The Federal Initiative in Rural Health

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THE ISSUES SURROUNDING rural health problems and rural health care have become increasingly prominent concerns throughout much of the country and, predictably, a subject of discussion in the Congress and within the Department of Health, Education, and Welfare (DHEW). A great deal of information is now being presented about the nature and magnitude of America's rural health problems and, as would be expected, a growing number of differing solutions are being proposed and new legislative mandates are being considered.

These problems need not only to be assessed and approached in the context of the rural character as it has evolved in the past decades and the varied experiences of the significant Federal, State, and local efforts in rural health and development, but also considering the present and future importance and promise of rural America.

Changes in Rural America

With the turn of this century, the United States began a large-scale shift from an agricultural economy to becoming the leading industrial nation in the world. Concomitant with this major change in our economic and technological bases and direction was a major, associated change in the country's rural character.

The population of the United States increased from approximately 76 million in 1900 to 131 million before World War II and now exceeds 210 million. With this substantial increase in population, there has been a major concurrent shift of people from rural to urban and suburban areas and a decrease in the population living in rural areas—from 43.5 percent of the total in 1940 to 30.1 percent in 1960 and to 26.5 percent in 1970 (*1*). Between 1960 and 1973, both the number of farms and the size of the farm population decreased by almost 50 percent (*1*). Today more than two-thirds of the nation's population live on only 10 percent of the land.

Despite these major economic and population changes, the 54 million people of rural America remain a vast and important resource to the country. The population loss of earlier years is now beginning to stabilize, and indications are that the flow of people to the cities has reversed (*1*). Industry and business are also shifting from the cities, and many small rural communities are growing as they attract industry and tourism (*2*).

Health care problems in rural areas are more and

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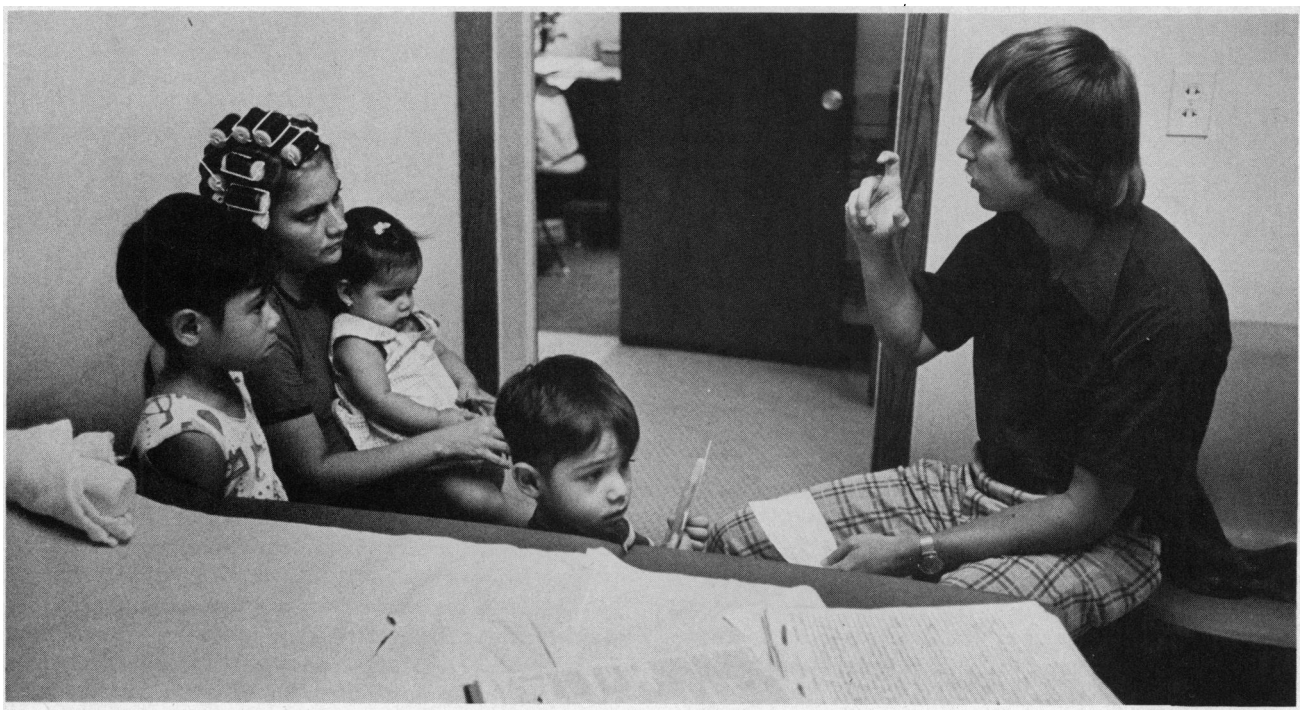
Delivering health services is particularly difficult where population is sparse and towns are far apart



In areas critically short of physicians, such as Harlingen, Tex., a National Health Service Corps physician cares for several family members

more being recognized as greater or more severe than those in metropolitan areas. Before beginning any discussion of rural health, it is important to remember that "rural" and "nonmetropolitan" are difficult to define, given the large population shifts and varying growth rates across the country. It is important to point out that even if one uses the standard Department of Agriculture definitions of farm, rural, and nonmetropolitan areas, there are serious limitations and exceptions to generalized assumptions or conclusions. Rural America is far from homogenous, and there are vast differences in the economic, occupational, cultural remoteness, population density, and demographic characteristics of the rural areas. Lumping rural Connecticut, Alabama, Kansas, and Alaska together to make assumptions creates as serious an analytic problem as considering inner city and suburbia as an aggregate for the purpose of assessment.

Critical Urban-Rural Differences

Among the differences between rural and urban areas that have become more apparent recently are that, in general, in rural areas the physician and dentist shortages are far more critical, emergency medical services are less available, occupational injury and accident rates are higher, comprehensive health and public health services are less available or accessible, and many indicators of health status indicate a serious and growing disparity in the health of rural Americans in contrast to the general population.

In part, these problems are due to the previously shrinking rural economic and employment base and, as in urban areas, they are significantly related to poverty and the demographic characteristics of populations. Rural family incomes are generally lower than urban family incomes, and of significant importance is that a considerably greater proportion of families live below the poverty level. In metropolitan areas, about 10 percent of the population exist on incomes under the poverty level while about 17 percent, or one out of every six people in rural areas, have incomes beneath the poverty level (*3*). Related factors such as educational level, adequacy of housing, and available transportation also reflect this difference.

An important demographic characteristic with implications for health care service needs and demands is the significantly greater percentage of rural Americans over the age of 65, 11.5 percent in contrast to 9.3 percent in urban America (*4*).

In many rural areas, low population density creates special problems since the critical mass of people in an area is often far less than that usually required to support, economically or functionally, service resources or facilities. This isolation also creates special problems in retaining technical and professional people on any kind of permanent basis (*5*).

Current Federal Effort in Rural Health

The Federal initiative and effort in rural health, as in all areas of health, has expanded considerably during the past 20 years. In the largest part, this expansion is reflected in the major efforts by the Congress through the Department of Health, Education, and Welfare to address problems of health care financing, organization, manpower education, research and development, services, and quality of care for the broader population.

Many of the broad health activities now undertaken by the Public Health Service have a widespread impact on rural and urban people alike. Among these approaches impacting upon rural health are the consumer protection activities of the Food and Drug Administration, the health research and training activities of the National Institutes of Health and the National Institute of Mental Health, the communicable disease surveillance and prevention programs of the Center for Disease Control, and the research, demonstration, and planning programs of the Health Resources Administration.

The recently enacted National Health Planning and Resources Development Act (Public Law 93-641) should have a broad and potentially positive impact upon rural America as it is implemented during the next few years. The act authorizes the creation of a variety of mechanisms to move toward more equal access to quality health care at a reasonable cost. The establishment of a network of health planning and resource development agencies at the regional and State levels is viewed as a major step toward rationalizing the management of the current health service delivery system prior to the initiation of national health financing. The newly established health systems agencies, State health planning and development agencies, and the proposed National Council on Health Planning and Development provide a framework for developing a national health policy which can deal with the current fragmented system.

A major goal of the agencies established under Public Law 93-641 is increasing access to health care. By means of the health systems plan, the annual implementation plan, the regulatory capability, and the area resources development funds, the agencies will be able to guide improvements in the health care system at the local level and, in particular, in rural areas. To this end, of the allotments to the States for medical facilities projects, not less than 25 percent may be used for projects for outpatient facilities which will serve medically underserved populations; half the allotments must be expended in medically underserved rural areas.

A large number of the categorical programs administered by the Public Health Service have a significant direct impact on health in rural areas (*6*). Of the 127 314(e) community health centers providing care to more than 1.4 million people, approximately 21 percent are rural projects, and many others serve rural populations as part of their service areas. The Family Health Center Program offers a range of services to enrolled populations on a capitation basis. Seventeen of the 30 family health centers are in rural areas.

The Migrant Health Program, which provides health care for migrant and local seasonal farmworkers, is essentially a rural program effort. The program is responsible for the health care of approximately 3 million farmworkers and their dependents in 900 agricultural counties throughout the United States and Puerto Rico. One hundred and three service projects are presently providing health care in rural communities in 35 States. Now being emphasized in this program are building the capacity to provide access to care in rural areas where medical services are scarce and developing community-based systems to deliver health care—systems that are capable of serving migrants as well as other medically underserved people in the target service areas.

Two hundred and fifty-six community mental health centers, 43 percent of all those funded, serve one or more predominantly rural counties, a total of 947 counties outside of standard metropolitan statistical areas. Almost one-half of all rural counties and eight States now have coverage for more than 75 percent of their rural population. Although these rural centers have small catchment area populations, they must bring services to people scattered over areas as large as 10,000 square miles.

The Indian Health Service (IHS) provides medical and community health services to 500,000 Indians and Alaskan Natives operating through 51 hospitals, 83 health centers, and 300 health stations and satellites. Because of the unique Federal responsibility for the Native American population, the IHS is generally not considered a rural health program, although the service population is overwhelmingly rural and represents a significant Federal contribution to health needs that would otherwise need to be met through other means.

The Maternal and Child Health Service's programs and projects provide support to States to promote health programs for mothers and children, for diagnosis and treatment of crippled children, and for special activities in maternal and child health research and development. Increasing emphasis is being given to rural and economically distressed areas.

The Office of Human Development administers the Older Americans Comprehensive Services Amendments of 1973 and is working to develop and strengthen, at State and area levels, a system of coordinated and comprehensive services to older persons, many of whom live in rural areas.

The Emergency Medical Services Systems Act is especially important to many rural communities have been unable to develop adequate capabilities for emergency care. The majority of grants awarded in this program have been for feasibility and planning in rural areas; they are reviewed to insure that adjacent rural communities are not excluded from a proposed emergency medical service system.

Especially critical for rural America has been the nation's maldistribution of health professionals, particularly physicians and dentists. The worsening geographic maldistribution is difficult to resolve in a rapid yet effective manner.

During the last decade, Federal policy and support have been directed at assuring an adequate aggregate supply of health professionals, and this policy and support has resulted in substantial increases in enrollments in schools for health professionals. During the past few years, direct economic incentives (through scholarships for service and loan

repayment) have been increased to influence students to practice in undeserved areas. However, during this same period the relative number of health professionals, especially physicians and dentists, has been decreasing in rural America as it increased substantially in metropolitan areas *(3)*. Further, the increasing median age of rural practitioners, their increasing sense of isolation, and the growing demands of modern medical care presage more serious problems in the decade ahead *(7,8)*.

A long-run effective solution will depend not upon purely economic incentives nor upon mandatory service by professionals for a 2- to 4-year period but upon the development of a health care delivery system in rural America that links providers to secondary care referral and hospital systems, that decreases professional isolation, and that utilizes extender personnel more effectively in isolated areas. The development of these rural health care systems will need also to be coupled with the development of schools for health professionals in nonmetropolitan communities and of mechanisms and incentives to move the residency training of more physicians out of major metropolitan areas. Efforts such as the Area Health Education Centers Program are being strengthened and modified to improve the quality and accessibility of care in rural areas with critical manpower shortages. Reorienting medical education and training toward primary care and increasing significantly the number of family practice and other primary care residencies are the purposes of other programs of the Health Resources Administration; their outcomes will have a major effect on the availability of primary care physicians in rural America.

The development of ambulatory care systems has been an increasing priority of the Public Health Service during the past several years. The National Health Service Corps (NHSC) has been strengthened and expanded to meet its primary mission of developing health care practices in areas with critical shortages of primary care providers. The NHSC has significantly improved its recruitment capability with the recently enacted provisions for variable incentive pay and loan repayment, and the NHSC will have more than 320 physicians, 90 dentists, and 100 physician extenders in 260 areas in 42 States (90 percent in rural areas) by the summer of 1975. More than 70 percent of the physicians recruited in 1975 are board eligible, and present extension rates indicate that more than 40 percent of the physicians and dentists recently recruited will remain to practice independently in the areas.

Given the expansion of the NHSC/PHS Scholarship Program and the present concern about primary care manpower in shortage areas, it is expected that the NHSC will continue to be strengthened and expanded to serve as a catalyst in developing viable primary care delivery systems in the more than 700 counties or service areas with critical shortages of medical personnel.

The Bureau of Community Health Services, Health Services Administration, is attempting to integrate the activities of the National Health Service Corps, the Community Health Center Program, Migrant Health Program, and the efforts of the Appalachian Regional Commission to develop county and multi-county primary care systems in areas with critical health manpower shortages. More than 60 of these integrated rural health primary care efforts will be operating by the summer of 1975.

The Impact of National Health Insurance

A number of the serious health care problems in rural areas are also problems for the entire country. Comprehensive health insurance available to all Americans is urgently needed. Medicare, Medicaid, and private insurance cover large numbers of people, but more than 25 million Americans cannot obtain coverage, and many others have unsatisfactory coverage. An affordable comprehensive health insurance plan would resolve some of the current inequities in access to health care.

The need to move expeditiously and thoughtfully toward a rational system of health care financing that provides a mechanism for the distribution of the cost of care over the broader population and provides effective incentives for cost control and quality assurance is clear. However, it will be critical to develop this system with assurances that the overall health care system can accommodate the significant increase in services that would be expected by the population at large with the implementation of any such financing system. Especially in the current era of inflation and recession, there is need to assure that a continued or aggravated inflationary effect would not be an outcome of new comprehensive health insurance coverage.

In addition, there would need to be distinct provisions to assure that a disproportionately greater share of funds do not continue to be expended in areas where resources are already available or to continue the reimbursement bias that is evident between rural and urban areas. For example, California, Massachusetts, and New York receive about one-half of all Medicaid expenditures and almost one-third of the Medicare funds, although less than one-fifth of the eligibles for these two programs reside in these three States *(9)*. In most analyses of health care financing entitlements, especially for primary ambulatory care, rural States and rural areas appear to have a significantly lower average reimbursement not only for eligible persons but also for services provided. Careful attention to the problems which the Medicaid and Medicare type of financing creates in the delivery of care in the rural areas is important.

Furthermore, the attempt to reduce financial barriers in and of itself may make the maldistribution of health professionals more unequal than it already is. Indeed the maldistribution of physicians may have been intensified during the late sixties and early seventies in part by the large increases in Federal coverage for health care. The number of physicians who can practice in communities which are already physician rich seems to be determined as much by the flow of Federal and other

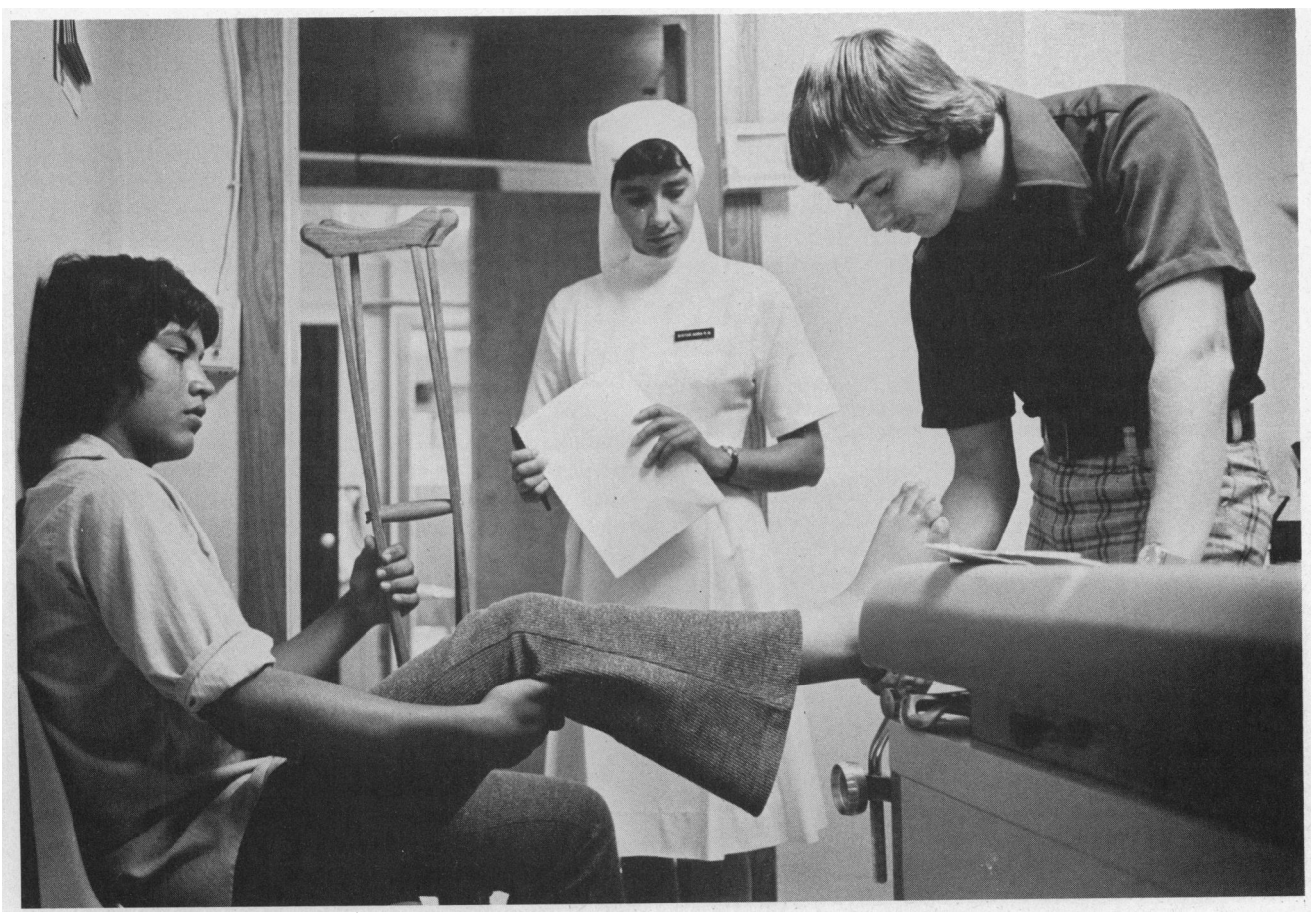
third party funds as by other market phenomena; that is, physicians' earnings are not limited because they practice in more desirable locations since Federal and other funds underwrite their locational preferences. Because no area of the country has an "oversupply" of physicians sufficient to depress their incomes, all areas have the potential for accommodating more physicians. Possibly, with the initiation of an across-the-board program such as a comprehensive health insurance program, demand will be increased in the physician-rich as well as the physician-poor areas, as indeed was the case with Medicare and Medicaid. Physicians seeking locations in which to practice will have as many, if not more, options available to them as they now have. If they can earn a comfortable living in either of two locations, factors such as the potential workload, the accessibility to specialty services, and the ability to associate with other physicians in an urban area will play an even more significant role in their decisions about where to locate.

Rural Development Act of 1972

In considering the Federal initiative in rural health, it need not be emphasized that health care is but one of the many interrelated and complex problems faced by rural Americans and that major efforts affecting health and the quality of living have been and are being undertaken by other Departments within the Government. Public Law 91-419, the Rural Development Act of 1972, requires that the Secretary of Agriculture establish goals for rural development of employment, income, population, housing, quality of community services, and facilities and report annually to Congress. The latest such report was published June 26, 1975 (*4*). This legislations's housing, sanitation, community services, and facilities aspects will especially have a great impact on the health and quality of life of the rural population, especially when one considers the increased prevalence of diseases and chronic conditions resulting from inadequate shelter, poor water supply, substandard sewage systems, and occupational and work-related illnesses among rural people.

In the President's fifth annual report to Congress on Rural Development, there was an indication of significant programatic expenditures and assistance in rural areas being given not only by the Department of Agriculture, but by the Departments of Commerce, Housing and Urban Development, Interior, Labor, and Transportation and the Small Business Administration and Veterans Administration (*10*). The proportion of total Federal outlays applicable to rural areas increased slightly from 34.6 percent in fiscal year 1972 to 35.1

Many rural Americans lack access to health care, particularly emergency medical services



percent in fiscal year 1973. The report indicated that evaluation of individual Federal programs revealed that there were frequently good reasons for program outlays being sharply at variance with the population distribution between urban and rural areas. The relevance of particular programs to the problems or deficiencies in rural areas made it difficult to make clear-cut comparisons about the equity of the allocation of most Federal program outlays, especially since the majority of categorical approaches were directed to problems that are found in urban as well as rural areas. It was difficult to disaggregate the funds that were expended predominantly in one area but were significantly affecting another.

Data on the outlays, presented in the report, nevertheless indicated some clear inequities in rural and urban shares of Federal program services. While about half of the poor reside in rural areas, rural people receive significantly less than one-half of the food stamp bonus coupons, of manpower training program services of both the Department of Labor and the DHEW, of ESEA (Elementary Secondary Education Act) funds, of public welfare assistance, and of OEO (Office of Equal Opportunity) legal services. In the President's report the allocation of health program services of DHEW, OEO, and the Veterans Administration appear to be disproportionately low in rural areas in relation to their populations. The report did, however, point out the difficulties of using this aggregate data in making these assessments and judgments.

Need for Integrated Approaches

Historically, Federal approaches to health problems have been categorical ones, and little activity has been specifically dedicated to the development of primary care or service systems for all persons living in particular geographic areas independent of their socioeconomic or beneficiary status. Most programs have focused upon individual groups or populations with either specific problems or special beneficiary status. In rural areas, it will be necessary to reconsider this approach, especially in the growing number of areas with critical health manpower shortages or significant resource shortages, or both.

Cooperative efforts such as "Su Clinica Familiar," sponsored by Catholic Charities and the United Organization Inc., and partly staffed by National Health Service Corps assignees, may help solve rural health care needs

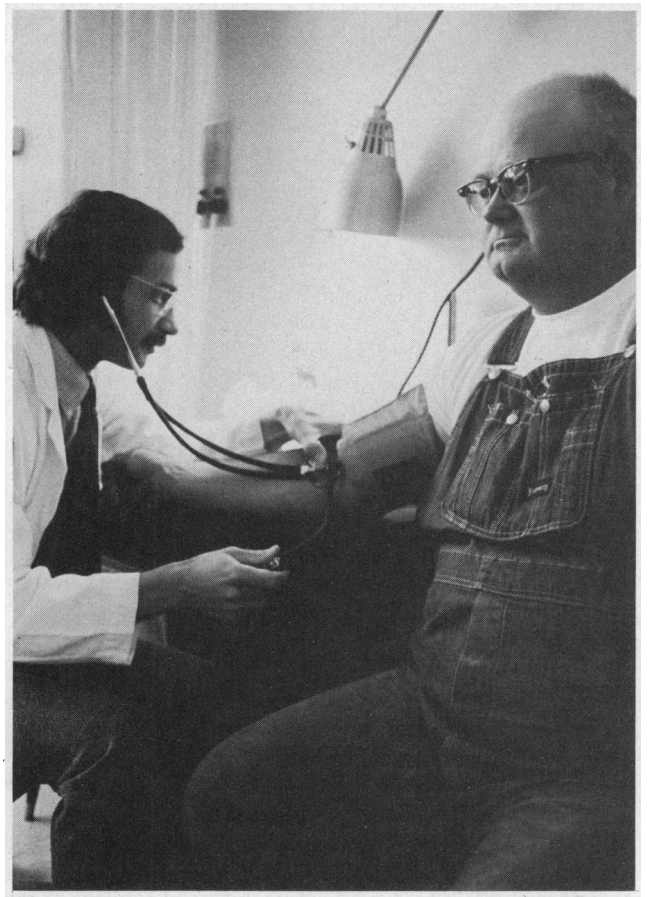
A priority consistent with a new broader approach would be the strengthening of the rural health system's capacity in primary and preventive care through the integration of service and other activities at the local level. Such a priority would require pulling together the requisite manpower, support, facilities, and technical assistance at the local level to create an independent and self-sustaining capability to manage and further develop local activities in health care. This integrated local effort should be designed to increasingly utilize local and State resources after the initial startup.

The recent move to a more effective and accountable decentralized Federal administration, given more adequate and appropriate resources, should strengthen the capacity of the Federal Government to coordinate the categorical programs with other Federal, State, and local programs at the community, county, and multicounty level in far more effective fashion. The service programs, particularly, should relate to more effective community-wide solutions and not to individual projects scattered across the nation like so many pins on a map, in many areas the projects being competitive rather than being related and supportive of other projects.

The integration of categorical approaches is particularly important since, given the low population densities in rural areas, it is difficult to develop effective systems for primary care that are targeted toward one population group and seek to emphasize an entirely separate system for the delivery of care.

Implementation of a more effective Federal initiative in rural health will require closer ties among the large number of local, State, and Federal activities, those being conducted by consumer and professional groups, and the innovative approaches being supported through foundation and other funding. Some State medical associations are making efforts to design mechanisms to supply health services to rural areas and are developing, in some areas, at the county and multicounty level, modifications of the delivery and financing systems to create a more integrated approach. Even with those projects that are federally funded, success appears to be correlated with the active participation of local community groups and organizations and especially health professional groups and organizations.

Among the many forces that will influence the role of the Public Health Service in improving the health care system in rural areas, three will have special impact: (*a*) the serious national economic problems that will result in severe constraints on the ability of the Federal Government to assume large additional responsibilities or develop broad new programs; (*b*) the positive trend established by the policy of placing more reliance upon States and localities to assume a greater responsibility



National Health Service Corps physician measures a patient's blood pressure in Martin, S. Dak.

for health resource development and assuring the delivery of health services; and (*c*) the National Health Planning and Resources Development Act, which should be a major force, guiding and directing the use of Federal resources in all parts of the country.

In the face of these forces, and consistent with one of the major goals of the Public Health Service in improving the access to appropriate health care, the Service, in its forward plan for 1976-80, proposes to focus attention on resolving health care problems by emphasizing a more systematic and targeted approach in achieving specific improvements in health systems. Undoubtedly, there will be proposals for a new agency, bureau, or office to focus more attention upon rural health within DHEW. However, a persuasive case could be made that a great deal of what is needed exists among the large and diverse resources already available through present categorical and other program activities, and these resources could be brought more effectively to bear upon the significant health problems in rural America. This strategy would not consume the time and resources needed to create yet another organizational system.

It is probable that a great deal of activity and effort will be the response to the increasing concern about rural health care problems which have been gradually worsening through the past decade. The Federal role in resolving these problems will undoubtedly be strengthened as the problems have so significantly increased in the past 10 to 15 years. It is to be hoped that the approach to these problems will always recognize the heterogenous, viable, and important nature of rural areas and rural Americans and would seek to develop from the strength and resources which are indeed found in almost all rural areas. To think of rural America as either disenfranchised or dying or to think of health as independent of many other related issues in housing, transportation, sanitation, and employment would be rendering a serious disservice to 54 million rural Americans. Predictably, such an attitude would create a climate where success would be far less possible.

Many people believe that rural America indeed expresses many of this nation's positive values and that it has great potential for the development of reasonable and appropriate systems of health care. Rural communities offer an exciting challenge for effecting programatic activities at the local and State level which may some day be viewed in retrospect as demonstrating the ability of the Federal Government to act as a catalyst and a partner, roles which strengthen rather than further weaken the State and local leadership that is essential for a rational, effective health system in this country.

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