

## Journal of Rural Social Sciences

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Volume 10

Issue 1 *Southern Rural Sociology Volume 10,*  
*Issue 1 (1994)*

Article 2

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12-31-1994

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#### Recommended Citation

Parent, F., and Bonnie Lewis. 1994. "Changing the Health Care System: Opinions of Rural and Urban Residents." *Journal of Rural Social Sciences*, 10(1): Article 2. Available At: <https://egrove.olemiss.edu/jrss/vol10/iss1/2>

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# **CHANGING THE HEALTH CARE SYSTEM: OPINIONS OF RURAL AND URBAN RESIDENTS**

**By F. Dale Parent and Bonnie L. Lewis**

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## **ABSTRACT**

This paper examines the opinions of rural and urban residents toward a full health care system provided by the government. The data used in the study come from a statewide poll conducted by the Louisiana Department of Health and Hospitals. Because of a greater need for health care reform in rural areas, it was assumed that rural Louisianians might be more supportive of a government health care system than their urban counterparts. However, analysis of the data indicates that a person's residence had no statistically significant effect on attitudes toward government sponsored health care.

## **INTRODUCTION**

Health care reform has become one of the most significant issues facing the nation today. Virtually every state is debating new health care policies and programs. It appears that the federal government is now ready to move forward with national discussion of the problem. While it is difficult to know exactly what will be done to improve the medical system, it is important to have a clear understanding of how different segments of society feel about possible changes in the health care system. This paper focuses on the differences in opinions between rural and urban residents in Louisiana. There are significant reasons to believe that these two groups have very different opinions about changes in the health care system. This is true because of the general cultural and structural differences between rural and urban residents and their unique health and health care experiences.

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Historically, there have been great distinctions between rural and urban residents in the United States. Prior to World War II these differences were reflected in everything from different occupations, family structures, eating habits, and social, political and religious beliefs (Hill, 1988). Health care services were vastly different between the two populations, with most rural areas severely underserved. Rural Southerners have consistently reported the highest rates of restricted activity days due to poor health or injury (Rosenblatt and Moscovice, 1982). Rural and urban dwellers have also had different perceptions of health and health care (Gilford, 1981). One example is that rural residents, and especially rural Southerners, have been more likely than the rest of the population to incorporate non-"scientific" treatments into their medical care (Hill, 1988).

During the last half of this century many of the fundamental differences between city and rural people have diminished. The rural population, once a very homogeneous group, is now much more heterogenous. The two populations have become more similar in terms of income, occupational status, educational attainment, household size, and in the labor force participation of women (Hill, 1988). Health care delivery has improved considerably in rural areas and the health status of the rural population has become more similar to that of urban dwellers. These facts have led some people to conclude that the only major distinction between rural and urban Americans is location. Many sociologists dispute this assumption and maintain that rural and urban people remain distinct in both culture and social structure (Rogers, et al., 1988; Miller and Luloff, 1981; England, et al., 1979; Larson, 1978).

Probably one of the most important factors contributing to rural/urban differences is the extremely high rate of poverty that exists in rural areas. This economic condition, which affects almost all other aspects of social life, is especially linked to health and health care. Since 1980 rural communities have not performed as well economically as urban areas. This has had an especially negative impact on the rural poor (Deavers and Hoppe, 1992).

The rural South, and rural Louisiana in particular, have very high poverty rates. At the close of the 1980s "the nonmetro poverty rate in the South was 21.2 percent, compared to 13.6 percent for the rest of

the country" (Deavers and Hoppe, 1992:16). The rural South also has the highest proportion of working individuals who earn wages below the poverty line (Gorham, 1992). In Louisiana, 29 percent of the rural population lives in poverty compared with 21 percent of the urban population (U.S. Bureau of Census, 1991). This is a very significant factor in a nation whose health care system is based on people's ability to pay. In fact, the South, along with the West, have the highest percentages of individuals lacking health insurance, with rural people in both regions more likely than urban residents to be without insurance (Davis and Rowland, 1990).

For rural Louisiana the health status is similarly poor. Seventy-one percent of the state's parishes (counties) with a high number of infant deaths are rural. Sixty-eight percent of areas with a high health professional shortage are rural parishes. Ten rural parishes have had hospitals closed in the past three years, and now there are eight rural parishes with no hospital at all (Louisiana Department of Health and Hospitals, 1991).

As is well known, the United States remains the only Western nation without some type of comprehensive universal health care system financed by the government. At the same time, the nation's health care expenditures are among the highest in the world. In 1970 health care expenditures were about \$75 billion (Fuchs, 1990); by 1991 the costs had risen to \$839 billion (Letsh, 1993). The United States also spends a higher proportion of its gross domestic product (GDP) on health care than any other industrialized nation. In 1970, health care costs accounted for 7.4 percent of the GDP, in 1980 they rose to 9.1 percent and by 1991 they had reached 13.2 percent (Letsh, 1993). Further, many people assume that if this trend is allowed continue, the proportion spent on health care could reach as high as 20 percent in a few decades.

The high costs of this health care system do not translate into greater access to health care. The General Accounting Office recently reported that "...over 32 million Americans under age 65 lack either public or private insurance coverage. These uninsured Americans must either pay out-of-pocket or rely on public hospitals, clinics offering free or subsidized care, and other forms of charity care" (General Accounting Office, 1991:21).

There frequently are differences between operational public

policies and public opinions. Surveys indicate that a majority of Americans have consistently supported the idea of a government financed universal health care system since the 1940s, and that this support is growing (Blendon and Donelan, 1990). Support is as high in the United States as it is in many other Western societies with much more extensive programs (Prescosolido, et al., 1985).

In research documenting the public's attitudes toward the current health care system, what is lacking is detailed analysis of the different segments of the population most likely to support or reject various modifications or alternatives to the current system. The purpose of this paper is to determine what variation, if any, occurs between rural and urban residents in Louisiana in their opinions toward the current health care system as compared to a government financed universal health care system. Demographic factors included in the analysis are age, sex, race, income and personal health status.

The literature describing the characteristics of supporters and nonsupporters of universal health care in this country is very limited. Two different sources are used to develop a conceptual framework to guide the analysis. First, the literature describing differences between rural and urban residents in their access to health care and in their overall health status is examined. It is assumed that health status and access to care may affect attitudes toward the health care system. Second, the general literature on attitudes toward spending on human services is presented.

## LITERATURE REVIEW

Research has consistently shown that the health problems of rural residents are greater than those of urban residents (Gesler, et al., 1992). The health status of rural Southerners is among the worst in the country (Hill, 1988). "Some of the reasons suggested for rural/urban discrepancy in health status include the prevalence of more hazardous and strenuous work activities in rural areas, limited access to health care, and insufficient financial means for purchasing health services" (Gesler, et al., 1992:12).

The shortage of physicians in rural areas has been a major problem in this country. Physicians have tended to locate overwhelmingly in cities rather than establish rural practices

(Rosenblatt and Moscovice, 1982). As concern grew over this problem in the 1960s and 1970s, several federal programs were developed to reduce this maldistribution by increasing physician numbers in rural communities. Through these efforts significant progress was made, but inadequacies remain (Mick and Moscovice, 1993). Although the physicians supply increased in the rural South, as in other rural regions, it continues to have the lowest regional level of physicians (Louisiana Department of Health and Hospitals, 1993).

Because of the physician shortages it is not surprising that much of the early research found that rural residents were less likely to use health care services than urban residents. Two other factors contributing to low utilization were the greater likelihood of being uninsured and substantial travel distances to service locations (Berk et al., 1983). More recent studies reveal that the differences in access to physician care between rural and urban residents may not be as significant as in the past (Gesler, et al., 1992). Hospital utilization is now proportionately higher among rural than urban residents. One reason for this may be "...that since rural patients are less likely to be under the care of a physician, they may be more ill by the time they receive care, thus necessitating hospitalization" (Gesler, et al., 1992:14).

Historically, the free-market medical care system has neglected rural, and especially Southern rural, Americans. Improvements in access to health care services for rural people have been in large part due to the efforts of government, such as the above mentioned federal programs to attract physicians to rural areas. Also notable is the Hill-Burton Act, which constructed and modernized hospitals in many rural communities, significantly improving health care in many rural areas. Medicare and Medicaid have succeeded in providing medical care for the rural elderly and poor. Improvements in roads have made travel to urban medical centers more efficient. Because of the poorer health status and the positive impact of government programs to improve health care in rural areas, it would seem reasonable that rural residents would be more likely to support government financed universal health care than urban residents.

A contradictory assumption can be developed when examining recent public opinion polls toward government spending on social services (Erikson, et al., 1988). In general, rural residents tend to be

more conservative and therefore less receptive to spending on social services than their urban counterparts. It is possible that this conservative ideology may be a more important factor.

To strengthen this investigation other relevant variables and their association with social service spending opinions are examined. First, research has shown that in general there is a negative relationship between income and approval of social services spending. Although this relationship has existed since the 1940s, there are indications that it is not as strong today as in the past (Erikson, et al., 1988). Second, there appears to be a "gender gap" in attitudes on this subject, with women more supportive than men of government assistance for human welfare services. However, the differences are typically not that large (Shapiro and Mahajan, 1986).

Race provides one of the most clear divisions in attitudes toward social service spending, with blacks much more likely than whites to take a liberal position. For age the pattern is not as clear. "On most issues the young are the more liberal, but on issues like government-supported medical care the older group [having a vested interest] is more liberal" (Erikson, et al., 1988:184). It is, of course, the medical issue that is of most importance to the current investigation.

## METHODOLOGY

### Population and Sample

The data utilized in this analysis are from the Louisiana Statewide Health Care Survey. This telephone survey was conducted for the State of Louisiana Department of Health and Hospitals in December of 1989. Using current telephone directories, a sample of 1011 Louisiana adults was selected. Two hundred ninety-three (293) respondents were removed from the analysis because of missing data. Therefore, the final N=808. Because women were over-represented, the sample was weighted so that males and females represented equal proportions. Women tend to make health care decisions for families, making the skewed sample in some cases justifiable. However, because this is descriptive study, it was felt the weighting would be more appropriate.

## **Measurement**

Survey respondents were asked the following question:

"Some people say it is their belief that every American has a fundamental right to a full health care system provided by the government, while others feel the present system of health care is better. What is your opinion? do you favor a system such as we have now, or full health care provided by the government?"

Persons supporting a system with full health care provided by the government were labeled as "supporters," and persons favoring a system "as now" as "nonsupporters."

Rural/urban status was based on whether the respondent lived in a metropolitan or non-metropolitan Louisiana parish (county) as defined by the census bureau. Response options for age and household income were in 4 categories, as shown in Table 1. Race included white, black, Asians, Hispanics and other. Because of the small number of Asian, Hispanics and others, those categories were omitted from the study.

An additional independent variable, personal health status, was included. It is assumed that the worse a person's health, the more likely he or she is to support a government health care program. People in good health are less likely to be concerned and therefore less interested in such a proposal. For personal health status, respondents were asked whether they rated their general health as poor, only fair, good, or excellent.

## **FINDINGS**

Of the 808 respondents for whom complete data were available, 48 percent favored a "system provided by government," while 52 percent supported a "system such as we have now." The level of support for a new health care system is somewhat lower than recently published polls on this topic. There are two possible reasons for this. First, people tend to be less supportive of increased government spending during economic hard times (Blendon, 1988). In 1989,



**Table 1. Correlation Coefficients Among All Independent and Dependent Variables (N=808)**

	1	2	3	4	5	6
1. Rural/Urban 0=rural/1=urban						
2. Age 1=18-25 2=26-44 3=45-65 4=65+	-.02					
3. Race 0=black/1=white	-.02	.09*				
4. Income 1=\$10,000 or less 2=\$10-25,000 3=\$25-45,000 4=\$45,000+	.13*	-.21*	.24*			
5. Sex 0=female/1=male	-.01	-.07*	.06	.02		
6. Health Status 1=poor 2=fair 3=good 4=excellent	.05	-.33*	.06*	.33*	.02	
7. Govt. Health Care 0=nonsupporter 1=supporter	-.03	-.04	-.16*	-.15*	.01	-.13*

\*Indicates significance at p=.05 or less

Louisiana was in the sixth year of a major economic downturn. Further, the wording of the question can affect the response. The item phrasing, "system provided by the government" is less likely to elicit a positive response than one that uses the term "national health insurance" (Blendon and Donelan, 1990).

Table 1 reveals the zero-order relationships between attitudes toward a government sponsored health system and the other

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independent variables. As can be seen there is no significant correlation between attitudes toward government sponsored health and whether people are rural or urban. In fact, the percent breakdown between the two groups is almost identical. For rural respondents, 51.7 percent support the current system and 48.3 percent support a government financed system. For urban respondents, 52.4 percent favor the current system and 47.6 favor a government financed system.

A look at the other independent variables reveals that the strongest correlation is a negative relationship (-.15) between income and attitudes toward government sponsored health program. This is consistent with the literature on income and government spending on social programs. The other two independent variables with statistically significant relationships with the dependent variable are race (-.16), indicating blacks are more supportive of universal health care than whites, and personal health status (-.13). It should be noted that while the relationships between the three independent variables (income, race and personal health status) and the dependent variable are statistically significant, the coefficients are weak.

Table 2 presents the results of the multiple regression analysis. The first column has the standardized regression coefficients for the total sample. Controlling the effects of all other independent variables on government financed health care, it can be seen that rural/urban status has almost no impact on the variation in the dependent variable. The coefficient is -.01 and is not statistically significant. This finding is consistent with the notion that there is a growing similarity between attitudes of rural and urban residents. The different health and health care experiences of the two populations plays no apparent role in the formation of opinions about such a major change in the medical care system. This is especially interesting in Louisiana where rural health care is noticeably inadequate. Although the health care delivery system in rural Louisiana is lacking, efforts by government have improved it substantially in the past decades. This fact apparently does not impact rural Louisianians to favor universal health care in any greater numbers than their urban counterpart. Obviously many other factors are involved in the development of this health care reform opinion.

**Table 2. Multivariate Effects of Independent Variables on Support for Government Sponsored Health Care System (N=808)**

	Standardized Regression Coefficients		
	Total Sample	Rural Only	Urban Only
Rural/Urban	-.01		
Age	-.10**	-.11 <sup>+</sup>	-.10*
Income	-.12**	-.07	-.15**
Sex (1=male)	-.00	.00	-.01
Race (1=White)	-.10**	-.11 <sup>+</sup>	-.09 <sup>+</sup>
Personal Health	-.11**	-.10	-.12**
R <sup>2</sup>	.05	.04	.07
Adj. R <sup>2</sup>	.05	.02	.06
N	808	300	508

\*\*Indicates significance at  $p < .01$

\*Indicates significance at  $p < .05$

<sup>+</sup>Indicates significance at  $p < .10$

The independent variable with the greatest net impact on support for government financed health care is income. The -.12 coefficient indicates that wealthier people are less likely to support universal health care provided by the government than people with lesser incomes. This supports the literature on income and opinions toward social service spending in general. The relatively weak relationship is also consistent with the findings of Erikson, et al. (1988), that the diversity in opinions toward social service spending among income groups is no longer as great as it once was.

Following income are personal health status (-.11), age (-.10) and race (-.10). The directions of the effects of these three variables are the same as observed in the bivariate analysis. Probably the most interesting aspect of these relationships is their relative weakness. Race is of particular interest. Race has historically been a strong predictor of attitudes toward social service spending, with blacks more supportive than whites. Blacks have also been more likely to face

discrimination in the private medical care system than whites (Hill, 1988). It is clear that governmental action has helped and could continue to enhance the health conditions of blacks (Miller, 1990). These data do not indicate that this is a defining factor among blacks in the sample.

There is no impact of the remaining independent variable, sex, on the dependent variable. The well documented "gender gap" associated with many social issues does not divide the sexes in this analysis. Overall, only about five percent of the variation in opinions toward government financed universal health care is explained by the independent variables.

Because rural/urban status is so important to the analysis, it seemed important to check for whether there are any effects that are being obscured by the use of the dummy variable in the equation. Using the dummy variable implies that the general relationship among the dependent and independent variables are the same regardless of whether the respondents are urban or rural. Table 2 (columns 2 and 3) show the standardized regression coefficients of the rural and urban residents in separate equations. What can be seen here is that the regression coefficients are almost the same for the total sample and the urban sample. The equation for the rural sample is quite different. There is a loss of significance among the independent variables, and even less explained variance than that of the total sample. This implies that there is more variation in the opinions of urban residents than among the rural population.

The strongest coefficient within these two equations is the  $-.15$  relationship for urban residents, between income and support for government financed universal health care. This indicates that income is a more significant predictor of the dependent variable for urban dwellers than rural residents. Personal health status for the urban group is the next highest coefficient ( $-.12$ ). It is very similar to the rural sample.

Age and race are the two most significant predictors within the rural equation. Both of the relationships are similar to the ones found in the urban model. Among both groups, younger people and blacks tend to be most supportive of the dependent variable, but the variations are not that great. Examining the percentage breakdown by race and residence reveals that 63 percent of rural blacks and 60

percent of urban blacks support national health care, indicating no significant variation among these two groups. This is also true for whites, with 46 percent of rural whites and 43 percent of urban whites in favor of an overhaul in the United States health care system.

## **SUMMARY AND CONCLUSIONS**

The United States remains the only Western nation without some type of comprehensive universal health care system financed by government. This country's current system is one of the most expensive in the world, but the health status of Americans is no better and in many cases much worse than citizens in comparable nations. Addressing the problems of the health care system is now a major issue and is currently being debated at the national and state levels. It remains unclear as to how this society will correct its health care system and whether it will follow other industrialized nations and eventually develop a national health care system. In a pluralistic nation such as the United States, opinions toward the establishment of such a health care program can vary widely. It is important to understand the diversity that exists on such an important issue. The primary purpose of this paper is to examine the opinions of rural and urban residents toward a full health care system provided by the government. The data utilized in the study were from a state wide poll of Louisiana residents conducted by the Louisiana Department of Health and Hospitals.

Rural and urban citizens have experienced great differences in health status and medical care. Historically, rural people's health has been poorer and they have had more difficulty obtaining health care than urban residents. These problems were most pronounced in the South, with rural Southerners constituting one of the most unhealthy and most medically underserved segments of the United States population. Through government intervention, vast improvements in health and health care have been made in rural America, including the rural South. In spite of these efforts, discrepancies still exist between the rural and urban populations.

It was a primary assumption of this paper that rural Louisianians would be more supportive of a government health care system than their urban counterparts because of a greater need for such a system in

rural areas and also because of the success of government health care programs from which rural residents have benefited. It was recognized that this assumption might be contradicted by the fact that, in general, rural people are more conservative in their opinions toward social service spending than are urban residents. To aid the analysis several other independent variables were included that were found in the literature to be related to social service spending opinions. These were age, race, income, and sex. Personal health status was also included in the analysis.

The most important finding in the analysis was that a person's residence had no statistically significant effect on his/her attitudes toward government sponsored health care. This was found to be true both in bivariate (Table 1) and multivariate analysis (Table 2).

Debates have continued for decades in rural sociology over the relevance of the rural/urban variable as an explanatory factor in the analysis of differences in lifestyle, attitudes, opinions and beliefs. Findings have been mixed, with many researchers continuing to demonstrate the uniqueness of rural residence and the importance of the rural/urban comparison. On the topic of health care reform, based on these findings this is not the case among Louisiana residents. This is surprising considering the nature of the health care problems in rural Louisiana. The state is one of the poorest in the country and although problems exist in both rural and urban areas current analysis reveals that health problems and medical care delivery problems are most acute in the rural parishes of the state (Louisiana Department of Health and Hospitals, 1993).

Income was the strongest predictor of variation in the dependent variable, followed by personal health status, age and race. There was no discernable relationship between sex and the dependent variable. Thus, higher income, healthier, white, and older persons are more likely to want the health care system to remain as is, regardless of whether they live in rural or urban areas. This is quite consistent with theories that persons with greater stakes in the status quo would support the continuation of the status quo. It must be noted that the overall explained variance was quite small, indicating that there clearly are other factors not included that are related to opinions toward the nation's health care system.

To enhance the analysis, separate equations were created for the

rural and urban respondents, using the remaining five independent variables. It was found that the regression model obtained for the urban sample was very similar to that of the total sample. The predictability of attitudes of rural residents was almost impossible with the given variables selected in this analysis. This indicates that much of the variation found among the total model was due in great part to the variation among urban residents. For example, among rural residents there was very little variation among individuals in the different income levels and their support for national health care. High income rural residents were almost as likely to support national health care as were low income respondents. While the variation among urban income groups was not overwhelming, it was more substantial than for rural income groups.

As health care reform unfolds, it is important for policy makers to keep in mind the diversity of desires and needs of different segments of the population. While rural and urban status has often been used as a predictor of varying socio-political attitudes, it is not a factor in opinions toward establishing a government sponsored health care system among the citizens of Louisiana. This is an interesting finding considering the great historical diversity between the health statuses and medical care delivery systems of rural and urban residents in the country as a whole and Louisiana in particular.

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