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RESPONSE TO CHALLENGE - NEW PROGRAM DIRECTIONS.

BY- CARTER, LISLE C., JR.

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ALTHOUGH ONLY 36 PER CENT OF OUR POPULATION LIVE IN RURAL AREAS, 52 PER CENT OF OUR POOR RESIDE THERE. RURAL INFANT MORTALITY AND RURAL DEATHS FROM INFECTIOUS DISEASES ARE MUCH HIGHER THAN THE NATIONAL AVERAGE, AND RURAL MIGRATORY FARM WORKERS HAVE SIMILARLY HIGH MORTALITY RATES. RURAL AREAS HAVE SUBSTANTIAL SHORTAGES IN ALL HEALTH SERVICES. ALTHOUGH RECENT FEDERAL PROGRAMS HAVE BEEN INITIATED TO ALLEVIATE THESE SHORTAGES, LITTLE PROGRESS HAS BEEN MADE IN IMPLEMENTATION. NOT ONLY IS SKILLED MANPOWER RELUCTANT TO MOVE TO RURAL AREAS, BUT LOCAL RESOURCES, SERVICE DELIVERY SYSTEMS, AND INSTITUTIONAL ARRANGEMENTS ARE VIRTUALLY NONEXISTENT IN MANY AREAS. FEDERAL PROGRAMS OF HEALTH SERVICES WILL HAVE LITTLE CHANCE FOR SUCCESS UNTIL LOCAL INITIATIVE CAN PROVIDE FOUNDATIONAL SUPPORT. THIS SPEECH WAS DELIVERED AT THE NATIONAL OUTLOOK CONFERENCE ON RURAL YOUTH, OCTOBER 23-26, 1967, WASHINGTON, D. C., SPONSORED JOINTLY BY THE U. S. DEPARTMENTS OF AGRICULTURE, HEALTH, EDUCATION, AND WELFARE, INTERIOR, AND LABOR, OEO, AND THE PRESIDENT'S COUNCIL ON YOUTH OPPORTUNITY. (BR)

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Health Services for Rural Youth

Speech presented at
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Hon. Lisle C. Carter, Jr.
Assistant Secretary for Individual and Family Services
U. S. Department of Health, Education, and Welfare
Washington, D. C.

I am pleased to be with you today to discuss what we are doing to help meet the acute health needs of rural America.

The needs of rural areas are, in general, no different from those which trouble us in urban areas, except in magnitude and setting. As dramatic as urban problems are, however, rural problems can be in their less visible way, even harder to deal with realistically.

Of all our domestic problems -- aside from the cities themselves -- poverty has drawn our most consistent attention. Poverty is strongly entrenched in non metropolitan areas, where 52 percent of the nation's poor live. This becomes especially impressive when we realize that only about 36 percent of our population live outside metropolitan areas.

The extent of rural poverty and its impact on rural health is vividly illustrated in these statistics.

In the Appalachia region infant mortality is twice the national average. Deaths in that region resulting from infectious diseases are some 33 percent higher than the national average. The same area has serious deficiencies, in long-term care facilities, and general hospital beds.

Another depressed rural population, migratory farm workers, displays similar health characteristics. Infant mortaility among migrants is 30.6 per 1,000 live births as compared to a national average of 24.8. There are 4.4 maternal deaths per 10,000 live births for migrants compared to a national rate of 3.5 Both infact and maternal mortality rates for migrants exceeded the national average by approximately 25 percent.

Comparing isolated rural areas against the nation in numbers of physicians and dentists available, reveals substantial shortages. Isolated rural areas have only 59.1 physicians per 100,000 as compared with a national rate of 100.8. There are only 27.4 dentists per 100,000 of isolated rural population as contrasted to a national rate of 54.1.

The result of these shortages is demonstrated by the amount of medical services the population receives. According to the National Center for Health Statistics persons on farms outside of an SMSA averaged only 3.3 physician visits per year compared to 4.8 for those living within the SMSA. For dental visits the deficiencies were sharper. People living on farms averaged .9 visits per year or one-half those made by the population within SMSA. Families living in poverty or belonging to minority groups averaged fewer visits than the rest of the population so it can be assumed that the rural poor and rural non-white population received less medical treatment than the low averages for the total farm population.

We have as a nation deplored these conditions and problems that accompany them: poor schools, poor housing, inadequate income and social services, unemployed and underemployed people. And the Administration is concerned that these conditions be eliminated. We have far to go before we can meet our own expectations; but we are just as determined that these standards be achieved in rural areas as in the cities.

Yet, while illness is just as debilitating in the country as in the town, while the goals are the same for rural as well as urban dwellers, the means of coping with the problems and reaching the goals must necessarily differ.

Many programs have been fashioned to address health needs, a number of these activities especially relevant to rural areas and people. I'd like to describe just a few of these.

Particularly significant in rural areas is the Federal Hill-Burton Hospital and Medical Facility Construction Program, which has generally favored rural areas. Seventy-six percent of the program's more than 3,000 projects have been developed in communities of less than 50,000 population.

The recently enacted Partnership for Health promotes the development by States of comprehensive health services, rather than the growth of separate, categorical, disease-related programs which restricted the flexibility of funds. With its provision for State-wide planning, the Partnership can go far to sponsor efficient use of health resources in rural areas.

The Migrant Health Program supports programs of services and sanitation improvement to improve the health of this group, the most deprived and rootless of the rural poor. While scattered population presents difficulties in serving almost all rural areas, the transitory life of the migrant makes it even more difficult to bring him and his family adequate health care. The program emphasizes services in home-base areas for migrants. As of this June, more than 40 counties in Florida,

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Texas, New Mexico, Arizona, Southern California, and Missouri reported an out-migration of 200,000. In addition, more than half of the nation's counties with peaks of 3,000 or more migrants during the season now include migrants in projects offering health services. During 1966, Migrant health projects supported 183,000 outpatient visits for medical and dental diagnosis as well as 100,000 more visits for nursing services. The Migrant Health Program costs eight million dollars in the fiscal year 1967 and is expected to grow to nine million dollars in 1968. These projects are working out ways to bring continuity to the care of migrants and their families.

Medicaid, Title XIX of the Social Security Act, will purchase health services for the non-aged persons who cannot afford them. This could have significant impact on rural health, although it, in itself, cannot solve problems created by shortages in rural health facilities and personnel.

From the first, the public child welfare program was concerned with the welfare of rural children. Early studies of infant and maternal mortality, child dependency and mental retardation pointed to the unevenness and, in some States, the total lack of facilities and social services for rural children.

Child welfare grants-in-aid were established, therefore, to assist State public welfare agencies to develop public child welfare agencies in predominantly rural areas. Legislation now requires that these services be available in all parts of the States by 1975, but there are still 1000 counties, mostly rural, with no child welfare services at all. This year, the President has proposed that the Federal government aid States to meet the costs of employing and training these needed workers.

He has also proposed legislation to promote early casefinding and treatment for crippled children. We are also requesting increased funds for the "Medicaid" program, as it affects needy children. This would require States to provide early case-finding and treatment for poor children and it would benefit, especially, needy children in rural areas.

In addition, President Johnson has proposed pilot programs in both maternal and children's services and in dental care. Location of these pilot projects will be determined by the need of an area; priority will be given to those areas, rural or urban, where the resources are poorest and the needs are the greatest.

The President has appointed a National Advisory Committee on Rural Poverty to take a broad view and national leadership in this area of

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major concern. One of their major interests will be health services. Each of the Departments and agencies must continue to seek new approaches in their particular areas of experience and knowledge.

But, in spite of the programs and proposals I have just enumerated and in spite of our increased efforts on several fronts, we are still faced with serious rural health problems. And while it might be assuring to say that we have all the answers, that the tools we have are adequate, or that a few more dollars here or there would solve the problems, such observations would not be accurate.

Efforts to improve health services anywhere presume local will and initiative. In some areas, these are weak, or lacking, or inequitable. But even where initiative and determination are high, they are not enough. In order to employ HEW resources effectively, local initiative must be supported by at least three fundamental ingredients.

First, there must be skilled manpower for implementing programs. Yet, we simply cannot expect to increase the availability of health services in rural areas if there are no medical personnel available, just as we cannot expect children exposed to inferior education be ill-prepared teachers to acquire the tools necessary to cope with the complex circumstances of the modern world.

Secondly, we must have service delivery systems and adequate institutional arrangements in order to see that vitally needed services and programs actually operate to the benefit of the people. As informed people know, a wide gap exists between the best medicine can offer and the services actually available to many patients. In some cases, this is due to income differences, but in rural areas, even the wealthy are unable to purchase a range of conveniently located health services. Rural areas are less well equipped than their urban counterparts to administer available resources efficiently. Governmental structures in rural areas are often rudimentary; county welfare units are frequently seriously understaffed public health agencies and other important service units in many areas are virtually non-existent.

Finally, although this does not complete the list of basic necessities, there must be adequate resources to bring together and generate necessary manpower and institutional and service systems. On this score, we also find the rural areas deficient. It is more difficult and more costly to mount comprehensive and high quality programs in thinly populated areas. The unit costs for providing services are higher; the local tax base is weak; the property tax acts as a barrier to local program development; and matching money for State and Federal programs is more difficult to find.

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The Department of Health, Education, and Welfare, as I described earlier, is engaged in activities that will contribute to meeting these requirements.

To confront serious manpower shortages in health, education, and social services we shall continue to try to attract new professionals to rural areas. However, we do so in full knowledge of the difficulties entailed. Doctors and nurses are drawn and social amenities. Indeed, even urban areas are feeling the serious shortages in professional health manpower. Projections of needs in health resources show that an estimated 2.85 million new health workers will be required within the next decade to meet already great and growing national health needs. In any event, whether in rural areas of large cities, it will be difficult to continue offering health services in the ways we have been. There just are not enough doctors and nurses to go around. For these reasons we are trying to find ways to train people to work, with professional supervision, to take over a number of basic health services and functions which do not require the time and attention of a doctor. The armed services have developed a good model with their use of highly trained corpsmen. And some of the innovative techniques used in urban neighborhood health centers will give us guidance in developing new kinds of health workers.

In addition to ongoing programs for training professionals, then, the Department is supporting the development and training of new kinds of auxiliary health personnel: health aids, community mental health workers, personnel for "new careers" in child care and the like, to perform those functions that do not require the long years of training necessary for supplying people with needed services. Many of these activities are getting support under existing authority for adult education, vocational rehabilitation, and other programs. Two OEO programs in which HEW participates significantly, Foster Grand Parents and Home Health Aids, have already proved the value of such programs.

In addition, we have to work out methods to make it possible for limited numbers of professionals to serve wider populations and areas.

There is much to be done in improving health service delivery in rural areas. In cities, we have witnessed the recent development of neighborhood health centers under the auspices of OEO. Operating in poor communities, the centers bring together a range of health services -- from prenatal to emergency care -- to serve the people on a readily available basis. The same kind of ingenuity and adaptation can be applied in rural areas as well. Such approaches as mobility of health facilities, for example, need to be carefully considered. Not only can imaginative use of limited facilities help limited numbers of professionals to be more efficient; it might ultimately create new rural health systems that will prove challenging enough to draw more professionals into rural health practice as well.

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The benefits of automation and other technology have only just begun to be widely recognized in the broad delivery of medical care. Systems studies, operation research, better economic analyses, behavioral and attitude studies as well as other techniques must be applied to the study and solution of many of these problems. This will not be a simple task. Medical care in this country does not lend itself easily to the techniques that have been effectively applied in industry and in other fields.

In his Health and Education Message this year, President Johnson said:

> "America's annual spending for health and medical care is more than $43 billion. But despite this investment, our system of providing health services is not operating as efficiently and effectively as it should.
>
> "We must marshall our best minds to:....Design hospitals, nursing homes and group practice facilities which provide effective care with the most efficient use of funds and manpower.
>
> "...Develop new ways of assisting doctors to reach more people with good health services.
>
> "...Devise new patterns of health services.
>
> "...To begin this effort, I have directed the Secretary of Health, Education, and Welfare to establish a National Center for Health Services Research and Development."

The process of establishing the Center within the Public Health Service has begun. We are consulting with a number of people in and out of government in order to develop the concepts and programs that will form the substance of the Center. It is very possible that within the next ten years the program of health services research and development supported by the Center will reach the same scope, magnitude and significance as the biomedical research programs now supported by the National Institutes of Health.

But the most potent combination of established programs and new proposals still won't provide all the answers. Leadership for action on these concerns must come -- not from Washington -- but at the State and local levels and from private citizens. There must be a willingness to take advantage of these opportunities. We can then offer our resources, technical assistance and advice.

This combined search and the range of cooperation represented here today can be very important in creating the support and initiative we need to address the significant problems which face the rural areas of our nation.