Health Care Needs of the Disadvantaged in a Rural-Urban Area

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HEALTH CARE is a community affair. The report of the National Commission on Community Health Services states that "health services, operated to meet the needs of every individual, should be located within the environment of the individual's home community" (*1a*). The report further points out that "the performance of community health services should not be considered the province solely of the physician and the public health officer. It must be recognized that the health 'team' is not a closed fraternity. . . . The vested interests of voluntary, private, and public agencies and of the professions must be subjected to the overriding interest—that of the health of the people" (*1b*).

In the summer of 1970 I was asked to chair a special Task Force on Priority Populations for ALPHA (Area-wide and Local Planning for Health Action, Inc.), a community health group for a six-county region headquartered in Syracuse, N.Y. The task force operated under the premise expressed by the national commission that health care is not the province of any special group.

Our task was to identify the health care needs of poor people, older people, and members of disadvantaged minority groups in this upstate New York area. The area consists of urban and rural sectors and, in many respects, is a prototype of middle-sized metropolitan communities throughout the nation. Syracuse is its hub. It has a population of approximately 200,000 and is often used as a setting for commercial market research because of the representativeness of its population.

The Survey

The task force contacted by mail nearly 200 health professionals, agency executives, and community association leaders. Contacting the care givers, of course, is a second best approach. We should have surveyed a representative sample of the people who suffer adversities and inadequate health care and cataloged their problems. But the task force's resources were insufficient to conduct that kind of an investigation, and we therefore used the second best approach of surveying the care givers, the providers of community services.

Leaders in the community were asked to give their professional assessments, informed judgments, or best guesses about the major health care needs and problems of poor people, old people, and minority groups. The minorities in the six-county area are mostly Negroes, Puerto Ricans, American Indians, and Mexican-Americans.

Within a month approximately half of those contacted responded. Seventy percent of the 74 contacts in Onondaga County—the

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urban political jurisdiction—responded, and 47 percent of the 115 contacts in Cayuga, Cortland, Madison, Oswego, and Tompkins—the counties with sizable rural sectors—answered our letter. Replies of 13 respondents —11 in Onondaga and two in the five-county area—were not included in this analysis because their organizations had regional responsibilities beyond the study area. The data in this report were derived from the opinions of 41 health and community association leaders in Onondaga County and 42 leaders in the other five counties.

My report focuses on the health care needs of the poor, the elderly, and the members of disadvantaged minority groups because these are the people so inadequately served. As late as 1967, William Gorham, Assistant Secretary for Planning and Evaluation of the Department of Health, Education, and Welfare, wrote, "the Nation's $46 billion health industry has done very little examination of its health delivery system—a fact that makes future planning somewhat hazardous" (*2a*). Because evaluations of health service organizations are inadequate, health professionals seldom realize how little health care is available to the poor.

The Department of Health, Education, and Welfare's report, "Delivery of Health Services for the Poor," asserts that "maldistribution of health care personnel and facilities and their inefficient organization in relation to health needs is in large part responsible for the problem. In addition, the behavior of the providers of health services toward low-income patients may have a negative influence on patients seeking and continuing care" (*2b*). The goal of our investigation was to determine the extent to which these and other circumstances are associated with the health care needs of populations outside the mainstream of community concern in a typical middle-sized metropolitan area in the United States.

The Urban County's Needs

For urban Onondaga County, ALPHA found that the most outstanding health care and service needs of the priority populations were ambulatory care, mental health services, and community services for the elderly (table 1). These needs were ranked by our informants in the order listed, according to the frequency that a need was mentioned.

Poor people especially needed ambulatory care. Often it was linked with statements about the insufficient numbers of health personnel. The absence of caregivers who will accept and work with poor people forces many to rely on the hospital emergency room as their major source of medical care.

Complaints about the hospital emergency room, of course, are legion. The long periods of waiting and the impersonal treatment of patients are common irritants. Even though the quality of medical care rendered may be good, practitioners in the emergency room tend not to share with patients adequate information, including information about the diagnosis, treatment, and prognosis of their conditions. Moreover, each complaint tends to be dealt with as an episode of illness unrelated to previous episodes. The hospital emergency room does not provide continuity in medical care.

The shortage of medical personnel is, in part, a function of the failure of medical educational institutions to increase the number of trained professionals. But more is involved. Our respondents stated that some medical practitioners refuse to accept patients whose fees would be paid through Medicaid. Thus, more medical care personnel would not automatically result in adequate ambulatory care, if they, too, boycott Medicaid patients.

In addition to increasing the supply of professional personnel, other changes are required to insure adequate ambulatory medical services for the poor. A structure to deliver medical services not dependent on fee-for-service and solo private practice would appear to be needed if the poor are to be served adequately. Our respondents also stated that the

Table 1. Major problems identified by 41 care givers in Onondaga County, N.Y., summer 1970

Problem category	Number who ranked it major
Ambulatory care and inadequate personnel	18
Mental health services	13
Community services for older people	11
Drugs and alcoholism	8
Nutrition	6
Housing and environmental conditions	5
Dental health	4
Other health concerns	30

NOTE: Some respondents listed 3 or 4 major health problems, some only 1. Each problem could have been listed 41 times.

hospital emergency room is not an acceptable alternative for comprehensive health care and continuity in medical care, although the entire facilities of the hospital could become a community health center.

Some immediately available setting is necessary where poor people may have access to a wide range of medical personnel and where medical services are personalized and not characterized by the long waits which are standard in emergency rooms.

The community health center is the only model for ambulatory medical care for the poor that has emerged thus far which appears to be adequate for delivering comprehensive health care to low income populations. Since no other workable arrangement has yet surfaced, we must increase the number of health care centers available to the poor and those left out of the mainstream of community life. Such centers should be comprehensive in their services, providing, for example, psychiatric and dental as well as other medical services.

The concept of community health centers strategically located throughout a metropolitan area probably should replace the current concept of neighborhood facilities. Health care services for the future should not be tied to the pattern of racially and economically segregated housing which has characterized the social ecology of city neighborhoods in the past. The extensive patient load of the hospital emergency room indicates that the availability of a service, rather than its location, is an important variable in its use. Thus, several community comprehensive health centers strategically located within a metropolis are necessary, so that the concept of the catchment area can be abandoned. The catchment area is a rigid administrative device that would appear to encourage segregation and separatism in service patterns and in the social ecology of city life.

Outpatient mental health services, and especially mental health services for children, were identified as the second most important need for poor people and for racial and ethnic populations in Onondaga County. Three major service needs were indicated: (*a*) therapeutic outpatient care primarily for adolescents and emotionally disturbed children, (*b*) consultation for community institutions such as schools, courts, and families, and (*c*) day care facilities for children and older people. A few words about items *b* and *c* follow.

Families are listed with other institutions which could benefit from mental health consultation on how to deal with situations having psychological dimensions. Consultation rather than therapy may suffice to help some families deal with difficult situations. The absence of extended households in which relatives with more experience are available for advice and help means that many families must face alone the daily difficulties of living. Most families are capable of dealing with a variety of circumstances adequately. From time to time, however, families, like the personnel of schools, courts, industries, and other institutions, may need advice, counsel, and support. Such help might be considered as mental health services which prevent institutional breakdown and may contribute to a more wholesome resolution of conflicts within these institutional systems.

Indeed, the regenerative processes of existing systems should be activated to deal with difficulties in interpersonal relations rather than to require that individual persons become direct participants in the mental health care-giving system in order to receive help. The shortage of mental health personnel and facilities means that ways other than requiring everyone to become a patient must be found for helping people to deal with psychological and social psychological problems in the setting where they normally interact. Mental health consultation in the local community is an underdeveloped service which deserves more attention in the future.

The overwhelming need for therapeutic services for individual patients leaves little time for thinking about and planning consultation services for institutions. What we have experienced is an outcome of the shortsightedness of mental health professionals in allocating their time. Despite the pressing need for patient therapy, time must be reserved to develop and implement programs of consultation which, in the long run, could help lighten the load of direct patient care by enabling community institutions to provide the advice, counsel, and support that individual persons need and that institutions are capable of giving.

Our respondents' call for day care facilities for children and older people was a call for facilities that serve therapeutic and preventive functions. Day care centers provide new socializing experiences for young children, on the one hand, and opportunities on the other hand, especially for mothers, to participate more fully in their communities. Day care centers should be looked on as liberating for women and children; they can open up new ex-

periences for both. Freedom is an important contributor to the development of a healthy personality. Day care centers can contribute to freedom and probably should be classified as a preventive mental health service.

Day care facilities for older people were mentioned by respondents as a way of providing medical care without resorting to confinement in an institution. Some older people who experience mild forms of mental illness could receive care in day care centers and return to their homes at night. This arrangement would enable older people to continue contacts with family, friends, and the community and yet not be dangerous to themselves if they are ill or be burdensome to others who may not know how to obtain or provide home care. Moreover, the day care center for older people is a possible insurance against loneliness which some older people experience when their kinsmen and friends are away at work.

Several of our informants pointed out that the needs identified for mental health services are not necessarily limited to the poor. Probably therapy for poor children is more pressing than the needs of the affluent, but mental health consultation and day care for children and older people are pressing needs for all.

The third major health care need identified for Onondaga County was community services for older people. In general, our informants referred to medical problems other than psychiatric ones for which older people needed long-term care. They called for institutions to provide various levels of medical service to patients who are bedridden, for domiciliary care, and for short-term institutional care for older people. In addition to the institutional care that would be flexible enough to accommodate older patients at different levels of disability, the need for a good home care program was frequently mentioned. Home care was emphasized as a way of reducing costs as well as a way of keeping older people in familiar surroundings. A major reason why a full-fledged program of home care has not developed, some informants believed, is that the public has not fully grasped the concept.

Among other problems mentioned with which the poor, the elderly, and minorities need help are drugs, alcoholism, poor nutrition, dilapidated housing, unsanitary environmental conditions, and inadequate dental care. Health education was mentioned by three respondents as an important need. Teaching poor and disadvantaged people how to recognize problems was what respondents usually meant by health education; however, a new concept also emerged of teaching the poor and disadvantaged how to demand and get from the community what they rightfully ought to receive.

Table 2. Major problems identified by 42 care givers in Cayuga, Cortland, Madison, Oswego, and Tompkins Counties, N.Y., summer 1970

Problem category	Number who ranked it major
Ambulatory care and inadequate personnel	31
Community services for older people	20
Mental health services	13
Transportation	7
Housing and environmental conditions	7
Drugs and alcoholism	6
Dental health	5
Other health concerns	23

NOTE: Some respondents listed 3 or 4 major health problems, some only 1. Each problem could have been listed 42 times.

Rural Counties' Needs

The outstanding problems and major needs in Cayuga, Cortland, Madison, Oswego, and Tompkins Counties were similar to those identified for Onondaga County. They were ambulatory care, community services for older people, and mental health services. The three top needs were identical in counties supposedly rural and in an urban county; however, care for the elderly was listed as the second most important need for Cayuga, Cortland, Madison, Oswego, and Tompkins, but third for Onondaga County (table 2).

The similarity of the problems identified in all six counties of this upstate New York region raises a question as to whether the rural-urban difference, which is thought to exist, is as significant as some persons believe it is. Some social scientists, such as the late Louis Wirth, professor of sociology at the University of Chicago, have asserted that urbanism is a way of life which affects all sections, including cities, suburbs, and farming areas. It is possible, therefore, to have a unified planning approach, since the similarities between the counties tend to be greater than their differences. The differences that do exist,

however, should be recognized and accorded special attention.

A recurring theme in all five counties was the need for more ambulatory care. Particularly mentioned was the absence of local medical professionals. These counties are hard pressed to attract and hold good medical personnel. Also, some of the limited number of physicians who practice in the five counties are not available to poor people because they will not accept patients whose fees would be paid through Medicaid. Such a boycott further reduces ambulatory care resources in the local community.

The hospital emergency room is the major source of care for many disadvantaged people in the five counties. Some travel nearly 40 miles to the Upstate Medical Center in Syracuse. A call for community clinic services was voiced by several respondents. Permanent comprehensive community health centers have been identified as an important need. They should be supplemented with mobile units to reach the people in the outlying areas, especially the migrant workers who help harvest the crops and the large families on farms.

A special advantage of community health centers is that they may enable counties like these in upstate New York to attract and hold physicians and dentists. They need the stimulation of daily interaction with other professionals. Some medical personnel are concerned that their skills might atrophy and their knowledge become stale in a solo practice with only limited contact with other professionals. The community health center, then, can be a place where patients obtain a range of services and where practitioners may maintain their professional contacts and experience the stimulation which these tend to provide.

A review of the responses of health professionals and others who have close contacts with the people in the five counties indicates why community services for older people is the second most frequently mentioned need. These counties need more of everything if older persons are to be cared for decently and humanely. There were calls for more nursing home care, custodial care, and domiciliary care. Several informants mentioned the need for home care, as well as programs for the delivery of hot meals to older people and help in securing eyeglasses, dentures, and hearing aids.

Loneliness was mentioned as a problem for the elderly. Some thought that trained visitors or even live-in companions might deal with this problem. Special housing for the elderly also was proposed. It was suggested that medical facilities be built in as part of the housing complex. The need is so great for services for older people in counties like Cayuga, Cortland, Madison, Oswego, and Tompkins that it is almost overwhelming.

The absence of focus in enumerating services needed indicates how extensive is the problem of care for the elderly. Obviously, all of the problems cannot be tackled simultaneously with the same intensity. Further study is required to sort out the priorities.

In this age of self-determination, such a study for the benefit of older people should be done by older people. We know the range of problems, but we also need to know in what order to address these problems. Priorities ought to be set by the people who are suffering the adversities. Thus, a group of older people ought to be called together as consultants and given the task of determining priorities in community health services for their age group.

Mental health services in the five-county area was stated as a general need, rather than emphasizing children and older people as special populations in need of more mental health services as they were in Onondaga County. Inpatient as well as outpatient services were called for. In this respect, the five-county area differs from Onondaga County respondents who emphasized outpatient services. Inpatient care for people in these counties usually requires that they leave the local community. Some informants believed that nearby general hospitals ought to reserve a few beds for short-term psychiatric care.

Not much attention was given to the kinds of outpatient services needed, although services for the mentally retarded and sheltered workshops were mentioned. A refrain on the unavailability, inaccessibility, and absence of mental health services cropped up in most of the remarks.

One might conclude that there is a need for the general practice of psychiatry and psychology in counties like Cayuga, Cortland, Madison, Oswego, and Tompkins. Any comprehensive community health centers established in these counties should include outpatient mental health services. If the local hospital is the only health center available, special effort should be undertaken to establish mental health care as part of its services.

Other problems mentioned, but less frequently, were dilapidated housing, unsanitary envir-

onmental conditions, drugs, alcoholism, and inadequate dental care. These mentions indicate that the people in urban and rural communities have similar difficulties.

Another problem, not overwhelming but mentioned often enough to be included in this report, is transportation. Lack of or inadequate transportation is unique to counties like these five. The people simply cannot get to the services they need because public transportation is inadequate. Geographic isolation is an impediment to receiving good health care regularly, especially for older people and families with preschool children. The mobile health centers referred to earlier might be one way of dealing with this problem. At least they should be tried.

Conclusions

In summary, the task force found similar concerns among all six counties in this central New York region about major health care problems for poor people, old people, and minorities. Inadequate ambulatory services was the most outstanding problem in all counties. In the predominantly urban county, insufficient mental health services and inadequate care for older people were given second and third priority. The counties with large rural sections had similar problems; but the rank order was reversed—inadequate services for older people was second and insufficient mental health services, third.

Reports from urban Onondaga County tended to be specific in terms of the ambulatory and mental health services needed. Although reports from the five counties with large rural sections tended to be general, this generality did not mean that the specific problems do not exist. These three problems are probably so pervasive in the rural counties that observers could not break them down into component parts.

New health care structures seem to be necessary to increase ambulatory services for the poor, the elderly, and for members of disadvantaged minority populations and to improve methods of delivery. Community health centers strategically located throughout the metropolitan area would appear to be the most feasible way of achieving and maintaining comprehensive services and continuity in health care. Such centers should provide medical, dental, and psychological services.

While psychiatric and psychological services should be part of any comprehensive community health center, our respondents indicated that more than direct services for patients are needed. Consultation and other preventive services are required.

The problems and needs identified in this study should be reconsidered when indicated by new information. Eventually, information should be fed into the planning system directly from the people who are experiencing inadequate and insufficient services. Until arrangements are made to tap such information directly, the ideas of informed observers should be acted upon immediately, especially the idea of comprehensive community health centers.

While the idea of the centers emerged from an analysis of the study data, it corroborates conclusions reached in other investigations. The National Commission on Community Health Services has stated, "organizational arrangements, ranging from informal associations to formally organized groups, merit exploration as a means toward integrating personal health services in a community." The report further states that "group practice of medicine, as a specific way of integrating the services of physicians, has demonstrated that it can provide an effective and efficient method of furnishing comprehensive medical care of a good quality. Such organization of services should be stimulated and encouraged as one of the best routes toward comprehensive personal health services" (*1c*).

It should be noted that the national commission, a private corporation, has called group practice of medicine "one of the best routes toward comprehensive personal health services." A similar conclusion is reached by an agency of the Federal Government. Comprehensive health centers have been proposed as a way of insuring easy access to family-centered health care resources for low income populations. Such centers, which emphasize early preventive services and continuity of patient care, should help eliminate mortality and morbidity differentials between the poor and other income groups, according to the Department of Health, Education, and Welfare (*2c*).

REFERENCES

(*1*) National Commission on Community Health Services: Health is a community affair. Harvard University Press, Cambridge, Mass., 1967; (*a*) p. 1; (*b*) p. 14; (*c*) pp. 23, 24.

(*2*) U.S. Department of Health, Education, and Welfare: Delivery of health services for the poor. U.S. Government Printing Office, Washington, D.C., 1967; (*a*) p. i; (*b*) p. 1; (*c*) p. 5.