

# SWEET THE BITTER DROUGHT

Why Rural America  
Needs Health Care Reform



CENTER *for*  
COMMUNITY CHANGE



CENTER *for*  
RURAL AFFAIRS  
Lyons, NE 68026 Population 963

Authored by Jon Bailey, Sally Kohn & Angie Evans  
September 2009



# Introduction

*God made the country, and man made the town;  
What wonder then, that health and virtue, gifts  
That can alone make sweet the bitter drought  
That life holds out to all, should most abound  
And least be threatened in the fields and groves.  
—William Cowper, “The Task”*

Rural America is indeed grappling with a prolonged and pernicious drought, not only the kind that affects crops but the sort that bankrupts family farms, shutteres small towns and family businesses, and leaves hardworking loved ones struggling for life-saving care. Yet the health care reform debate has suffered greatly from a false dichotomy that ailing urban poor folks are the main beneficiaries of reform, while the hardy rural middle class is healthy and well-served by the current system. The truth is that rural people and rural communities are faced with many of the same health care challenges confronting the rest of the nation—exploding health care costs, large numbers of uninsured and underinsured, and an overextended health care infrastructure. In addition, numerous exacerbated health care issues face rural people and places.

In communities from Maine to Montana and everywhere in between, rural Americans know that the current patchwork of unregulated and limited private insurance is failing, and the need for reform is desperate and urgent. Rural Americans are more likely to be underinsured, less likely to have choices in private insurance coverage, and in dire need of the medical services and technology that public health care investment has brought to big cities. The majority of rural Americans are suffering silently in our broken health care system and want change now. James from Union City, Tennessee, put it best: “We’re not screaming, we’re pleading.”

Rural communities have always been the geographic and moral heart of America. Pulling together to till fields, raise barns and trade crops reminds us that, in United States of America, we are all in it together. Just as the rapid decline of family farms and small towns in middle America has ripple effects throughout the culture and economic infrastructure of our nation, the health policy debates in Washington will potentially re-seed the future of rural communities.

This report is not an exhaustive list of the health care issues facing rural communities but a survey of the most critical issues that the heartland of America needs addressed through health care reform. As the debate over health care reform continues in Congress, we hope this report and the stories herein ground that debate in the prairies and core principles of our nation.

**The majority of rural Americans are suffering silently in our broken health care system and want change now.**

# An Economy Based on Self-Employment and Small Businesses

The rural economy is unique in its composition, making issues of uninsurance and underinsurance more prominent in rural areas. Since the late 1990s, rural areas have witnessed a significant decline in manufacturing jobs and a rise in service sector employment, losing jobs with higher rates of employer-sponsored health insurance while gaining jobs with much lower rates of such coverage. The lack of employer-sponsored health insurance is particularly acute for low-skilled jobs, which are more common in rural areas.<sup>4</sup>

The rural economy is largely based on self-employment and small businesses. Since 1969, the number of self-employed workers in rural areas has grown by over 240 percent (by comparison,

rural wage and salary workers witnessed only a 61 percent growth over the same period).<sup>5</sup> With an economy dominated by small businesses and self-employment (as well as seasonal and “patching” employment), rural people are generally less insured, more underinsured, and more dependent on the individual insurance market. While rural residents have higher rates of uninsurance, underinsurance may be just as large an issue. There are twice as many underinsured in rural nonadjacent areas (those areas not adjacent to a metropolitan area) as in urban areas, and the challenges faced by the underinsured are ultimately similar to those of the uninsured.<sup>6</sup> Rural nonadjacent residents

are responsible for nearly 22 percent more of their total health care costs (premiums and out-of-pocket costs) than urban or rural adjacent residents.<sup>6</sup> Further, the odds of rural Americans being underinsured are 70 percent higher than for urban residents, suggesting the “value of private health plans held by rural residents is lower than for urban residents.”<sup>6</sup>

Any health care reform provision that relies exclusively on maintaining the current employer-sponsored health insurance system will not be as relevant for rural areas because of lower rates of employer-sponsored insurance and the composition of the rural economy. Issues related to underinsurance must be addressed for health care reform focusing on achieving universal coverage and access to health insurance to be relevant to rural areas. And the problem is exacerbated as health insurance premiums rise and out-of-pocket

medical expenses increase, resulting in more and more self-employed and small businesses dropping unaffordable coverage for themselves and their employees or resorting to higher deductible insurance with less coverage. Any health care reform legislation must provide options—including public solutions—to small businesses and the self-employed that provide

“We had a furniture manufacturing business for 18 years. We were providing health insurance to the employees for several years and then it became too cost prohibitive. My husband and I had always wanted to have our own business and do something that we could grow and help provide a decent living for us and other families. That’s part of the American dream. When we had to drop the benefits, that was the beginning of the end of us offering a good business in Maine.”  
watch video: [bit.ly/NancyME](http://bit.ly/NancyME)



**Nancy** from  
**Skowhegan, ME**



comprehensive, affordable, and continuous coverage in ways that are comparable to larger group coverage.

**The odds of rural Americans being underinsured are 70 percent higher than for urban residents.**

A key policy issue in this regard is how insurance is made affordable for those who need assistance with the cost. The details of any proposed subsidy plan will be crucial for rural people and small businesses because issues of affordability and cost are more acute in rural areas due to reduced ability to pay. How subsidies are structured and who receives them are fundamental issues affecting rural areas for both private and public health insurance options.

## An Aging Rural Population

Many rural areas of the United States are experiencing significant demographic shifts, chief among them an aging population. In 2007, approximately 15 percent of rural residents were 65 years of age or older, 25 percent greater than in the nation as a whole.<sup>1,2</sup> The nation's population of those 65 or older is predicted to double by 2030, reaching 20 percent of the total population, and the fastest growing age group in rural America are residents 85 and older.<sup>2</sup> An increasingly aging population leads to greater incidences of chronic diseases and disability, taxing an already stressed rural health care system. An aging population also brings with it numerous social and community issues. For example, nearly a third of rural Minnesotans 65 years of age and older reported being limited in activities due to physical, mental or emotional problems.<sup>3</sup> A large portion of rural seniors live at home alone, without a spouse or family caretaker to provide or obtain necessary health care services.

While seniors have nearly universal health care coverage due to Medicare, there are certainly issues related to rural seniors that should be addressed in health care reform legislation.

*"I've been really lucky and I've worked all my life, saved my money and did everything I was supposed to do. When you reach a certain age, money isn't as critical but health care is critical. I lost my job when I was about to turn 60. I took my COBRA option. It was expensive, but it was do-able and it was a good plan but I was only able to do it for about 18 months. That took me to age 62. Then I had to buy my own insurance and that is expensive. I pay \$415 a month for a \$10,000 deductible policy and I consider myself blessed that I am able to afford that. But, I had better plans for my retirement savings than that and so I am very much looking forward to Medicare which I will be on in 5 months."*  
watch video: [bit.ly/CaritaNE](http://bit.ly/CaritaNE)



**Carita Baker** from Lincoln, NE



Providing health care services in community settings that allow rural seniors to remain in their communities (through rural health clinics and federally qualified health centers, and critical access hospitals), addressing rural health care worker shortages, enhancing Medicare funding of telemedicine and other health care information technology uses in more health care facilities frequented by rural seniors, and strengthening long-term care services and supports are just a few examples.

## A Sicker, More At-Risk Population

The Center on an Aging Society at Georgetown University summarizes the health status of the nation as this: “The rural population is consistently less well-off than the urban population with respect to health.”<sup>14</sup> More rural people have arthritis, asthma, heart disease, diabetes,

hypertension and mental disorders than urban residents. The differences are not always large, but they are consistent—the proportions of rural residents with nearly every chronic disease or condition are larger than comparable urban communities.

The Kaiser Commission on Medicaid and the Uninsured found that despite an older population and higher rates of disability in rural areas—which should require higher health care needs—rural residents actually receive less care in many instances, suggesting rural residents may be receiving inadequate care. For example, rural residents receive fewer regular medical check-ups, blood pressure checks, cholesterol checks, pap smears, and mammograms than they medically and statistically should.<sup>15</sup> The ultimate result of less than adequate care is a worsening of health status and an increase of chronic conditions—exactly what has occurred.

Despite an array of health care differentials between urban and rural people, there is evidence that the ultimate health status of rural people has much to do with health insurance coverage and the type of coverage. There is evidence that rural people with employer-provided health insurance obtained more health care at a lesser cost than people with privately-purchased health insurance.<sup>15,21</sup> Insurance that provided better coverage at lower cost, therefore,

“My office administers the health care benefits for county employees. But insurance gets more expensive every year and we struggle to pay the premium for our employees. I’m a cancer survivor, I had cancer 6 years ago. I haven’t had a physical in the last three years. It costs the county \$300 for me to have a physical and I just choose not to spend that money. I’d rather spend the \$300 on people who need help.”  
watch video: [bit.ly/MayorTN](https://bit.ly/MayorTN)



**Mayor Franklin Smith** *from*  
**Haywood County, TN**



resulted in more—and presumably more regular and higher quality—health care services. Unfortunately, as discussed above, many rural people lack such coverage.

Individuals and families are also at greater risk of higher premiums or being denied coverage when pre-existing conditions exist, which is more likely among rural people due to higher rates of most chronic diseases and conditions and higher rates of disability. While some states prohibit coverage discrimination based on health status, most do not. Current federal law prohibits discrimination based on health status in group plans but not for individual plans that are more common in rural areas. Health care reform legislation should enhance and promote health, but it should also remove barriers to affordable health insurance coverage. Barriers such as denial of insurance for pre-existing conditions have a potential disproportionate affect on rural people and should be addressed in health care reform legislation. Public programs are also key to non-discriminatory coverage of at-risk rural communities.

## Need for Preventive Care, Health and Wellness Resources

It is unsurprising that rural communities, which disproportionately suffer from lack of access to care, suffer from a dearth of preventive wellness resources as well. This alone would be a problem if rural communities were as healthy as the rest of the American population. But given the added health risks of rural communities, this dynamic is compounded. For instance, a growing body of research documenting problems in nutrition and activity in rural areas has found that rural residents generally fare worse than their urban counterparts in regards to obesity, which is opposite to the situation that existed prior to 1980.<sup>16</sup>

No one explanation appears satisfactory for why problems with nutrition, activity and weight are so prominent in rural America. In spite of this uncertainty, it is critical to consider some of the most widely discussed factors, most of which concern the environment of modern rural living. The relative lack of nutritious food in many rural food systems; challenges to and decreases in physical activity, especially among rural children; fewer people employed



**Angel Romero Kiester**  
from **Lyons, NE**

“I am the oldest woman in my family to have all my female organs. Every woman in my family has had them all removed when they were younger than I am. I am supposed to have screenings three times a year to check for cancerous cysts and ovarian problems but I can’t keep up with them without health insurance. As a wife and as a mother, it scares me knowing the risks that I’m taking on a daily basis not having preventive care to stay on top of something that could become terminal.”  
watch video: [bit.ly/AngelNE](https://bit.ly/AngelNE)



in agriculture and other physically rigorous occupations than in the past; strong social networks which may actually reinforce unhealthy eating and sedentary behaviors; and a deficit in health education are all factors leading to worsening health situations in rural areas.

Perhaps the most important factors working against rural areas with regard to obesity and general health concern demographics. Rural residents are older, less educated and poorer than urban residents. All of these demographics increase the risk for obesity.<sup>16</sup>

As another example, over half of the counties in the United States have no mental health professionals, a situation that has changed little in 45 years. Mental health or behavioral health issues are estimated to take 20-25 percent of primary care physicians' workloads, taxing an already stressed system of medical care.<sup>1</sup> Research has shown that for rural patients in need of mental health care, receiving only general medical care is significantly more likely than receiving specialty mental health care.<sup>17</sup> Since patients receiving care in the specialty mental health sector are substantially more likely to receive adequate care than patients receiving care in the general medical sector only, this indicates that rural individuals are receiving lower quality care.<sup>17</sup>

Health care reform policy should do more to enhance and promote health and wellness in order to prevent major health conditions and their long-term costs. Rather than being satisfied to provide affordable and accessible health insurance to address "sickness," we should also develop a real "health" care system—that addresses preventive physical and mental health care. Health insurance reform—getting costs and abuses in check and providing coverage to all—is the first, critical step toward holistic improvement of our health care system for all Americans, including rural communities.

## Lack of Access to Private Insurance

Rural Americans are well aware of what occurs when a marketplace contains too few competitors. Farmers and ranchers, particularly small and medium-size ones, are well-versed in being left without access to markets, or certainly access to competitive markets when grain

and livestock markets are dominated by only a few companies that can set unfair or discriminatory prices. The history of rural America in the industrial age is very much one of consolidation and the consequences of corporate mergers and corporate power, whether it is in agricultural, mining, forestry or Main Street businesses. Rural people, rural businesses, and the economy of rural

communities are in large measure at the whim of corporations located in faraway cities and whose decisions are made by unknown people in distant boardrooms.

**According to the report, of the 10 states with the most consolidated health insurance markets, only two—Hawaii and Rhode Island—have a rural population of less than 30 percent of their total populations.**



Consolidation and a lack of competition apply to health insurance costs as well. The recent report *Premiums Soaring in Consolidated Health Insurance Market* shows that in the past 13 years more than 400 corporate mergers have involved health insurers, resulting in a “small number of companies” now dominating local markets.<sup>23</sup> At the same time, from 1999 to 2007, average health insurance premium growth outpaced average wage growth in the United States by over 300 percent.<sup>23</sup>

These concentrated health insurance markets appear to affect smaller, predominantly rural states more than larger states. According to the report, of the 10 states with the most consolidated health insurance markets, only two—Hawaii and Rhode Island—have a rural population of less than 30 percent of their total populations. States such as Alaska, Vermont, Alabama, Maine, Montana, Wyoming, Arkansas and Iowa—all with large rural populations—face a combined market share of their two largest health insurance companies of between 80 and 95 percent.<sup>23</sup>

The problem of inadequate coverage is striking when considering one critical population in rural America, family farmers and ranchers. In 2006, The Access Project used survey data from over 2,000 non-corporate farm and ranch owners in Midwestern states to see how health insurance affected individuals and families involved in agriculture. Even though 95 percent of non-corporate farmers and ranchers had health insurance, it is clear that the coverage was generally inadequate. Twenty percent of the respondents said they had debt for medical expenses and around 25 percent reported that medical expenses “contribute to their financial problems.”<sup>21</sup>

The main reason for the inadequate coverage is likely due to the fact that many family farmers and ranchers have to buy individual health insurance policies. Compared with group policies often offered by employers, individual policies generally provide less comprehensive coverage with high deductibles and co-pays. While only eight percent of the general population has individual policies, the survey found that around 33 percent of family farmers and ranchers relied on such policies.<sup>21</sup>

As a result of income, health status and occupation, there are significant portions of rural America that are not attractive to private insurers, or who are out of range of private insurance due to cost. Public programs are important means of reaching rural residents with affordable and meaningful health insurance coverage.<sup>17</sup>

“We’d rather be farming but we can’t afford that life anymore. We want to have children and things like health insurance are just too costly to maintain on a small farmer’s income. We decided to get local jobs but there are only a few companies that are big enough to provide health insurance around here.”



**Kendra and Steve Koblentz**  
from Rolla, MO



Healthy competition does not “require an endless array of choices,” but rather a “reasonable number of meaningful choices.”<sup>22</sup> A public health insurance plan can provide consumers a number of choices on price and coverage features that private insurance does not or cannot provide, while also recognizing that private plans have unique features that may be attractive to consumers.<sup>22</sup> It’s ultimately about competing options and the choices that come out of that competition—something rural Americans are familiar with being denied.

## Public Health Insurance Plans: Dependence and Need

With a population that is older, poorer, and with less employer-based coverage, a larger segment of the rural population relies on public health care programs such as State Children’s Health Insurance Programs (SCHIP), Medicare and Medicaid. The number of rural non-elderly residents covered by public health insurance programs has increased by nearly 122 percent since 1987; nearly a third more rural people are covered by public plans compared to urban residents.<sup>4</sup> Yet many rural people and businesses who need care are not eligible for these public programs.

Viable health care reform legislation should strengthen those public programs currently depended upon by many rural people. Public insurance has a history of health care cost controls; Medicare, for example, had about a 60 percent less health spending per enrollee than did

private insurance between 1997 and 2006.<sup>22</sup> Public insurance has also pioneered payment and quality-improvement methods that both control costs and improve the quality of care. This has happened primarily because public plans are public—unlike private insurance companies, public health insurance plan data and information is open to public research.<sup>22</sup> Strong public health insurance plans also provide needed competition to private plans. The strengths of public health insurance plans are what many rural people and businesses need—stability and cost controls while providing health insurance access to vulnerable populations like low- and moderate-income families, small business employers and employees and the self-employed.<sup>22</sup> As Jacob Hacker states, the choice between private and public health insurance plans is not an either-or proposition. Rather,



**Ida Landry** from  
Norridgewock, ME

“I had Maine Care [the state’s Medicaid program]. It really saved my life. I was diagnosed with breast cancer a couple of years ago. I didn’t know what I’d do, what my family would do, or even how to get all the treatment. Luckily Maine Care stepped in and provided health insurance for me so that I could get all the treatments I needed. I survived the cancer, but I don’t know how I would’ve done it without Maine Care as an option.”



they are complementary and both are needed for a high functioning health care system that provides coverage for all. A system that provides the choice of public or private health insurance plans “serve simultaneously as a safety valve and a spur for improvement.”<sup>22</sup>

## A Stressed Health Care Delivery System

The health care infrastructure in much of rural America is a web of small hospitals, clinics and nursing homes (frequently attached to the hospitals) often experiencing significant financial stress. Many rural hospitals have financial margins too narrow or too low to support investments in critical plant and technological upgrades.<sup>8</sup> Medicaid and Medicare reimbursement rates remain generally below actual costs of services provided, thus stressing providers that depend

### Medicaid and Medicare account for about 60 percent of rural hospital revenues

on reimbursements from public programs. The promise of federally qualified health centers across rural America has yet to materialize, thus affecting the available care for low-income and uninsured rural people. And many rural long-term care facilities are at risk of closure, affecting the health care safety net for the rural elderly.<sup>3,9</sup>

The financial stress on the rural health care system is in large measure an expression of public policy. It is estimated that Medicaid and Medicare account for about 60 percent of rural hospital revenues; both programs are subject to legislative and administrative decisions and state and federal budgets that may result in declining hospital revenues.<sup>6</sup> It is also estimated that nearly half of those classified as underinsured are facing collection or other legal action for their medical debts, causing a domino effect of financial stress for rural families, health care providers and facilities.

Health care reform legislation should address the plant and technology needs of rural health care facilities, provide resources to expand health care facilities such as federally qualified health centers to unserved or underserved rural areas, and address the current health insurance model that causes financial stress for rural families and rural health care providers.

“I’m a veteran and POW with VA benefits and Medicare. I’ve worked my whole life and I’ve still got problems with getting health care. I can get great service and coverage if I can get to the right facility. Problem is, the closest place for me to use is 70 miles away in Paducah or 110 miles away in Memphis, and when my wife needs services than we have to try to make our appointments at the same time and day so we don’t go broke on the cost of gas getting there.”



Sam Huey from Union City, TN



# Health Care Provider and Workforce Shortage

More than a third of rural Americans live in Health Professional Shortage Areas.<sup>10</sup> Nearly 82 percent of rural counties are classified as Medically Underserved Areas.<sup>4</sup> Only nine percent of America's physicians practice in rural areas.<sup>11</sup> Most rural areas in the nation have a shortage of practicing physicians, dentists, pharmacists, registered nurses, and ancillary medical personnel. And trends in this regard are not improving. For example, the number of rural counties

designated as either whole or partial county dental shortage areas increased by nearly 160 percent from 1981 to 2005; now nearly 60 percent of rural counties are designated as dental shortage areas.<sup>4</sup> Only three percent of recent medical students are planning to practice in small towns and rural areas.<sup>12</sup>

The medical professionals that do practice in rural areas are also aging. Nearly 30 percent of rural registered nurses are over 55; the median age of rural physicians is 48. More than half of rural general surgeons are over 50, and the nation is producing essentially the same number of

**Nearly 82 percent of rural counties are classified as Medically Underserved Areas.**

general surgeons now as in 1980. Of the cohort of clinically active physicians who graduated from medical school from 1988 to 1997, only 11 percent practiced in a rural area.<sup>13</sup>

Many national and professional trends work against rural areas. Factors such as the decline in the number of family physicians and primary care physicians, the lifestyle preferences of younger physicians and the increasing amount of student debt all negatively affect rural health professional recruitment.<sup>10</sup> The rural need for primary care physicians is a major long-term

concern. According to the *Journal of the American Medical Association*, only two percent of medical students plan to go into a primary-care practice.

All of these workforce shortages exist despite the fact that, in general, rural people have greater medical care needs than do non-rural people.<sup>4,14</sup> A lack of family physicians that provide care from birth to death in every medical aspect, the so-called "medical home," leads to a lack of preventive care that results in more serious (and more expensive) medical problems down the road. Health care reform legislation will need to address promotion of rural medical practice, incentives to practice in rural areas and recruitment and education for all forms of rural health care professionals. Perhaps as importantly, new methods of financing health care must not contribute to a worsening of the rural health care shortage by providing even more economic disincentives to rural, primary-care medical professionals.



**Margaret Cardin** from  
Rolla, MO

"My husband had a heart attack. We don't have heart surgeons at our local hospital. One shot they gave my husband just so they hoped he would survive to make the flight to get him to St. Louis was \$5,000. It ended up throwing us into bankruptcy." watch video: [bit.ly/MargaretMO](http://bit.ly/MargaretMO)



## Increasing Dependence on Technology

Medical providers are increasingly employing health information technology to improve patient safety, quality of care and efficiencies. However, adoption of health information technology has remained slow in rural areas. For example, a consortium of rural health research centers has shown that while 95 percent of critical access hospitals have computerized their administrative and billing functions, only 21 percent employ forms of electronic health records.<sup>18</sup> Use of telehealth applications by rural providers is also mixed. Eighty percent of critical access hospitals use teleradiology, yet only 24 percent employ telepharmacy services.<sup>18</sup>

Several barriers exist in rural areas to the expansion of health care information technology. Lack of broadband and high-level telecommunications technology coverage in rural areas is a significant barrier. Without a national commitment to provide accessible and affordable broadband and high-level telecommunications technology in all rural areas, rural use of health information technology will likely remain limited. Capital resources are also constrained for rural health care providers. Often rural providers have to choose between medical equipment, building improvements and technology resources. Rural areas often have difficulty in recruiting and retaining information technology professionals, particularly in small hospitals, clinics and physician practices. The Agency for Healthcare Research and Quality has identified physician resistance to health information technology as a barrier to rural use. Many rural physicians believe more technology will negatively affect productivity and workflow, and additional reliance on technology is often financially impractical for small offices and providers.<sup>19</sup>

Congress and states must begin to address rural disparities in accessible and affordable broadband and high-level telecommunications technology in order to realize the full potential of health information technology. Health care reform legislation should include the resources, incentives and education necessary for the enhanced use of health information technology by rural providers.

“I have been given the wrong medication multiple times at the hospital. The local hospitals are often understaffed and underfunded in my community and I know that these simple but deadly mistakes wouldn’t happen under better circumstances. If I hadn’t interceded then they would’ve given me medication that could’ve killed me.”



**Steve Calvin**  
from **Rolla, MO**

## Conclusion

As our nation grapples with the worst economic drought in generations, we look to the heartland of America, where the main crop has always been our country's core values of shared responsibility and shared prosperity. As we fix our nation's broken health care system, the crucial step in healing America's families and the economy, rural communities are at the forefront of need—and the forefront of pleading. For rural America, health care reform cannot wait.

For more information and videos on rural America and our health care crisis, visit [statefairstories.org](http://statefairstories.org)



# References

- 1 Rural Assistance Center, [http://www.raconline.org/info\\_guides/aging/](http://www.raconline.org/info_guides/aging/)
- 2 United States Administration on Aging, *Statistics on the Aging Population*, 2007.
- 3 Office of Rural Health and Primary Care, Minnesota Department of Health. *Health Care Reform: Addressing the Needs of Rural Minnesotans*. 2007.
- 4 National Advisory Committee on Rural Health and Human Services. *The 2008 Report to the Secretary: Rural Health and Human Services Issues*. 2008.
- 5 Goetz, Stephan J. 2008. "Self-Employment in Rural America: The New Economic Reality." *Rural Realities*, Vol. 2, Issue 3, 2008.
- 6 Ziller, Erika C., Andrew F. Coburn, and Anush E. Yousefian. 2006. "Out-of-pocket Health Spending and the Rural Underinsured," *Health Affairs*, Vol. 25, No. 6, 1688-1699, 2006.
- 8 Critical Access Hospitals Financial Indicators Team Report. 2006. *CAH Financial Indicators Report: Summary of Indicator Medians by State*. Chapel Hill, NC: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research.
- 9 N. Rehkamp. 2006. *Mapping the Future: Enhancing LTC for Older Minnesotans, 2005 to 2030*. Minneapolis, MN: LarsonAllen.
- 10 Rabinowitz, H.K., James J. Diamond, Fred W. Markham, and Jeremy R. Wortman. 2008. "Medical School Programs to Increase the Rural Physician Supply: A Systematic Review and Projected Impact of Widespread Replication," *Academic Medicine*. Vol. 83, No. 3, 235-243, March 2008.
- 11 Gazewood, J.D., Rollins, L.K. and Galaska, S.S. 2006. "Beyond the horizon: The role of academic health centers in improving the health of rural communities," *Academic Medicine*, Vol. 81, 793-797.
- 12 Association of American Medical Colleges. 2006. *Association of American Medical Colleges Matriculation Questionnaire 2005: All Schools*. Available at <http://www.aamc.org/data/msq/allschoolsreports/msq2005.pdf>.
- 13 Chen, Frederick M, Meredith A. Fordyce, Steve Andes, and L. Gary Hart. 2008. *U.S. Rural Physician Workforce: Analysis of Medical School Graduates from 1988-1997*. Seattle, WA, The University of Washington Rural Health Research Center.
- 14 Center on an Aging Society. 2003. *Rural and Urban Health*. Washington, DC: Georgetown University.
- 15 Kaiser Commission on Medicaid and the Uninsured. 2003. *The Uninsured in Rural America*.
- 16 Tai-Seale, Tom and Coleman Chandler. 2003. "Nutrition and Overweight Concerns in Rural Areas: A Literature Review." *Rural Healthy People 2010: A companion document to Healthy People 2010, Volume 2*. College Station, TX: The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center.
- 17 Western Interstate Commission for Higher Education. 2008. "Assessment Of The Mental Health Funding Marketplace In Rural Vs. Urban Settings." Available at <http://www.wiche.edu/mentalhealth/ResearchCenter/research.asp>.
- 18 Flex Monitoring Team. 2006. *The Current Status of Health Information Technology Use in CAHs*.
- 19 Agency for Healthcare Research and Quality. *Health IT in Small and Rural Communities*. Available at [http://healthit.ahrq.gov/portal/server.pt?open=514&objID=5554&mode=2&holderDisplayURL=http://prodportallb.ahrq.gov:7087/publishedcontent/publish/communities/k\\_o/knowledge\\_library/key\\_topics/health\\_briefing\\_09202006031947/health\\_it\\_in\\_small\\_and\\_rural\\_communities.html](http://healthit.ahrq.gov/portal/server.pt?open=514&objID=5554&mode=2&holderDisplayURL=http://prodportallb.ahrq.gov:7087/publishedcontent/publish/communities/k_o/knowledge_library/key_topics/health_briefing_09202006031947/health_it_in_small_and_rural_communities.html). Accessed February 10, 2009.
- 20 National Conference of State Legislatures. 2000. *Emergency Medical Services in Rural Areas: How can States Ensure Their Effectiveness?* Denver, CO: National Conference of State Legislatures.
- 21 The Access Project. 2008. *2007 Health Insurance Survey of Farm and Ranch Operators*.
- 22 Hacker, Jacob S. 2008. *The Case for Public Plan Choice in National Health Reform: Key to Cost Control and Quality Coverage*. Berkeley, CA: Center on Health, Economic and Family Security, University of California, Berkeley School of Law.
- 23 Health Care for America Now. 2009. *Premiums Soaring in Consolidated Health Insurance Market: Lack of Competition Hurts Rural States, Small Businesses*. Washington, DC: Health Care for America Now.



[www.communitychange.org](http://www.communitychange.org)



[www.cfra.org](http://www.cfra.org)

[statefairstories.org](http://statefairstories.org)