

Perceived Health Care Needs of Amish Populations in Two Newly Established Districts¹

Karen McCrea

Assistant Professor

School of Nursing and Health Studies

Georgetown University

mccrea726@gmail.com

Abstract: The Amish population in the United States is growing rapidly, leading to many new Amish communities. This mixed-methods study establishes the demographic characteristics within two newly formed Amish districts in New York State and determines the community's perceived health care needs. The study targeted married individuals within the two districts, utilizing informational meetings, individual meetings, and the creation of a Perceived Health Care Needs Questionnaire. The findings included baseline demographics, barriers to health care access, desired health care provider qualities, and perceptions related to health care costs. Conclusions: The Amish are an underserved population with significant barriers to health care, and newly established districts located in rural geographical areas where Amish communities previously did not exist face additional challenges. Opportunities exist for health care providers to help the newly established Amish districts meet their desired health care needs in a culturally competent manner.

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Background

The Amish population is one of the fastest growing in the United States today, averaging seven live births per couple (Dickinson, 1995; Wiggins, 1983). In the United States, the Amish population increased by 195%, rising from 174,785 to 344,670, between 2000 and 2020 (Young Center for Anabaptist and Pietist Studies, 2020b). The Amish organize themselves into church districts, also known as districts. A district typically consists of 20 to 30 families, all of whom live within a two- to three-hour horse-and-buggy ride from one another (Donnermeyer & Friedrich, 2006). With this organizational structure, Amish households are not in a commune-type setup, but rather interspersed among non-Amish, “English,” households within a geographical area.

Accurate accounting of the Amish population is difficult. Although the United States Census Bureau initially tracked religious preferences, it stopped this practice in the 1930s (U.S. Census Bureau, 2002). In 1905, the Amish population of the United States and Canada was estimated at 8,300, but by 1977 the number had increased to 75,000 (Wiggins, 1983). With current growth rates, the Amish population will double in less than 25 years (Donnermeyer & Friedrich, 2006).

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In 2020, the Young Center for Anabaptist and Pietist Studies (2020a) estimated the Amish population in the United States to be 344,670 individuals.

Initial North American Amish settlements, in the early eighteenth century, were in the mid-Atlantic area of the United States. Since that time, Amish migration has spread across the midwestern, southern, and northeastern portions of the United States and the province of Ontario in Canada (Hostetler, 1980). The Young Center for Anabaptist and Pietist Studies (2020a) reports that Amish currently reside in 31 states within the United States, four Canadian provinces, and two South American countries.

Between 2006 and 2010, more than 2,360 Amish families migrated across state lines (Kraybill et al., 2013, p. 181). As the Amish migrate and establish new districts in communities without a prior Amish presence, there is uncertainty regarding what Amish health care needs and desires are. Assessing health care needs from the Amish perspective is one important step into gaining better understanding. The community utilized for this study was recently established in an area with no prior exposure to the Amish and consists of a two closely linked church districts whose families reside across two counties in a rural locale. The purpose of this study is to assess the perceived health care needs of these two church districts with a goal of gaining insight.

The theoretical framework chosen to guide this study is the culture care diversity and universality theory developed by Dr. Madeleine Leininger. The culture care theory has been established as a major, dominant, and relevant theory after more than 50 years of study and research (Leininger & McFarland, 2006). Leininger asserts that *caring* is the essence of nursing, and furthermore, the provision of culturally competent care is beneficial and necessary for the health, well-being, and healing of people of all cultures (Leininger & McFarland, 2006). Leininger also bases her theory on the premise that all people, regardless of their cultural background, can inform and guide professionals so that they receive the type of care they want and need (Welch, 2002).

In essence, Leininger integrates two opposing concepts— cultural care diversity and cultural care universality—into one theory. The concept of cultural care diversity relates to learned and transmitted values, beliefs, and patterned lifeways that assist, support, facilitate, or enable other individuals to maintain their well-being and health (Welch, 2002). Leininger states that characteristics unique to one individual can assist others who have differing life experiences. Leininger also developed the concept of cultural care universality, which asserts that certain basic fundamentals of health meanings, beliefs, and values are found across all cultures (Welch, 2002). These universal traits allow commonalities to exist regardless of culture. Leininger's theories serve as an ideal guiding framework for this study, which focuses on identifying the health care needs of a newly established, culturally unique population within a geographical area that had no prior exposure to the Amish.

Review of Literature

A review of the literature was undertaken to ascertain relevant background information and determine gaps in the literature. Several case study and observational articles related to Amish health care have been published. Examples include Blair and Hurst (1997), who offered Amish

and non-Amish observations directly related to Amish health care; Guyther (1979), a physician who presented a case study of one of his Amish patients; and Weyer and colleagues (2003), who also discussed a case study of an Amish patient. Although these articles provide some context and background, they lack rigor and true Amish perspective of pertinent issues.

Multiple qualitative studies were located. Perhaps the most influential and relevant was the seminal research conducted by Anna Francis Wenger. Wenger (1988, 1995) utilized Leininger's theory of culture care diversity and universality to explore Amish culture, community, and health care, and she provided a culturally centered look into the Amish way of life that was previously unexplored. Dellasega et al. (1999) published a qualitative study focusing on the views of nine advance practice nurses, procured through snowball sampling, who provided care within Amish communities. Andreoli and Miller (1998) published the results of their qualitative study examining the topic of aging within the Amish community. Their sample group consisted of ten Old Order Amish and an unnamed number of non-Amish individuals, and their findings suggest that the Amish approach to care of the elderly should be considered by policy makers as they face a growing, aging, baby-boomer population. The qualitative studies that were examined offered valuable general insight into the Amish culture and certain aspects of Amish views related to health care but did not address the specific needs of the focus community.

Multiple quantitative studies were also reviewed. Miller et al. (2007) performed one of the first systematic surveys of Amish women. They examined health status, health conditions, and health behaviors. Bassett et al. (2007) examined physical activity and the body mass index of Amish children, providing concrete evidence that the active lifestyle of Amish youth results in lower childhood obesity rates. Of note, there are a multitude of studies related to genetic and congenital abnormalities among the Amish. These studies were not examined as part of the literature review.

Armer and Radina (2006) performed a mixed methods study that examined the definition of health and health promotion behaviors among the Amish. Thomas et al. (2002) undertook a literature review to examine health-related research among Amish women, while Yoder (1987) explored existing literature and suggested nursing interventions when providing care to the Amish. Wiggins (1983) explored the literature and provided information regarding health and illness beliefs and practices among the Amish. A severe limitation of several of these articles is the use of aging textbooks without actual input from the Amish. Beachy et al. (1997) explored existing literature related to the Amish and applied the transcultural assessment model.

A limited number of needs assessments related to Amish health care have been completed. Cates (2005) explored mental health issues within Old Order Amish communities. Miller et al. (2019) performed a health needs assessment in Lancaster County, Pennsylvania, that incorporated Old Order Mennonite and Old Order Amish populations. Finally, a study completed in Kentucky was used to determine the need for a genetic medical clinic (Hunt et al., 2018).

Overall, the literature review identifies the Amish as a growing and underserved health care population. However, a major gap identified in the review relates to the health care needs of newly established Amish communities. No studies were located that addressed this issue, either from the Amish perspective or from the perspective of health care organizations and providers. Given the

rapidly expanding number of new Amish districts, the current study was developed to explore these needs from the Amish perspective.

Methodology

Design

The study took place in New York State, which is experiencing a rapid influx of new Amish communities. Since 2000, there have been 42 new Amish settlements and 119 new Amish districts in New York State, a majority of which are in areas with no prior established Amish presence (Young Center, 2020b). New York is one of America's most vital agricultural states, ranking second in apple, maple syrup, and pumpkin production and third in dairy, wine, grape, cabbage, cauliflower, and corn silage production (New York State Agricultural Society, 2021). Even though New York has remained a top agricultural producer in the United States, the number of farms and utilized farmland has dramatically declined. Study participants reside in two counties. In one of those counties, there were 995 farms utilizing 180,750 acres of farmland in 2012. This is a significant reduction from 1959 when there were 2,391 farms utilizing 456,961 acres of land (New York State Agricultural Society, 2021). The availability of unused farmland was a major impetus leading to the recent establishment of the Amish communities in this study (study participant, personal communication, June 2010).

This study was part of a larger study that aimed to determine baseline functional health status, identify perceived health care needs, and facilitate a strategic plan of action to address identified gaps. The first step in the project plan was ensuring that the researcher had buy-in from the target population. Without buy-in, the project could not proceed. The Amish community surveyed for the study consisted of two church districts with close ties to each another. One district contained 22 families and the other district contained 14 families.

An informational meeting was held to allow members of the districts to hear information regarding the proposed project, ask questions, and review the questionnaire. The date and location were determined in collaboration with an Amish bishop. Fliers were distributed to children in the two Amish schools, and a total of 24 adults attended the meeting, listened to the presentation, asked questions, and reviewed the proposed questionnaire documents. As a group, the community unanimously agreed to participate in the project, and the details related to determining participants and collecting data were decided at the meeting. At the community's request, no audio or video recordings of visits were made.

Creating an opportunity for open dialogue between the researcher and potential Amish participants had multiple outcomes. The informational meeting allowed potential project participants to meet the researcher and determine trustworthiness. It also allowed them to help shape and guide how the project would move forward.

Sample

The attendees at the informational meeting identified their community as a relatively young one. Within the two districts, there were no widows or widowers, and the vast majority of single adults

were in their late teens to early twenties. These individuals continue to reside with their parents until they marry. For this reason, at the request of the community, married couples were identified as the target population. The meeting participants also requested that the questionnaires be completed during face-to-face meetings within individual homes and not in a large group setting, with the researcher present to answer any questions participants might have.

The question of how to identify and locate all eligible married couples was resolved by two Amish men who attended the informational meeting. All married couples carry fire insurance on their residences, and each district appoints one individual to maintain all fire insurance records. Both elders agreed to send the researcher a list of names and addresses of all married couples in their district. A total of 36 married couples (72 individuals) within the two districts were identified as possible participants for the study. Participation was completely voluntary.

Questionnaire

A search was undertaken to locate an existing, validated, and reliable questionnaire that would assess perceived barriers to care, priority health needs, and desired health care provider characteristics among the Amish. An exhaustive literature review revealed no existing tool that fit all, or even most, requirements. The tool that came the closest was a community health center survey utilized by Dickinson et al. (1996). This tool had only been used once and had no reliability or validity data (Dickinson et al., 1996). It focused specifically on services offered or being considered at a community health center serving Amish and non-Amish individuals in Wisconsin. The tool was not directly translatable to the proposed project in New York, but it provided the researcher with an idea of how to proceed with the development of a tool. The Perceived Health Care Needs Questionnaire was created to meet the needs of the proposed study. It provided options to select from and opportunities to write in additional responses. A certified nurse midwife who works with the Amish in another area of New York State and two Amish individuals who reside in the targeted Amish community reviewed the document and offered suggestions to improve comprehension and understanding. The reviewers also ensured that the questionnaire was culturally appropriate. The survey incorporated specific questions about the personal, social, environmental, and cultural needs and beliefs as they related to the potential health care needs assessment of these districts' members.

Data Collection

This project used convenience sampling. Participants signed up for times to complete the questionnaire at their convenience. Volunteers from both districts agreed to collect the sign-up sheets on Sundays after church services. Those who chose not to participate simply did not sign up for an interview time. Questionnaires were completed during face-to-face visits during which the researcher provided the evaluation tool, discussed the project, and obtained informed consent. The researcher was present to clarify questions that participants did not understand and to ensure that questionnaires were completed. All possible efforts were made to not influence participant responses.

Data Analysis

Descriptive statistics were used to analyze demographic characteristics of the respondents including age, gender, marital status, number of residents within the home, and number of live births. Rank orderings were calculated for topics including why individuals did not seek care from health care professionals, which health care services were deemed important, and what qualities were preferred in a health care provider. Mean, median, and mode were used in the analysis of reasonable costs for health care visits.

Results

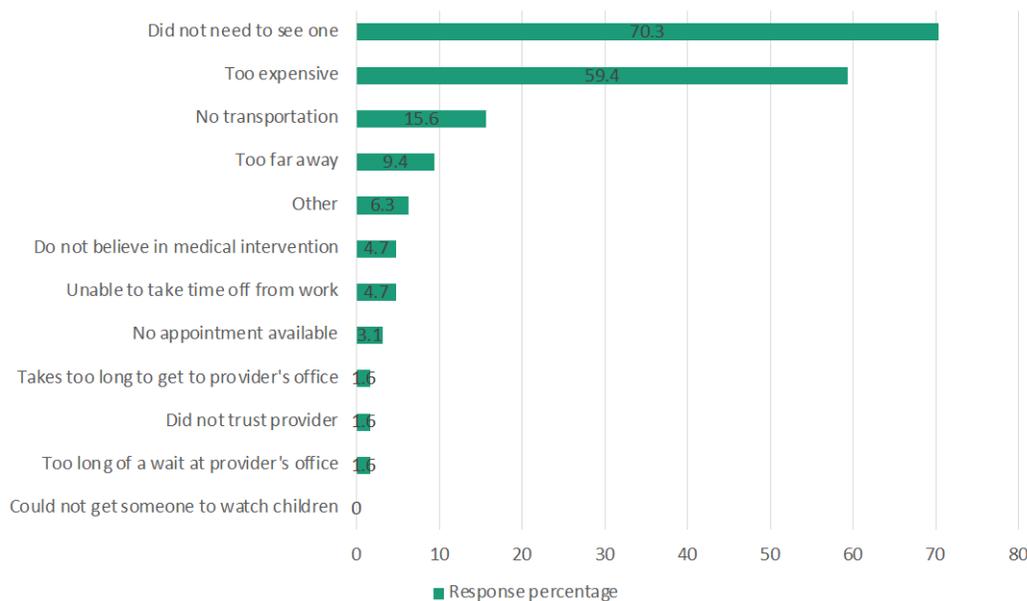
Demographic Characteristics

A total of 65 individuals completed the survey, an individual participation rate of 90.3%. The participants represented 34 of the identified 36 households, a household participation rate of 94.4%. Females represented 50.3% of the respondents, while males represented 47.7%. The average age of participants was 39.4 years, with 81% of respondents under the age of 50. The average household size was 5.94 people, and the average number of live births per household was 5.85. All households consisted of a husband, a wife, and, in some cases, biological children. No extended family or non-relatives resided in any household in the study.

Perceived Barriers to Accessing Health Care

Participants were given a list of 11 possible reasons for not seeking health care plus an “other” category, where they could write in additional reasons. They were instructed to choose all the reasons that applied during the previous year. (See Figure 1.)

Figure 1
Reasons for Not Seeking Health Care



Sixty-four participants responded to this question. It is not known why one individual did not respond to it. The main reason for not seeking health care was identified as “not needing to see a health care provider,” an option chosen by 70.3% of the participants. The next most frequent response was “too expensive”; 59.4% of respondents chose this option. While completing the survey, many participants openly said that they often opt to go to the Emergency Department when health care is needed. They noted that because they do not typically seek routine preventative care, many primary care providers and health care organizations refuse to add them to their patient lists and are not willing to see them on an as-needed basis. The next two most commonly chosen selections were “no transportation,” chosen by 15.6% of respondents, and “too far away,” chosen by 9.4%. A total of 6.3% of respondents chose “other” as a reason for not seeking health care. Written-in reasons included “It was too easy to put off going,” “The provider does not use natural remedies such as burdock leaf and B&W salve,” “We try natural remedies,” and “We try to keep costs down.”

Desired Health Care Services

Participants were given a list of 17 types of health services and an option of “other,” and were asked to pick the top three types of health services that were most important for their family and community. (See Table 1.)

Table 1

Identification and Prioritization of Desired Health Care Services

Answer options	Most important	Second most important	Third most important	Number of responses
Birthing center (or home delivery)	19	16	3	38
Child health care provider	11	7	10	28
Basic dental care	5	9	7	21
Home health care services	6	6	7	19
Pregnancy care	9	5	4	18
Adult health care provider	7	3	6	16
Chiropractor	1	5	4	10
Pharmacy services	1	3	5	9
X-ray services	2	3	3	8
Laboratory services	0	3	3	6
Hospital for delivery or inpatient care	1	2	3	6
Other	2	2	3	6
Immunizations	1	1	1	3
Health education services	0	0	3	3
Physical therapy services	0	0	1	1
Mental health services	0	0	1	1
Child spacing services	0	0	0	0
Alcohol and tobacco counseling	0	0	0	0

The top priority was “birthing center or home delivery services” with a total of 38 responses, 10 more than “child health care,” which ranked second with 28 responses. “Basic dental care” ranked third with 21 responses. “Care delivered in the home” ranked fourth with 19 responses. “Pregnancy care” ranked fifth with a total of 18 responses. If “prenatal” and “delivery care” are combined, they rank first with a total of 56 responses, twice as many as the next ranking for “child health care.” “Adult health care” received 16 responses. The options of “child spacing services” as well as “alcohol and tobacco counseling” did not receive any responses. “Mental health services” and “physical therapy services” each garnered one response.

Desired Qualities in Health Care Providers

Participants were given a list of eight qualities and a choice of “other,” and asked to choose their top three desired qualities in a health care provider. (See Table 2.)

Table 2

Desired Qualities in Health Care Providers

Answer options	Most important	Second most important	Third most important	Number of responses
Other*				54
Honest and trustworthy	22	12	5	39
Reasonable fees	6	12	15	33
Willingness to come to your community	8	6	7	21
Knowledge level	7	3	5	15
Respect for your culture and beliefs	5	2	4	11
Open to complementary and alternative treatments	0	5	2	7
Willingness to take payment plans	0	3	3	6
Delivers up-to-date, high quality care	0	1	0	1

* See Table 3 for additional information

The “other” category received the most responses (54). “Honest and trustworthy” received 39 responses, the most responses for a named quality. That response was followed by “reasonable fees” (33 responses), “willingness to come to your community” (21 responses), “knowledge level” (15 responses), and “respect for your culture and beliefs” (11 responses). “Open to complementary and alternative treatments” and “willingness to take payment plans” garnered seven and six responses respectively and “delivers up-to-date, high quality care” received only one response.

Since many participants chose the “other” category, an analysis was made of those responses. (See Table 3.)

Table 3*Other Desirable Qualities for Health Care Providers*

Quality	Number of responses	Quality	Number of responses
Delivers a certain type of care	14	Easy to get along with	1
Female	7	Trustworthy	1
Communicates (listens and explains)	7	Experienced	1
Friendly	5	Cheerful	1
Caring	2	Responsible	1
Be there when needed	2	Openness	1
Makes house calls	2	Concerned about patients	1
Self-assured	1	Reliable	1
Service	1	Open minded	1
Helpfulness	1	Respectful	1
Integrity	1		

Fourteen respondents wrote in certain types of health care, such as health care for children or midwifery. Seven noted a desire for a female health care provider, and seven valued the ability to communicate well: taking time to listen to patients' concerns and taking time to explain. Five indicated the desire for a "friendly" provider. Most other responses followed these themes, with "caring," "be there when needed," and "makes house calls," receiving two responses each. Other traits included "responsible," "respectful," "concerned about patients," "open-minded," "reliable," "integrity," "experienced," "trustworthy," "cheerful," "experienced," "helpful," and "self-assured."

Reasonable Cost for Health Care Visits

Participants were asked what they thought a reasonable cost for a visit would be. Six of the 65 participants opted to leave this question blank, a higher lack of response than for any other question. The range was \$10–\$100, the mean was \$45.88, the median was \$44, and the mode was \$50.

Discussion***Demographic Characteristics***

The average age of the participants (all of whom were adults) was 39.4 years, with 81% under the age of 50. In comparison, the United States Census Bureau (n.d.) indicates that the average age of all United States residents, including children, is 38.5 years of age. Only 12% of the Amish participants were age 60 or older. The CDC estimates that 16.5% of the general U.S. population, including children, is at least 65 years old. This evidence supports the Amish community's assertion that they are a young group.

Females represented 52.3% of all participants in the study, and males represented 47.7%. Female data was represented in 100% of participating households, and male data was received

from 91% of participating households. Overall, the opinions and ideas of both genders were well represented in the data.

Average household size in the community was 5.94 people, which is significantly larger than the average household size of 2.41 people determined by the 2020 United States Census.

One potential issue in comparing the collected data to the United States Census data is the fact that only households of married couples were evaluated in the study. However, according to Amish participants, single-person households are relatively rare in their community. Young adults remain at home until they marry, divorce is not recognized, and this particular community did not have any widows or widowers. All households consisted of a husband and a wife, and 77% contained at least one biological child. No participating households identified any other residents besides husband, wife, and biological children.

Data regarding the number of live births per participating household were examined. The average number of live births per household was 5.85 births. In comparison, the World Bank Group (n.d.) states that in 2019 the average number of live births per woman in the United States was approximately 1.7. The collected data indicate an Amish community birth rate significantly greater than the national average. Participants indicated that the community birth rates were representative of the Amish population in general. Wiggins (1983) estimated that the birth rate among the United States Amish was approximately six live births per household. This estimate is essentially replicated with the information gained from this study. Of note, a total of five participating households had no children. All these households consisted of young, newly married couples, and two of them indicated that they were expecting their first child. Given the relatively high number of young, newly married couples in the community, there is a high probability that the actual number of live births per couple is underestimated in this study.

Overall, the demographic characteristics of the two Amish districts are similar to national Amish demographic characteristics, which enhances the generalizability of the results. Additionally, the data backs up the community's assertions that it is a young, mobile group.

Perceived Barriers to Accessing Health Care

Transportation issues are identified as a significant barrier to seeking health care, which is not surprising since the primary mode of transportation for the Amish is horse and buggy. When horses cannot reasonably accomplish travel distances, the Amish either hire private vehicle transportation or rely on public transportation. In the rural area where the members of this Amish community reside, public transportation options are extremely limited.

While completing the survey, many participants openly stated that they often opt to use the Emergency Department when they need health care. Participants noted that because they do not typically seek routine preventative care, many primary care providers and health care organizations refuse to add them to their patient lists and are not willing to see them on an as-needed basis. Not surprisingly, this results in high health care costs. Since the Amish in the study do not participate in privatized health insurance plans or government-based Medicare/Medicaid options, all health care costs are paid for on a cash basis. For this reason, it is not unexpected that health care costs

would be a major concern. Based on the barriers to health care identified through the questionnaire, local and affordable care would be welcomed by the Amish community. Local health care agencies might consider adjusting policies that require patients to be seen routinely for preventative care. Increased flexibility to accommodate the Amish population has the potential to decrease existing barriers, reduce health care costs, and improve overall Amish health.

Interestingly, no participants chose “not being able to get someone to watch children.” Given the high birth rate in the community, the fact that no one chose this response demonstrates the high level of social support within the Amish community. Wait time to make an appointment, wait times at the health office, and lack of trust were not highly prevalent reasons cited by the participants. A total of 26.6% of respondents said that lack of transportation, distance, and time it takes to get to provider’s office were reasons they did not seek health care. Health care organizations might consider implementing a ride service or pop-up clinics to decrease the impact that transportation barriers have on health care access for the Amish.

Desired Health Care Services

Given the high birth rates and number of children in these two districts, it was not surprising that child health care was identified as a priority. Along with child health care, many participants voiced the desire for immunizations, although only three chose immunizations as a priority. Participants did not voice a desire for routine well-child visits, but rather wanted a provider to handle many of the illnesses and injuries that accompany infancy and childhood. The expressed priorities of a birthing center or home birthing service combined with pediatric care expose large gaps in needed care among the Amish. Creative problem solving between health care organizations that offer these services and the Amish community has the potential to develop novel and innovative solutions.

Basic dental care was the third priority identified by the Amish community. Many parents spoke of the difficulty of arranging transportation to dentists, who are located a significant distance away. Others voiced concerns about the high rates charged by many local dentists. Because of the community’s rural environment, the drinking water is not fluoridated, and no children were taking fluoride supplements. Lack of fluoride and poor dental care was evident in visibly poor dentition of many of the children and adults. Another potential cause for poor dentition was identified as high carbohydrate diets within the community. The quality of daily dental care was not assessed. Future exploration of these issues should be considered.

Not surprisingly, participants did not identify child spacing services, otherwise known as birth control, as a priority, or even important. This finding is consistent with the literature, which notes that the Amish consider children to be “gifts from God” and generally do not make efforts to prevent pregnancy. This finding also helps explain the unusually high birth rates among the Amish.

Several participants wrote in their desired health care services under the “other” option. These included “can handle fractures,” “health care for the elderly,” “primary care,” “family doctor,” and “health care provider.” One participant noted that “someone to provide transportation” was a priority. All these responses underscore the desire for basic primary care in this Amish community.

Desired Qualities in Health Care Providers

Dellasega et al. (1999) stated that to develop and maintain a professional nursing relationship with the Amish, a nurse needed to establish trust. Blair and Hurst (1997) asserted that the Amish tend to have a distrust of health care providers. These assertions were reinforced in this study: the category “honest and trustworthy” received the most responses—39—and many of the traits listed in the “other” category dovetailed with this theme as well. Reasonable fees and the willingness to come to the community were prioritized above provider knowledge level. The fact that a large number of participants chose the “other” category and 14 responses indicated certain types of health care (such as child health care or midwife) perhaps indicates that participants did not fully understand the question. If the tool were to be used again, modification of this question should be considered.

Reasonable Cost for Health Care Visits

Results indicate that the Amish are more than willing to pay for the services they receive. Furthermore, many community members indicated that if the care was provided in their home or nearby, they would be willing to pay even more since they would not need to hire transportation.

In New York State, the current Medicaid reimbursement rate for a level three, established patient visit (99213), is \$73.93 for a physician (Centers for Medicare & Medicaid Services, n.d.). Nurse practitioners are reimbursed at 80% of physician rates, which equates to \$59.14 for a level three visit. Data gathered from the Amish related to reasonable fees for health care visits indicate that the community is willing to pay for health care visits at a rate similar to Medicaid reimbursement. The Amish pay cash, and participants voiced a desire to pay on the day service is obtained. Same-day payment without the expense and time-consuming process of billing insurance companies for remuneration would significantly decrease overhead expenses for a potential health care provider. Furthermore, the gathered data supports the Amish assertions that they are not looking for a handout; rather, they just want health care services provided at an affordable rate.

Overall, the research provides information for health care providers seeking to provide culturally competent, high quality health care to the Amish population. The Amish are seeking affordable, quality care within their own communities. Their priorities include prenatal and childbirth care, care of children, and dental care. Health care providers hoping to provide care within the Amish community will need to excel in the areas of trustworthiness and communication skills.

Because the information came from the Amish themselves, the data has greater reliability and validity than if it was collected from non-Amish sources such as health care workers or social workers. Further strengths of the study include the high household and individual participation rates as well as the high rate of participation from both women and men. The biggest limitation of the study is the small sample size. Data obtained from two Amish districts, even with a high participation rate, cannot be generalized to the entire Amish population, nor can it be generalized to all recently established Amish communities. Additional, larger studies that encompass a more

geographically diverse Amish cohort need to be undertaken. A second limitation is that the assessment tool did not have established reliability and validity because it was newly developed.

Implications for Practice and Research

This study demonstrated respect and appreciation for cultural diversity and strived to increase knowledge about health care needs and sensitivity associated with providing culturally acceptable care. It provided valuable insight into the health care needs in two recently established Amish districts located in close geographical and social territory, and it identified significant unmet needs. However, caution must be used in generalizing the findings to all Amish communities, as much diversity among districts exists. The Amish are open to modern health care and assistance from the outside, but first, trust must be established. All individuals interested in providing health care to the Amish should be aware of their desire to have culturally competent care provided in a trustworthy and respectful manner. Providers need to take time to explain diagnoses, causes, treatments, and expected recovery, and they also need to be willing to allow the incorporation of folk-based remedies into the plan of care.

Satisfying, culturally based care enhances the well-being of clients. Culturally beneficial health care occurs when cultural care values, expressions, and patterns are sought, acknowledged, and used appropriately by health care providers. Health care that is not congruent with cultural beliefs and values will result in clients who experience cultural conflict, noncompliance, and ethical or moral concerns.

Additional research is needed to better understand and assist newly established Amish communities in meeting their health care needs. Care must be taken to provide health care within a context and framework desired by the Amish. Since many Amish do not seek routine health care, they are often unaware of actual chronic medical diagnoses, which presents additional challenges. By the time they seek medical attention, a condition is likely to be more advanced and the individual severely ill.

Amish population growth is presenting challenges to rural health care providers across the United States. This study, although small, offers insight into the needs of newly established Amish communities. Studies that are broader in both numbers and geography can further clarify the needs and expectations of Amish people. To augment the Amish perspective of desired health care, research should be undertaken to assess what knowledge and support health care providers need to provide care to newly established Amish communities. Although health care providers desire to provide high quality, competent, culturally sensitive care to all of their patients, most remain unsure of issues, desires, and preferences among those in the Amish community. With many new Amish communities being developed in areas with no prior Amish presence, this becomes an important need.

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