative paucity of more specialized internists, pediatricians and obstetrician/gynecologists. Despite a reasonable ratio of providers to the population, there were several data points indicating that rural residents were still experiencing greater access barriers to primary care compared with their non-rural counterparts. This includes more individuals going five or more years without a checkup, elderly patients foregoing routine annual exams and individuals claiming to have foregone needed care because of cost. Primary care providers in residency training were also not proportionally distributed in rural areas, pointing to potential issues in maintaining the rural workforce going forward.

In the realm of more specialized services, the picture was worse. Dental and mental health access was clearly problematic in rural areas, based on the much higher proportion of residents living in federal shortage areas for these services. The high rate of rural suicide also tends to confirm the need for rural mental health services. Specialized medical providers were also clearly concentrated in the non-rural areas of the region. There is also some evidence that public health and prevention issues may need additional emphasis in rural areas of the region, including nearly twice the rate of maternal smoking during pregnancy, and higher rates of teen pregnancy and late entry into prenatal care. Also, the rates of death from accidents and firearms were notably higher in rural areas.

The data highlight both the ongoing challenges in providing equitable access to health care services for residents of rural New England, as well as the results of the ongoing efforts put forth by rural communities and health care providers to meet those challenges. The region's rural health care system shows some ongoing disparities in access, however, the evidence suggests that some of these disparities would likely be much greater without the ongoing support of a network of programs that help maintain the fragile rural health infrastructure, and the work of providers to access these resources. Going forward, there are clearly several areas where improvements in access are needed. Addressing these will likely require the collaborative efforts of providers, community-based organizations, businesses, and policy makers. Stakeholders in the region's rural health care system must be as equally vigilant in protecting and building upon the resources currently available as in addressing the challenges that remain.

Lastly, one must note that additional study is necessary to further explore some of the key issues highlighted in this report. The readily available data were sufficient to provide a broad overview of many health and health-related statistics across the region and to highlight a range of key differences and disparities worthy of being addressed. An in-depth exploration of these areas, however, would require more detailed access to existing data maintained at the state level, and potentially research designs requiring unique information to be collected. We encourage the use of this report as a framework for ongoing examination of existing data on a rural-specific basis and to direct future efforts in addressing the key challenges identified for rural health in the New England region.

