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ABSTRACT

Rural people lose more days of school and work due to illness than do urban people; have higher infant mortality rates, and have more work-related injuries, all of which are aggravated by lack of access to or even the absence of medical services. Lack of doctors is the most glaring problem (in 1973 there were 138 U.S. counties which had no physician). Other rural health problems include farming injuries (the third most hazardous occupation) and inadequate or unsanitary water supply and disposal systems (according to a 1969-70 study, 30,000 rural communities need new or improved water systems). Recent legislative attempts to redress rural health problems have been less than successful (i.e., the Health Maintenance Organization Act of 1973 which earmarked only 20 percent of its funds for rural areas, even though slated for high priority). Examination of a recent survey comparing urban and rural Federal health allocations reveals an urban bias. In view of these problems, consideration should be given to: (1) paraprofessional programs, (2) mobile health delivery systems, (3) self-help programs, (4) networks of clinics created around a hospital center, and, especially (5) to a Federal commitment that will create special rural health programs and redress the current imbalance in Federal allocations. (JC)

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HEALTH SERVICES AND RURAL AMERICA

Rural people lose more days of school and work due to illness than do urban people, their infant and maternal mortality rates are higher, and they have more work-related injuries. (USDA Health Services in Rural America, July, 1973, Tables 14, 15, 16). As in urban ghettos, the prevalence of illness is directly related to poverty, which generally brings with it poor nutrition, housing, and depression, but in rural areas these conditions are aggravated by factors uniquely rural. Foremost among these are the lack of access to or even the simple absence of medical services.

The most glaring difference is the lack of doctors. In 1969 there were almost 5 times as many people per doctor in rural areas as in urban areas of five million. (Ibid., p. 8), an imbalance which is likely to increase as rural people become less able to pay medical fees and the cost of transportation. According to the American Medical Association there are already 138 counties in the U. S. which have no active federal or non-federal physicians. (Distribution of Physicians in the U. S., 1973, p. 21).

The vast majority of these counties without doctors are located in the Western United States. They cover 148,426 square miles, or 4.2% of the United States. They include almost one-half million people, ranging from Osage County, Missouri, which has 11,300 inhabitants, to Owyhee County, Idaho, whose 6,000 inhabitants must at worst travel across an area of 7,641 square miles in search of a physician.

As might be expected, rural people tend to visit physicians less often. The average person in the Standard Metropolitan Statistical Area visited a doctor 4.4 times in 1969; the average person living in rural areas but not on the farm went 4 times; and the average farm person saw a doctor 3.1 times. The discrepancy for specialists is much higher:

Visits per 100 families in 1964[1/]

	SMSA	Rural Non-Farm	Farm
Pediatricians:	92	46	15.1
Obstetricians:	75	44.4	19.2
Psychiatrists:	9.9	5.3	--

There are fewer nurses and dentists in rural areas, and fewer visits to nurses and dentists. On the other hand, there are more hospital beds (though generally not in good condition) in the countryside. The irony is that they are not fully used for lack of doctors, nurses, and equipment.

1/ Health Services in Rural America, USDA, Agr. Information Bulletin #362, July, 1973, Table 11. (An SMSA is a county or group of contiguous counties which contain at least one city of 50,000 inhabitants or more, or twin cities with a combined population of at least 50,000.)

They are also underutilized because, in those very regions of the country exhibiting the greatest frequency of transportation and job related injuries, there are fewer ambulances and emergency services.1/

FARMING THIRD MOST HAZARDOUS

The National Safety Council reported in 1969 that mining and agriculture were the second and third most hazardous occupations in terms of deaths and accidents on the job. The impact of occupational hazards extends beyond the immediate and visible disasters in fields and mines, however. As in other industries, the official statistics do not take into account the effect of dermal, oral, and respiratory ingestion of toxic substances--such as coal dust and chemicals--despite the possibility that these may be the most threatening to workers' health and longevity. Coal miners have been organized enough to force national recognition of black lung as an occupational hazard; with the institution of federally funded black lung benefits in 1969, they established a foothold on the slippery ground of government dealings with the coal industry. But, in agriculture, there is no national reporting system which would reveal the extent and effects of long-term exposure to pesticides; nor is there a workers' compensation fund to meet claims for medical and unemployment benefits.

In California, the only state which keeps farm labor occupational disease statistics, the number of reports of poisoning has ranged from 800 to 1,100 annually. (1972 Hearings, Senate Subcommittee on Migratory Labor). Scattered reports such as this provide only a hint of the size of the problem, however. According to Dr. Thomas Milby of the California Department of Public Health, the most debilitating effects of exposure to, for example, organophosphate pesticides are the ones least likely to be detected. Research which is still in its earliest stages include among these a gradual impairment of memory, hand-eye coordination, and other neuromuscular functions, loss of appetite, insomnia, and anxiety. The people (many of whom are children) exposed to these and other, even less understood, chemicals are those least protected by labor or other laws in this country. Their life expectancy, if they are migrants, is 49 years, 20 less than that for the average American.

POOR WATER AND SEWER SYSTEMS

Another particularly rural condition contributing to poor health and the danger of epidemics is the inadequacy and often absence of safe and sanitary water supplies and sewage disposals.

1/ Ibid, p.VI.

According to a 1969-70 study by the Farmers Home Administration, there are in excess of 30,000 rural communities that needed a new or improved water system. As the Commission on Rural Water (April, 1974) pointed out, the study did not take into account areas which were not suitable for central systems. Millions of rural Americans live in such isolated areas.

The Farmers Home Administration has had the primary responsibility for grant and loan assistance to rural residents in constructing water and sewer systems. In 1973, the grant portion of the program was eliminated, thus confining the programs' benefits to those communities which could afford the cost of constructing water and sewer systems with loan funds only. The budget for FY '75, however, has reinstated the grant program at a funding of $150 million; $470 million are allocated to loans.

Unsanitary water supplies were chiefly responsible for the typhoid epidemic which raged through a migrant labor camp in Florida two years ago. Both this and other recent outbreaks of communicable diseases, (such as diptheria and polio in southern Texas) are especially difficult to bring under control because of other missing ingrediants in rural areas: public health services, nutrition programs, and enforcement of immunization regulations. Only 60% of the nation's children are immunized against communicable diseases; the poor quality of rural health services in general is a strong indication that a disproportionate number of these unprotected children are to be found outside urban areas.

PRIORITIES FOR INCREASING AVAILABILITY OF HEALTH SERVICES

1. Incentives for attracting medical personnel to rural areas.

Adequate Rural Income is Not a Likely Solution

Increasing the ability of rural people to pay for services would seem to be the obvious first step in attracting practitioners to small communities. It is also the strategy most likely to be dismissed as impractical, when conceived of in terms of providing a minimum income through a negative income tax or other means. Income maintenance proposals are generally not intended to supplant the subsidization of health services for the poor, and even so are encountering tremendous opposition because of the expense involved. Should they receive congressional acceptance, it is unlikely that they will offer adequate coverage of mushrooming health delivery costs. To do so, they would have to take into account the following alarming statistics:

In 1971, health expenditures for the average American were $358--more than 2½ times the bill of 1960 and 4½ times the bill of 1950. Since that year, when the total national health bill

was $75 billion, the price of medical services has outpaced other cost-of-living increases. From 1967 to 1971 medical care prices rose at an average annual rate of 6.6%, compared with 4.8% for all consumer items. (p.5). By 1974, total annual health costs were $104 billion, an increase of 10% over f/y 1973. (Health Security, p.3).

Since the lifting of price controls in April, 1974, health cost inflation has accelerated at an annual rate of 18%. All in all, the nation's total health bill jumped well over 100% in the last eight years. (Max Fine).

Since the basic requirements--food, housing, fuel, and medicine--already consume the entire poverty level budget, the poor must view inflation as an ever-tightening vice, squeezing out all options until they are forced to choose between being cold or going hungry, or, as one older man put it, "between pills or breakfast".

Private Medical Insurance is Not a Solution

Americans rely heavily upon insurance to cover medical expenses. But private and government insurance are not available to most low-income people or to rural folk such as farmers who do not have access to group coverage through policies offered by large business firms. They comprise a substantial proportion of the 40 million Americans who have no health insurance at present, and whose situation demands some kind of federal action which will eliminate cost as a factor in receiving medical aid.

Public Response - Pending Possibilities

A possible model for consideration is S.3, or the cradle-to-grave Health Security Act, introduced to this Congress by Senator Kennedy. As it is now formulated, the bill provides that in place of health insurance premiums, workers would pay 1% of their income up to $15,000 for Health Security. They would be provided with:

All doctors and hospital bills paid in full;
Dental care for children up to age 15 and eventually for all ages;
Mental Health Care;
Specialists' services paid in full;
All preventive care paid in full;
All rehabilitative care paid in full.

An especially attrative feature of the bill is the provision for consumer participation at all levels of policy-making and administration. The program would cost a total of $76 billion if enacted. According to the Committee for National Health Insurance, however,

only about one-third of the budget would be new federal money--however, these dollars are already being spent by Americans in direct payments to doctors, hospitals, and insurance companies. The remaining federal funds are already funneled through government health programs such as Medicare and Medicaid.

HMO's - What Kind? - What Role?

Health Security, as now envisioned, would rely heavily on the development of Health Maintenance Organizations and other forms of prepaid group practice plans. HMOs, when they are truly non-profit group-practice alternatives to traditional fee-for-service delivery systems, have a special appeal for rural areas because they may attract doctors and other medical personnel who would be discouraged by the prospect of maintaining a practice alone in isolated and underserved areas. Under the Health Maintenance Organization Act of 1973, which authorized millions of dollars to encourage the development of these pre-paid plans, priority for grants was given to three types of applicants: (1) nonprofit organizations; (2) those proposing HMO development for predominantly rural areas, and (3) those proposed HMOs which will serve both urban and rural "medically underserved areas".

Recent Experience with HMO's

Unfortunately, the HMOs' performance to date has been checkered, and has scarcely realized its potential for rural areas. While most HMOs are "non-profit" on paper, this year's disclosures in California, where many plans drained most of their state and federal funds into subsidiary profit-making organizations (mostly in the Los Angeles area), 1/ indicate that without strict monitoring or built in limitations in use of funds, the term is virtually meaningless. Only 20% of the HMO funding is earmarked for rural areas, and that "provided the interest exists and applications are forthcoming". The applications have not been flooding in, largely because technical expertise is required to undertake the initial planning of HMOs, and because the Act does not address specifically rural problems, such as the lack of outreach and supportive services.

Joanne Stern, Staff Attorney of the National Health Law Program, has elaborated on these deficiencies:

> "It should be pointed out that several of these problems were dealt with in the original Senate version of the HMO Act (the Kennedy Bill, S.14) by providing funds for construction of ambulatory care facilities and transportation and equipment and by authorizing premium subsidies and capitation grants to

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1/ 3/14/75 Washington Post.

assist in the operation of such HMOs. The compromise bill, however, eliminated all these assistance provisions without eliminating the priority for underserved areas. The result, in the case of rurally underserved HMOs is to make such priority almost meaningless.

Furthermore, the provision calling for a 20% set-aside of funds each year to assist in development of non-metropolitan HMOs will not necessarily assist HMOs in rural or rurally underserved areas. On the contrary, the set-aside for non-metropolitan areas is likely to result in the funding of HMOs serving an area which conforms to the statutory definition for non-metropolitan areas, but which actually contains a non-poor population group which can well afford to support and subsidize it. Moreover, if an insufficient number of "qualified" applications are not received in any given year, the 20% set-aside is lifted and the monies become available to everyone the next year through the general fund." (p. 606, Clearinghouse Review, 1/75)

Discrimination Against Rural People

Rural Communities have been compelled to look to Community Action Agencies and to the Appalachian Regional Commission for assistance in overcoming the gaps left by the HMO administration. Unfortunately, although over 40% of the nation's poor live in non-metropolitan America, it has received less than a fourth of the federal outlays for Community Action Programs. The ARC in 1974 allocated 15% of its appropriations (or $43,000) to health.

It is important to point out that the meager sums parceled out to health services in rural areas are not atypical of the urban-rural comparisons in federal outlays, and are one reason why doctors and nurses are not eager to settle in the countryside. The most recent survey of allocations is illuminating:

Federal Outlays for Health Programs Accruing to Metro and Nonmetro Counties, Fiscal Year, 1973 1/

Item	Agency	Total	Metropolitan						Nonmetropolitan						
			Total	Greater			Medium	Lesser	Total	Urbanized		Less urbanized		Thinly populated	
				Total	Core	Fringe				Adjacent	Nonadjacent	Adjacent	Nonadjacent	Adjacent	Nonadjacent
		Mil. dols.	Percent distribution												
Health															
Comprehensive Health Planning-Areawide Grants	HEW	19.9	84.7	38.6	35.1	3.5	35.4	10.7	15.3	4.2	6.2	1.6	3.0	.2	.1
CHP Public Health Services Formula Grants	HEW	74.6	80.6	26.4	24.4	2.0	43.9	10.3	19.4	14.1	2.5	.0	2.7	.0	.0
Crippled Children Services 1/	HEW	108.5	63.4	33.2	26.5	6.7	18.1	12.1	36.6	8.9	4.3	7.2	10.0	1.6	4.6
Family Planning Projects	HEW	99.3	84.6	47.5	40.7	6.8	30.0	7.2	15.4	8.2	2.4	.3	4.3	.1	.1
Health Services Development Project Grants	HEW	107.8	93.2	60.0	55.4	4.6	27.1	5.1	6.8	.1	.2	3.5	2.3	.0	.7
Indian Health Services	HEW	1.5	94.9	48.5	48.5	.0	44.7	1.7	5.1	.0	.0	.0	.0	.0	5.1
Indian Sanitation Facilities	HEW	.1	1.7	.0	.0	.0	1.7	.0	98.3	.0	80.7	.0	.0	.0	17.6
Maternal and Child Health Services 1/	HEW	9.9	74.2	45.9	40.2	5.7	22.5	5.9	25.8	9.2	2.6	4.8	5.4	.9	2.9
Maternity and Infant Care Projects	HEW	82.9	91.8	68.4	66.4	2.0	21.1	2.3	8.2	5.3	1.6	.2	1.2	.0	.0
Migrant Health Grants	HEW	23.1	62.6	14.7	13.4	1.2	24.9	23.0	37.4	22.8	5.3	3.5	4.5	1.3	.0
Mental Health-Community Assistance Narcotic Addiction and Drug	HEW	53.7	96.8	67.3	60.6	6.7	25.8	3.6	3.2	1.5	.7	1.1	.0	.0	.0
Mental Health-Community Mental Health Centers	HEW	172.4	80.1	51.6	23.4	28.2	19.2	9.3	19.9	5.2	6.1	3.1	5.3	.2	.1
Comprehensive Health Services	OEO	77.1	81.3	54.5	51.6	2.9	17.5	9.2	18.7	4.3	5.4	1.3	2.7	.0	5.0
Family Planning	OEO	14.9	77.4	41.0	37.4	3.6	15.8	20.7	22.6	6.7	3.3	5.8	4.7	.6	1.5
Drug Rehabilitation	OEO	19.7	96.9	75.4	70.8	4.6	21.1	.4	3.1	1.0	2.1	.0	2/	.0	.0
Health Services Delivery	HEW	174.8	93.2	80.2	66.2	14.0	8.7	4.4	6.8	.7	.5	3.7	1.2	.2	.6

1/ Rural Development, Fifth Annual Report of the President to the Congress on Government Services to Rural America, Appendix Table 1, page 56.

Recent Attempts at Staffing Rural Areas

Federal financial incentives for physicians to locate in rural areas have taken other more forceful but just as unsuccessful forms. The National Health Manpower and Training Act of 1971 established a National Health Service Corps, whose participants were chiefly drawn from medical school graduates who paid off their student loans with a two-year tour of duty in "underserved" areas. Experience in these areas has not engendered the commitment hoped for; of the 140 physical "volunteers" whose tour of duty ended in summer, 1974, less than 40 say they will stay in their communities. Under the assumption that the more recruits there are, the greater the number will be of those who decide to remain in an underserved area, S.989, the Health Professions Educational Assistance Act was introduced. Student loan forgiveness through work in medically deprived regions and communities would be made mandatory in this bill, which was reintroduced in March, 1975.

Perhaps because of their obligatory odor, recruitment programs have not to date been effective. When they draw upon urban recruits, they run the danger of appearing patronizing to rural residents, and punishing to dislocated urbanities. For psychiatrists in particular, such dislocation may benefit neither themselves nor their patients, for whom cultural identification is the basis of trust and problem-solving.

Health professionals, like most people, are most likely to settle in areas similar to those in which they were raised; it makes sense, therefore, for medical schools to undertake special efforts to recruit students from rural areas, even if that means lowering academic eligibility standards; it makes even more sense to decentralize undergraduate and medical education through greater use of community colleges and rural hospitals for training programs and internships.

2. Alternatives to existing health delivery services.

If we accept that in the immediately foreseeable future the prognosis for attracting doctors to rural areas is not good, then we must conclude that the current preoccupation with luring the professional medical elite into mountain hollers, clay country and western grasslands is misdirected. Small rural clinics, staffed by nurses and paraprofessionals, can provide most medical services, including some from which they are excluded by law, such as prescriptions for drugs and serving patients who qualify for Medicaid. These clinics, along with community college outreach programs, should be allocated federal funds for (1) training paraprofessionals such as midwives and (2) teaching self-help methods, e.g., examinations for breast and other cancers, pregnancy, symptoms of heart disease and malnutrition.

There are two primary strategies for filling in the gap presented by small clinics which can neither attract nor afford full-time specialists' services: one is to create networks of clinics around an adequately staffed hospital center; another is to promote mobile health delivery services, whose personnel would be comprised, perhaps on a rotating basis, of medical specialists. These are not mutually exclusive strategies; both have been effectively combined, through the use of federal Emergency Food and Medical Services funds, in a heart disease outreach program now serving 8,000 children in South Texas. (South Texas Children's Heart Clinic).

THE NEED FOR A FEDERAL COMMITMENT

Unfortunately, none of the existing or suggested programs outlined will make a dent in the pervasive health problems of rural areas until there is a national commitment to (1) create programs applicable to the unique needs of these areas and to (2) redress the current imbalance in federal allocations. As indicated above, Medicare provides an outstanding example of "metropollyana" in Federal requirements, which in this case demand that there be a doctor on the premises as a prerequisite to Medicare reimbursement. This stipulation reinforces the many disparities in Medicare benefits: In 1970, the U. S. average reimbursement was $7.81; in California it was $12.38; in West Virginia, however, it amounted to $4.49. 1/ Federal programs must also address themselves to the outreach and transportation problems peculiar to rural areas.

NHPS ACT HEIGHTENS DISCRIMINATION

The new National Health Planning and Services Act of 1974 threatens to intensify the urban bias in health service delivery, since it has a 500,000 minimum population requirement for formation of health service areas. There is no reason for rural people, who still comprise a formidable political constituency, to accept this kind of dismissal from their legislators and the Administration. They must make certain that their needs are clearly stated by their representatives, and that every piece of legislation passed provide not only for equal distribution of funds, but for the mechanisms which will ensure that those funds reach their intended destination.

1/ Rural Health Care Delivery, Testimony of M. H. Ross, July 8-10, 1974

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