It is difficult to quantify rural health problems and to make informed policy decisions without a clear definition of what and where "rural" areas are. Small population, sparse settlement, and remoteness are all features intuitively associated with "rural. " These features exist on a continuum, however, while Federal policies usually rely on dichotomous definitions.

Urban and rural areas are often defined using the designations of either the Office of Management and Budget (OMB) or the Bureau of the Census. Rural areas are the remaining areas that are not captured in either OMB's "metropolitan statistical area" (MSA) designation or in Census' urban or urbanized area definitions. Counties are the building blocks of OMB's MSAs and are easy to use, because county-based data are readily available. One or more counties form an MSA on the basis of population size and density, plus the degree of area-wide economic integration as reflected in commuting patterns. The Census' urban and urbanized area definitions rely on settlement size and density without following county boundaries, making them more difficult to use. Both methods identify about a quarter of the U.S. population as rural or "nonmetropolitan," but these populations are not identical. For example, about 40 percent of the Census-defined rural population live within MSAs, and 14 percent of the MSA population live in Census-defined rural areas. The Census' rural population includes residents of small towns and cities but excludes those living in towns larger than 2,500, many of whom might be considered rural. MSAs can include areas that are sparsely populated and could be considered rural, while nonmetropolitan areas show significant within-area variation.

There is no uniformity in how rural areas are defined for purposes of Federal program administration or distribution of funds. Different designations may be used by the same agency. For example, Congress directed the Health Care Financing Administration to use Census' nonurbanized area designation to certify health facilities under the Rural Health Clinics Act, but to use OMB's MSA/nonMSA designations to categorized hospitals as urban or rural for purposes of hospital reimbursement under Medicare. In general, rural hospitals are reimbursed less than their urban counterparts. While persistent differences between metropolitan and nonmetropolitan hospital costs have been observed, hospital location may be a correlate rather than a determinant of cost differences. Therefore, hospital-specific measures are being sought that might replace the present MSA adjustments to the basic prospective payment formula. Topologies that categorize counties according to their degree of urbanization or their employment and commuting patterns could be used to refine the definition of labor market areas, an important component of the Medicare formula.

There have been calls to develop a standard rural typology that would capture the elements of rural diversity and improve the use and comparison of nationally collected data. These topologies usually are based on the following features: population size and density; urbanization; adjacency and relationship to an MSA; and principal economic activity. Although a standard typology may be desirable, it will be difficult to arrive at, because the different topologies have merit for various purposes. Nevertheless, there continues to be a need for a standardized nonmetropolitan topology. It is especially important to display vital and health statistics in a standardized way, because markedly different conclusions can be reached, depending on the definition of rural used. Better measures of population concentration or dispersion within counties would be helpful--especially for sparsely settled "frontier" areas --to distinguish between urban and rural areas within the same counties.