Rural Women’s Health

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Twenty-five percent of the population of the United States lives in rural areas. Women make up about 52% of these residents (Office of Technology Assessment, 1994). People in rural communities are often poorer than in urban communities; have fewer health resources; have long driving times to health care, and are characterized by familiarity among residents (Bushey, 1998). There are variations within rural communities that need to be considered when generalizing about rural women’s health. Before addressing issues in the health of rural women, it is necessary to review issues in women’s health generally in order to have a context for discussing rural women’s health.

This chapter reviews the scientific assumptions underlying today’s health care system as it affects women’s health. The authors also discuss literature on selected women’s health issues. The literature is confined to that from the United States, as presenting cultural differences as they influence women’s health care is beyond the scope of this chapter.

The authors used the American Association of Colleges of Nursing (AACN) definition of women’s health in developing the chapter. The definition states, “Women’s health refers to wellness and illness issues that are unique to or more prevalent or serious in women, have causes or manifestations specific to women, and occur across the lifespan and within the context of women’s lives” (American Association of Colleges of Nursing, 1999).

The issue of women’s health is often met with questions such as, “Why women’s health?” or remarks such as, “Pathophysiology is pathophysiology,” or other such comments. The reason for a focus on women’s health is that there are health care issues, such as reproductive technology, and diseases, such as breast cancer, that are more prevalent or unique in women. Other social issues and diseases, such as depression, obesity, eating disorders, sexual harassment, and child care, while affecting men, have a different manifestation or larger impact on women’s lives. To give one example of a condition that has a differential outcome on women’s lives, consider incontinence. It is estimated that 50% of nursing home admissions are due to incontinence. Three times as many women as men live in nursing homes (Austin & Jacobson, 1986). If incontinence could be managed to permit more women to live independently in their own homes, their quality of life would be improved and significant economic savings could accrue.

Some justify the lack of focus on women’s issues because women outlive men by about seven years. The average life span for people is increasing, but overall men die earlier than women. Although women live longer, they do not necessarily live better. More women suffer chronic diseases; they have higher rates of poverty and experience more days of disability than men. The context of a women’s life reflects that more elderly women live alone as widows. Also, more women than men care for a disabled
spouse at home (Johnson & Fee, 1997).

Women also are disadvantaged regarding access to necessary services (time, money, and geography), a critical variable in rural women’s health. Nancy Fugate Woods (1992) reported that women earn less than men and therefore have fewer funds for health insurance. More women than men have health insurance, but it is often Medicaid, which limits options for care, as many health care providers will not accept Medicaid patients. For individuals with low incomes, a good proportion of rural dwellers, many do not have adequate coverage from the Medicaid program. In the age group between 45 and 65 years, women are more likely than men to have no health insurance at all. Women workers are more likely to be part-time workers and ineligible for health care as a benefit. They are more likely to drop out of the workforce to care of an ill spouse, aging parent, or grandchild, thus losing benefits they may have had. Thus, a women’s marital status becomes a major predictor of her insurance status. Woods (1992) summarizes her review of the status of women stating that we live in a system of “unintended rationing of health care based on gender” (p. 162).

Women have differing life experiences, growing up in quite different social climates, maturing and aging in ways that diverge from men (Benderly, 1997). The biology and physiology of the genders are different. While there have been changes in the expectations of social roles of men and women in the recent past, the two genders still experience differing social status, different roles, and different stresses throughout life. It is not surprising, therefore, that men and women differ in the interaction between genetic endowment and life experience that leads to health or illness.

In order to set a context for women’s health, the next section will discuss scientific assumptions operating in the health care system. How these assumptions affect differentials in care for men and women will be presented.

**Scientific Assumptions in Health Care**

Students and scholars in many fields know the idea of a scientific paradigm. In the field of health care, the prevailing scientific paradigm is the biomedical model. This model is materialistic (positivism), reductionistic, and objective, as is its scientific antecedent in the natural sciences (Harman, 1994). There are debates about the model and some changes are emerging, especially in areas such as consciousness research and alternative therapies. Engel’s (1977) biopsychosocial model for medicine has received some attention. Engel posits that in order to understand health or disease, physicians must understand not only biology, but also the psychology and sociology of the patients. The biomedical model, however, is the prevailing paradigm. The idea that medical scientists are separate from what they observe and are objective (not subjective) in their assessment of situations, that mind and matter are two separate provinces of study, that person and environment are separate, are still foundational to modern biomedical thought.

The most basic paradigm in modern medicine is that the “normal” body is the male body. Historically, women were not included in clinical trials (Weisman, 1998). This was not questioned until the 1980s. If there was any reflection on the fact that men and women are different, an argument from “good science” could be made to exclude women from studies that might be less controlled if they were included. For example, most of the psychotropic drugs developed to manage depression did not have women in the clinical trials. To the extent that anyone questioned this fact, a “scientific” logic could be offered that women have menstrual cycles, characterized by mood swings, and these swings could contaminate the research, so excluding them was more scientifically sound. However, when the psychotropic drugs were given in practice, they were prescribed for men and women. The drugs did not work as well to relieve the depressive symptoms in women. Women were told they were “more refractory”—less amenable to treatment than depressed men. This is referred to as “blaming the victim” by women commentators on the phenomenon. It was only during the rise of feminism that this type of “science” was challenged and to some extent modified.

The assumption that the male body is the norm is still dominant. Two of the most flagrant