

# RURAL 2009 WOMEN'S HEALTH

## INTRODUCTION

The most important conversation about health care in a generation is happening now. As proposals for health care reform are offered and debated, it is critical that the needs of Minnesota's rural women and families are included and addressed.

While health care disparities affect women in every community, barriers to care for rural women are exceptionally complex. In Greater Minnesota, a combination of poverty, uninsurance, provider shortages, and simple geography

merge to create significant obstacles to basic health care services that impede the health outcomes of rural women. Rural women of color and American Indian women experience all of the above barriers in addition to cultural differences, racism and discrimination, language barriers, and migratory patterns that further fragment access to needed health care.<sup>1</sup>



of rural women. Rural women of color and American Indian women experience all of the above barriers in addition to cultural differences, racism and discrimination, language barriers, and migratory patterns that further fragment access to needed health care.<sup>1</sup>

More than 94% of Planned Parenthood's 64,000 patients are women, and nearly 60% live in rural Minnesota. This report contextualizes the health status of rural women, summarizing important public health indicators, examining barriers to improving health outcomes, and exploring solutions for addressing health care access among this often overlooked population.



## RURAL WOMEN'S HEALTH BARRIERS TO CARE

The obstacles faced by health care providers and patients in rural areas are vastly different from those in urban areas. Economic factors, social and cultural differences, limited educational opportunities, lack of recognition by legislators, and the isolation of living in remote areas all impact rural residents' ability to lead a healthy life.<sup>2</sup>

More than one in four Minnesotans lives in a non-metropolitan area, a proportion greater than 27 other states, including Alabama, Tennessee, Wisconsin, Utah, Ohio, Illinois, Missouri, Louisiana, Nevada, and Texas.<sup>3</sup>

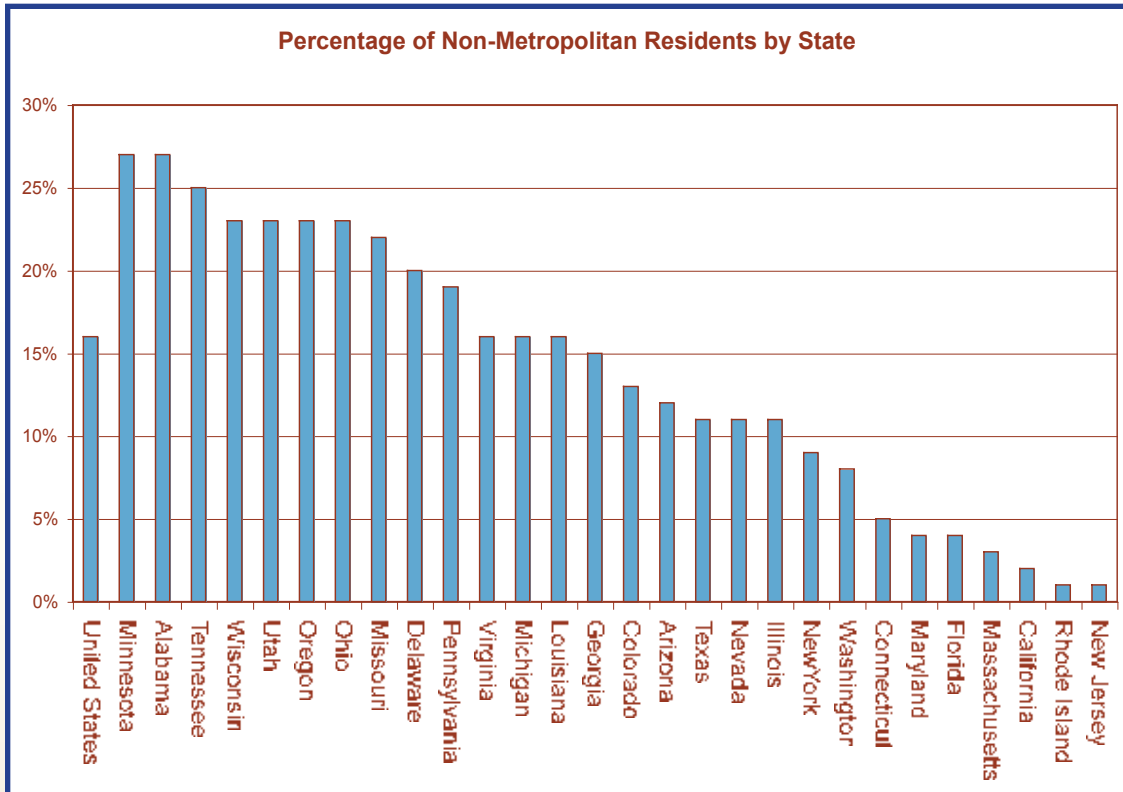


WOMEN'S HEALTH MATTERS

Visit us on the web: <http://www.ppmns.org>

**At Planned Parenthood, nearly 6 in 10 women and more than 6 in 10 men served in 2008 were rural Minnesotans.**

Minnesotans in rural communities are more likely to live in poverty and less likely to have health insurance coverage than their urban counterparts. Rural Minnesotans are also more likely to live in areas with health professional shortages, meaning that they must travel further distances to access needed health care services.<sup>4</sup>



## Poverty

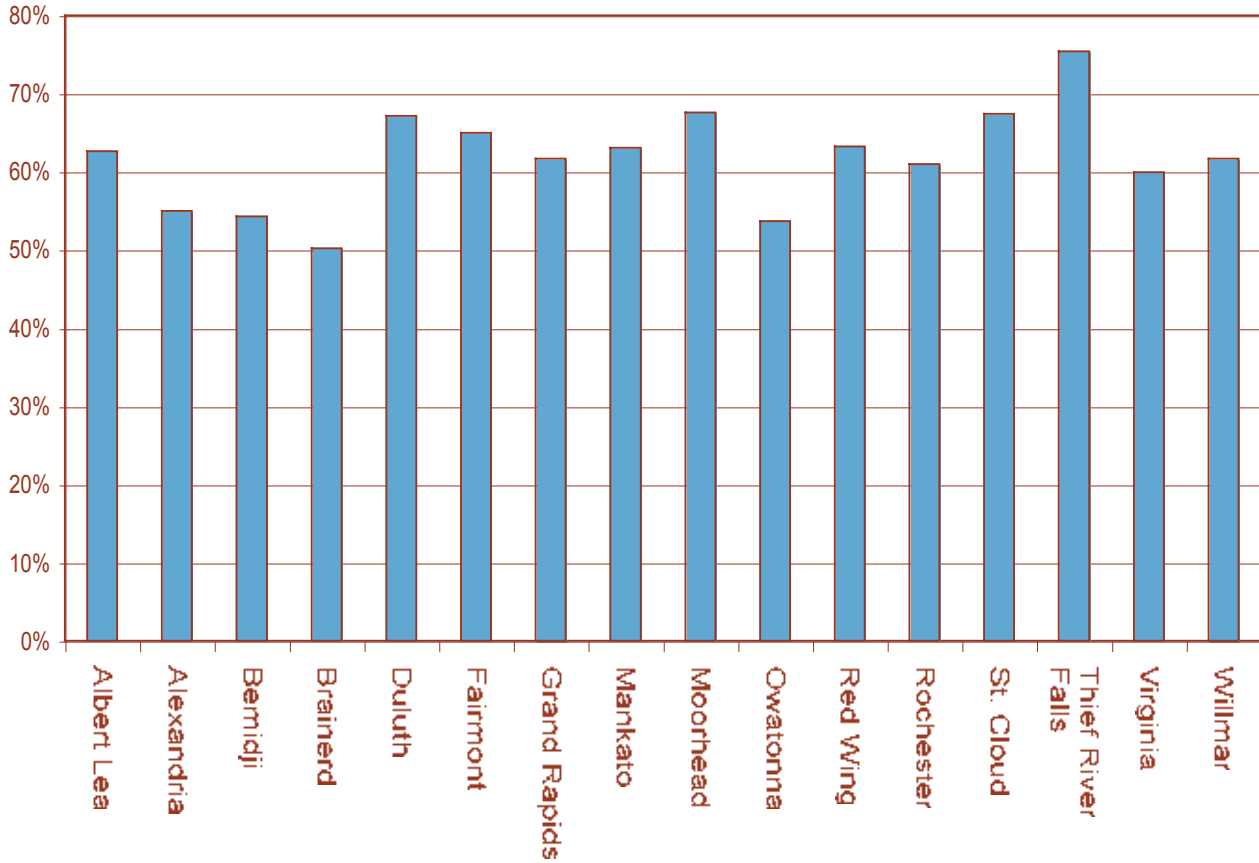
Minnesotans in rural communities are more likely to live in poverty (14%) than are their urban counterparts (11%).<sup>5</sup> This disparity in income is even greater for people of color living in rural areas.

In rural Minnesota, as in most communities, poverty disproportionately affects women and children. Poverty among rural women dramatically affects access to health and human services for entire families, particularly as women tend to be responsible for accessing health care services for their children.<sup>6</sup> Impoverished rural Minnesotans are consequently more likely to rely on public assistance payments than are their urban peers, including family assistance, food stamps, and supplemental Social Security.<sup>7</sup>

Several of Minnesota's rural communities are critically impoverished, with poverty rates more than 50% above the state average. These include the counties of Clearwater (12.4%), Mahnomon County (15.5%), and Beltrami (15.8%), and the cities of St. Cloud (13.1%), Duluth (15.5%), Moorhead (16.3%), Winona (17.3%), and Mankato (19.0%).<sup>8</sup>

At Planned Parenthood, more than half of our patients live at or below the federal poverty level. In our Greater Minnesota clinics, the number of patients living in poverty jumps to 63%.

Percentage of Greater Minnesota Patients Living in Poverty by Clinic Location



## Health Insurance Coverage

**Having health insurance is among the greatest predictors of accessing health care services.**

Rural residents are less likely to have employer-provided health care coverage or prescription drug coverage than their urban counterparts. They are also less likely to be covered by Medicaid or other public insurance programs.<sup>9</sup>

Rural Minnesotans who **are** insured more commonly have individually purchased policies, often with high premiums, large deductibles, and steep co-payments.<sup>10</sup>

Studies have shown that in rural areas, where there are large percentages of uninsured women and families, a higher percentage of rural residents also report fair or poor health, no visit to a health professional in the prior year, and less confidence in receiving needed health care services. A lack of health insurance coverage is associated with lower utilization of preventive services, such as cancer screening, and care for ongoing health conditions, including heart disease, diabetes, oral and dental health, and mental health.<sup>11</sup>

At Planned Parenthood's rural clinics, just 1 in 3 patients has public insurance and only 1 in 5 patients has private insurance. Just 3% of Planned Parenthood's Greater Minnesota patients can afford the full cost of their health care, and nearly half require subsidy in order to access needed health care services.

Having health insurance coverage is among the greatest predictors of accessing health care services. People with health insurance are more likely to have a primary care provider and to receive appropriate preventive care, including cancer screenings, immunizations, and early prenatal care.<sup>12</sup>



## Health Professional Shortages

**Under health care reform, “failure to account for the nuances of delivering care in rural areas may make access, care delivery, and health outcomes worse instead of better.”**

**– Minnesota Department of Health**

More than half of Minnesota’s rural counties have been designated as health professional shortage areas due to an inadequate number of primary care providers.<sup>13</sup> Accompanying this scarcity of physicians are significant shortages in registered nurses, pharmacists, and ancillary medical personnel. Nearly 40% of rural Minnesotans live in communities without adequate access to needed primary care services.<sup>14</sup>

Rural Minnesota families must therefore travel great distances to receive health care services, a requirement compounded by the geographic and topological limitations of our state. Minnesota’s severe weather, coupled with limited public transportation options and rural

roads in disrepair, can make accessing health care nearly impossible for rural residents.<sup>15</sup>

## RURAL WOMEN'S HEALTH HEALTH OUTCOMES

People in rural areas report higher rates of chronic disease and poorer reproductive health outcomes than do urban areas. In particular, rural women are disproportionately affected by higher rates of mental illness and suicide, nicotine addiction and substance abuse, obesity, and cervical cancer incidence.<sup>16</sup> Health outcomes for rural women of color and American Indian women include an increased severity of cardiovascular disease, diabetes, intimate partner violence, HIV/AIDS, breast and ovarian cancers, and infant mortality as compared to their urban peers.<sup>17</sup>

### *Cervical Cancer*

Minnesota statistics indicate that rural women are 30% more likely to be diagnosed with invasive cervical cancer than are women living in metropolitan areas. Rural Minnesota women are also more likely to be diagnosed at an older age, and at a later stage of the disease, when treatment options may be less successful.<sup>18</sup>

In addition, fewer rural women receive recommended, preventive gynecological care, including mammograms, Pap tests, and colorectal cancer screening than do their urban peers.<sup>19</sup>

### *Poor Pregnancy Outcomes*

Rural women are also more likely to experience adverse pregnancy outcomes than are urban women. A number of state-based studies have found increased rates of infant mortality among rural residents as compared to urban residents, which is related to a number of factors:<sup>20</sup>

- More rural than urban or suburban women receive delayed or no prenatal care. Rural women also receive less adequate care when it is available. This is a major concern in rural areas as risk factors for infant death include delayed or no prenatal care, contributing to a higher rate of infant mortality in rural communities.
- More mothers in rural communities are under age 20 or over age 40. Teen pregnancy rates in particular are often higher in rural communities than in major cities.
- Maternal smoking during pregnancy is higher in rural areas.
- Rural women are more likely to have more than three previous births, which contributes to an increased risk of pregnancy complications and is also linked to poverty.

Rural women are also less likely to receive even one family planning service over the course of a year than are urban women.<sup>21</sup>

### *Teen Pregnancy*

Teen pregnancy is endemic in rural Minnesota. Fully 43 counties in Minnesota have teen pregnancy rates higher than the state average; all but two of these counties are in Greater Minnesota.<sup>22</sup> The Greater Minnesota communities with the highest rates of teen pregnancy include Mahanomen, Nobles, Watonwan, Beltrami, Wadena, Clearwater, Chippewa, Mille Lacs, Kandiyohi, and Pine counties.<sup>23</sup>

## Sexually Transmitted Infections

The greatest increases in sexually transmitted infection (STI) incidence continue to occur in Greater Minnesota. In 2008, the chlamydia rate in rural Minnesota increased by 10%, while the gonorrhea rate increased by 14%. Indeed, Greater Minnesota was the only geographic region to experience an overall increase in gonorrhea incidence last year.<sup>24</sup> Women generally suffer more severe complications from STIs than do men, including pelvic inflammatory disease, ectopic pregnancy, infertility, chronic pelvic pain, and cervical cancer.<sup>25</sup>

In rural Minnesota, Planned Parenthood clinics are typically the only source of subsidized, comprehensive reproductive health care services available for women and families. In 2008, our 16 Greater Minnesota clinics provided nearly 165,000 units of contraception, more than 37,000 units of emergency contraception, more than 34,000 STI tests, nearly 5,000 HIV tests, nearly 9,000 pregnancy tests, more than 15,000 breast exams, and nearly 12,000 cervical cancer screenings. Patients tell us that the health care they receive at Planned Parenthood is often the only health care they receive all year.

## RURAL WOMEN'S HEALTH RECOMMENDATIONS FOR REFORM

Improving the health status of rural women will require health systems that adequately consider and respond to the unique needs of this patient population. As the nation discusses various models of health care reform, it is essential that any emerging proposals comprehensively address the complex needs faced by rural women and families.

The data overwhelmingly indicate that rural women are more likely to live in poverty, more likely to be uninsured or underinsured, and more likely to have limited health care resources available than are their urban counterparts. Any proposals for health care reform must reduce barriers to receiving health care services and improve health outcomes for rural women; to be effective, they must contain three components:

- Access to affordable health care services for all women, including comprehensive reproductive health care, regardless of income.
- Coverage for basic, preventive health care services that specifically impact women.
- Protections for trusted safety net providers on whom women depend for their care, particularly given the shortage of primary care providers in rural communities.



## END NOTES

- 1) Hargraves, Martha, PhD, MPH. *Elevating the Voices of Rural Minority Women*. American Journal of Public Health. April 2002. Volume 92(4), 514-515.
- 2) Rural Assistance Center. A Project of the Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services. *Women's Health*. [www.raconline.org](http://www.raconline.org).
- 3) The Kaiser Family Foundation. *Population Distribution by Metropolitan Status, states (2006-2007), U.S. (2007)*. [www.statehealthfacts.org](http://www.statehealthfacts.org).
- 4) The Kaiser Family Foundation. *Poverty Rate by Metropolitan Status, states (2006-2007), U.S. (2007)*. [www.statehealthfacts.org](http://www.statehealthfacts.org).
- 5) Ibid.
- 6) Rural Assistance Center. A Project of the Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services. *Women's Health*. [www.raconline.org](http://www.raconline.org).
- 7) Minnesota Department of Health. Office of Rural Health and Primary Care. *Health Care Reform: Addressing the Needs of Rural Minnesotans*. October 2007.
- 8) Boston, David. *Poverty Rates in Minnesota: Poor Residents in Inner Cities and Rural Areas Hit Hardest*. 07/20/2008. [http://poverty.suite101.com/article.cfm/poverty\\_in\\_minnesota](http://poverty.suite101.com/article.cfm/poverty_in_minnesota).
- 9) Southwest Rural Health Research Center. *Rural Healthy People 2010 Project. Rural Healthy People 2010, Volumes 1, 2, and 3*. <http://www.srph.tamhsc.edu/centers/rhp2010/publications.htm>.
- 10) Minnesota Department of Health. Office of Rural Health and Primary Care. *Health Care Reform: Addressing the Needs of Rural Minnesotans*. October 2007.
- 11) Southwest Rural Health Research Center. Rural Healthy People 2010 Project. *Rural Healthy People 2010, Volumes 1, 2, and 3*. <http://www.srph.tamhsc.edu/centers/rhp2010/publications.htm>.
- 12) Minnesota Department of Health. Office of Rural Health and Primary Care. *Health Care Reform: Addressing the Needs of Rural Minnesotans*. October 2007.
- 13) Minnesota Department of Health. Office of Rural Health and Primary Care. *Health Professional Shortage Areas, Primary Care*. <http://www.health.state.mn.us/divs/orhpc/shortage/designation.cfm?maph=hpsapcrural>.
- 14) Minnesota Department of Health. Office of Rural Health and Primary Care. *Health Care Reform: Addressing the Needs of Rural Minnesotans*. October 2007.
- 15) Ibid.
- 16) Hargraves, Martha, PhD, MPH. *Elevating the Voices of Rural Minority Women*. American Journal of Public Health. April 2002. Volume 92(4), 514-515.
- 17) The American College of Obstetricians and Gynecologists. *Health Disparities for Rural Women*. March 2009.
- 18) Tharaldson, K. & Sechler, A. *Women's Health: Reproductive Health Services in Rural Minnesota*. Rural Minnesota Journal, Volume 3, Issue 1. Fall 2008.
- 19) The American College of Obstetricians and Gynecologists. *Health Disparities for Rural Women*. March 2009.
- 20) Rural Assistance Center. A Project of the Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services. *Women's Health*. [www.raconline.org](http://www.raconline.org).
- 21) The American College of Obstetricians and Gynecologists. *Health Disparities for Rural Women*. March 2009.
- 22) Minnesota Organization on Adolescent Pregnancy, Prevention, and Parenting. *Minnesota Counties Ranked by Birth Rate, One Year*. [www.moapp.org](http://www.moapp.org).
- 23) Minnesota Organization on Adolescent Pregnancy, Prevention, and Parenting. *Top Ten Minnesota Counties by Birth and Pregnancy Rates*. [www.moapp.org](http://www.moapp.org).
- 24) Minnesota Department of Health. *STD Surveillance Statistics – 2008*. <http://www.health.state.mn.us/divs/idepc/dtopics/stds/stats/stdsurvrpts.html>.
- 25) Healthy People 2010. *Leading Health Indicators*. <http://www.healthypeople.gov/lhi/>.

Planned Parenthood Minnesota, North Dakota, South Dakota's 2009 Rural Women's Health Report was developed and designed by **Sara Beth Mueller, Kathi Di Nicola, and Karina Hill**.