Rudy Owens
Case 7, Day 1
Date Due: 101129

Learning Objective: Do current models of public health in rural areas provide equal service to minority communities, relative to non-minority communities in the United States, from rural African American communities in Mississippi to Indian country in northern Arizona to Latino agricultural communities in rural California and Washington. Explore why there may be inequities.

Why do rural minorities continue to experience poor health outcomes despite efforts to improve health delivery in rural and underserved areas?

***Abstract**: Rural residents have been found to be less healthy than their urban peers. Those health disparities are even greater for rural racial/ethnic minorities. In nearly all measurements, rural African Americans, Hispanics, and American Indians/Alaska Natives fare worse than their urban counterparts and all whites. These groups have distinct historic and geographic circumstances aggravating their health outcomes. Access to appropriate health care, less preventive care, and lower rates of health insurance have been identified as contributing factors.[1,2] Fewer health care resources in rural areas and lower care standards, along with educational and economic disparities between whites and minorities, contribute to the imbalance.[1,2] While the U.S. federal government provides support for primary community care in underserved rural areas, demands are not being met.*

A History of Health Disparities for Rural Residents and Rural Minorities:

In 1928, an influential federal study of American Indians/Alaska Natives, known as the Meriam Report, called attention to appalling health and nutritional conditions, poor housing, and no economic opportunity in Indian Country in rural America. The report partially blamed the federal government for creating a "vicious circle of poverty and maladjustment."[3] In 1970, a study of Greene County, Alabama, the first Southern area to elect a majority black local government, found a functioning health department and good facilities, but health services "rendered inaccessible by racist practices."[4] Today, health care inequities still confront rural American Indians/Alaska Natives, African Americans, as well as Hispanics. As our public health worker in the case contemplates the health challenges facing rural residents and how local health officials respond to such issues, the long-standing health inequities facing minorities in rural America need to be taken into account to assess how well federally funded public health initiatives mandated to serve underserved groups are doing.

The negative consequences of health disparities for 60 million rural residents and for 98 million minority/ethnic residents in the United States have been recognized as a serious concern by health researchers and federal health officials.[1,5] A comprehensive study of rural health issues called *Rural Healthy People 2010* found a health gap between urban and rural residents, and an even wider gap for rural minorities.[6] The health disadvantages experienced by rural racial/ethnic minorities have been called an issue of "race and place."[2] This paper first will first define "race" and then define " place," followed by a survey of how community-based health care is delivered to rural areas and rural minorities.

Rural minorities for the purposes of this paper include African Americans, Hispanics, and American Indians/Alaska Natives. They are concentrated geographically, based on historic circumstances such as slavery and their relations with the U.S. federal government. Half of all rural African Americans live in four Southern states: Mississippi, Georgia, North Carolina, and South Carolina. Most rural Hispanics are in the Southwest and West. Half live in California, Texas, New Mexico, Arizona, and Colorado. More than half of all American Indians/Alaska Natives reside in five states: Alaska, Oklahoma, Arizona, New Mexico, and North Carolina.[2] (Given that the U.S. Asian/Pacific Island population is mostly urban,[2] this paper will not focus on that group who live in rural areas.)

Population of rural residents, based on year 2000 estimate of 55 million residents living outside of metropolitan counties:[2]

Racial/Ethnic Group	Population (2000 Census Data)	Percentage
White	46 million	84%
African American	4.5 million	8%
American Indian/Alaska Native	870,000	1.6%
Hispanic (non-African American)	2.6 million	5%

Defining what is "rural," however, can be problematic. More than 15 definitions are used by federal programs. However, the most common definitions of rural are derived from the U.S. Census Bureau's "urbanized area" categorization or the Office of Management and Budget (OMB) description of counties as "metropolitan." Many federal programs use the metropolitan descriptor to declare all other counties as rural.[7]

To understand the hardships facing rural minorities and how health services are currently delivered to them, one must first examine the rural-urban health divide. The *Rural Healthy People 2010* study, published in 2003, found numerous rural-urban disparities in many areas—primary care, oral care, prenatal care, and rates of chronic disease. The study noted that persons in rural areas are more likely to be uninsured than those in urban areas (20% to 17%).[6] The report noted that the lack of health insurance in rural America was seen as a priority concern in most surveys of state and local health leaders. The study also found that those without health insurance were less likely to receive preventative care (for diabetes or mental and oral health), to get needed tests (such as cancer screenings), or to fill prescriptions. The combined effects of all these factors put rural residents at risk of not seeking adequate or timely treatment for their conditions.[6]

The delivery of health care in rural areas, regardless of the race or ethnicity of local populations, is influenced by the geographic challenges of remote communities, population density, and well-documented health workforce issues. These contribute to the rural-urban differences seen in health, disease, and disease-related outcomes. Overall, rural residents compared to urban dwellers have greater health burdens and fewer resources to address their health concerns.[1,8] Rural residents smoke more, exercise less, and have less nutritional diets than their non-rural peers.[9] Those living in rural areas have higher rates of chronic disease, life-threatening conditions, motor-vehicle accidents, and environmental hazards. They use alcohol more and experience severe consequences from its use (nutritional deficiencies, fetal alcohol syndrome). What's more, a greater proportion of rural residents report their health as "fair or poor," relative to urban residents.[1]

Among health care providers serving rural areas, access to quality health services is ranked as the top rural health priority.[10] The *Rural Healthy People 2010* study concluded that the core problems impacting health care are tied to medical provider recruitment and retention. For instance, only 10% of physicians in the United States practice in rural areas, though these areas make up nearly 25% of the U.S. population. [6]

However, rural ethnic groups and minorities, like their rural white counterparts, face the same health service delivery challenges, compounded by racial, economic, and educational factors. Relative to their rural white counterparts, racial and ethnic minorities have disparities for infant mortality, death rates by violent means, and death rates by major disease (cancer, cardiovascular, diabetes).[1] In rural areas, minority children, compared to their white counterparts, lack appropriate immunizations, have fewer clinical visits, and are more likely to delay care.[2] In the case of Southern rural African Americans, their specific burdens include isolation and inadequate transportation, poor education and training, lack of affordable housing, limited childcare, and persistent racial inequality.[11] Research on African Americans has found that their concentrations in some areas have negative effects on health and mortality.[2] A recent study 2010 study by Erwin et al. looked at mortality rates in 95 Tennessee counties and found that relative mortality rates of African Americans in rural counties were the highest when African Americans were a higher percentage of the population. The authors propose that such outcomes may stem from what they call "isolation from resources and opportunities and the chronic stress of racism."[12]

Health-related issues (rural residents only)	**African American**	**American Indian/Alaska Native**	**Hispanic**	**White**
Living in poverty[2]	3 in 10	3 in 10	1 in 4	1 in 9
Percentage in high-poverty job classifications[2]	68%	48%	62%	43%
Percentage of private insurance coverage, children (0-17)[2]	38%	22%*	39%	71%
Percentage working-age adults lacking a high-school diploma[2,13]	40%	23%	50%	15%
Percentage of counties that are health professional shortage areas (HPSAs) where minorities are > 50% population[2]	83%	81%	92%	NA
Percentage of adults without health insurance coverage[14]	25%	25%*	45%	15%

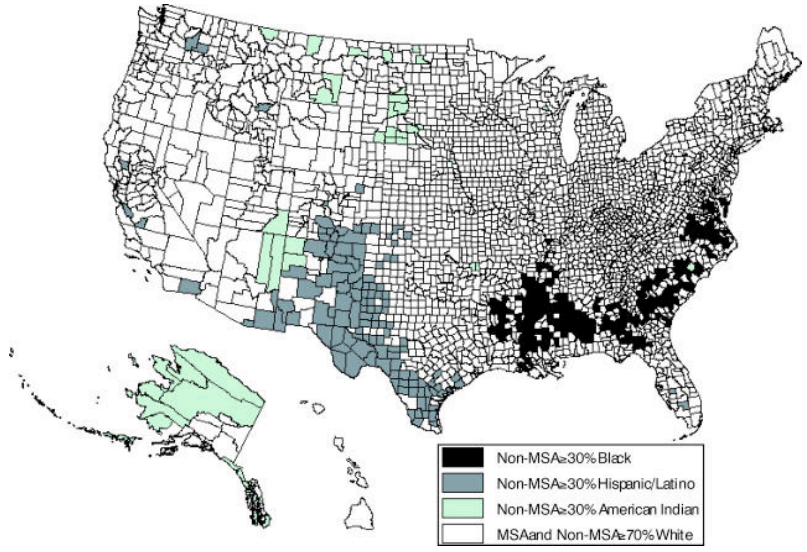
**Note, American Indians and Alaska Natives are entitled to free health care services by the U.S. Indian Health Service, which serves 1.9 million (out of a population of nearly 3 million) in 35 states.[15]*

In a frequently cited report on the effects of race/ethnicity and rural habitation on health, Probst et al. compiled multiple studies of health issues impacting rural racial minorities to document disparities in health care and access for rural minority/ethnic populations. They concluded those groups fared worse than rural whites and their urban counterparts (see "health-related issues" table). In rural America, 65% of rural counties are classified as health professional shortage areas (HPSAs).[2] But HPSAs are most prevalent where minorities comprised more than half the population, suggesting that these communities cannot fiscally support health care services.[2] A 2004-05 study by the American Medical Association also noted a racial/ethnic gradient was found in rural counties deemed "persistent" HPSAs, in which minorities made up the highest

percentage of the population, compared to rural counties that never received HPSA status, where minorities made up the smallest percentage of the population.[16] A typical county meeting this definition of persistent HPSA is Greene County Alabama, in Alabama's "black belt." There, African Americans comprise 79% of the population; 31% of all residents live in poverty. Only 4 primary care doctors serve the county's 9,200 residents.[17] The county's low-income public health needs are provided by a single federally funded community health clinic.

Probst et al. note that rural residence, minority status, and social and economic conditions have been mutually reinforcing for the last century, and many of the poorest rural counties, which also have the highest minority populations, continue to remain disenfranchised economically.[2] For instance, rural African Americans in the South remain among the nation's poorest residents. A swath of mostly rural 77 counties stretching from Georgia's "Black Belt" to the Mississippi Delta are labeled as being "persistently poor" counties, meaning 20% or more of the population has fallen below the poverty level for five census years in a row.[11]

Community Health Centers and Care Delivery in Two Rural States:
Rural minorities and all rural residents can be served by private medical providers and by a range of health centers, hospitals, and clinics supported by federal funding. Under the U.S. federal Public Health Service Act, the U.S. Health Resources and Services Administration (HRSA) funds community-based health centers, which today number more than 5,000.[18] Half are located in rural areas. By statute, they must serve a high-need community designated as a medically underserved population or area (MUP/MUA), the homeless, migrant farm workers, and public housing residents.[18] Underserved areas can be either rural or urban. The centers must be governed by a community board. They must treat patients regardless of ability to pay, and they must provide a range of health services.



Rural counties in which 30% or more of the population is African American, Hispanic, or American Indian/Alaska Native, by race/ethnicity; remaining counties are at least 70% white, 2000. Note: MSA=metropolitan statistical area.[2]

The HRSA each year also designates areas that are designated health professional shortage areas (HPSAs), in order to allocate funding.[18] These areas can be classified as having shortages of primary medical care, dental, or mental health providers.[19] In general, HPSAs are assigned when the population-to-clinician ratios are at least 3,500-1 for primary care, 5,000-1 for dental health care, and 30,000-1 for mental health care.[18] Presently, the nearly 14,000 primary care, dental, and mental health HPSAs lack enough providers to serve in those areas; two-thirds of those areas are in non-metropolitan counties.[20] Demand for federal assistance is high. With a

budget of $9 billion, HRSA serves 19 million patients, of whom two-thirds are members of minority groups.[18]

States coordinate funding and designations of primary health care centers, all of which are required to be in HPSAs. But not all state respond equally with funding. In Alabama, a state where 44% of all state residents are rural and where 64% of all rural residents are African American, 151 HRSA-supported primary care centers coordinate care with the state-run Office of Primary Care and Rural Health.[21] Though the state gives no direct funding support to the centers, the office provides some research and technical support to facilitate care for rural residents, minorities, and medically vulnerable populations. The office, like its counterparts in other rural states, is actively recruiting health providers through a free medical placement service program to help rural areas overcome shortages and recruit primary care physicians, dentists, physician assistants, and nurse practitioners.[17] It is not clear if the lack of state funding for community health centers should be seen as a historic carryover in a state the actively resisted efforts to abolish Jim Crow segregation in the 1950s and 1960s.

In Alaska, a nearly all-rural state where 19% of the population is Alaska Native, federally funded health centers are located in rural boroughs, where the population base is largely indigenous, and also in Anchorage, which has a high concentration of indigenous residents.[13] Nationally, the state is among the most deficient in doctors, nurses, psychiatrists, and other health professionals.[23] All told Alaska has 24 HPSAs.[22,] Unlike Alabama, Alaska does support the federally funded local community health providers. These are found all of the main regional population hubs, which in turn serve nearly 275 Native villages.[22] Federal funding also supports the 12 critical access hospitals in rural communities throughout the state, which also serve the state's Native residents.[22] The Alaska State Department of Health and Social Services office works to address workforce disparities in existing health centers and serves as a technical facilitator with the HRSA to designate underserved areas and coordinate with communities seeking federal funding for their community health centers. The recruitment of health care professionals to serve rural areas is high priority and perennial concern given the region's harsh living conditions.[23]

Back to the Case/Questions:
Researchers have long identified the problems of "health in the hinterlands" as those of distance, density, and delivery.[24] Data for decades has shown that rural minorities have lower socioeconomic status, less education, higher rates of poverty, and less insurance coverage than their urban peers and urban and rural whites. Overcoming the obstacles to improve these groups' health status remains daunting, despite the efforts by states, by the Indian Health Service to serve its clients nationally, and by the federal government through community and farm worker health centers that serve numerous underserved populations in rural America. These centers will continue to serve patients who are disproportionately poor, uninsured, or publicly insured—many of whom will be rural minorities. However, the centers are already short nearly 1,900 needed primary care providers.[25]

To improve health care for rural minorities and all rural residents, Probst et al. propose better surveillance through improved sampling of rural racial/ethnic minority populations and more regular reporting of data on those groups.[2] Researchers who study rural health also have called for health providers serving those areas to acknowledge that the many problems facing rural

areas, including their minority populations, require an approach similar to international health, sensitive to social and cultural contexts.[26] The federal government acknowledges the special health needs of rural minority populations, who account for 30% of all rural poor. The chronic poverty of the Southeast and language and cultural barriers faced by Hispanics remain of particular concern.[8] For its part the HRSA's Office of Rural Health Policy has begun calling for greater access to health care for rural minorities.[8]

Health care services for all rural residents may be improved by provisions of the Affordable Care Act passed by Congress in March 2010, but at significant cost and at a time of mounting concerns over budget deficits. One estimate places the cost of insuring 6.8 million out of the 8.3 million currently uninsured rural residents at $27 billion.[27] The Act also calls for $11 billion in new funding over the next five years to expand the operations of primary health centers.[19] But without concurrent efforts to combat institutional racism and mechanisms to provide greater education and employment opportunities in pockets of low employment and limited opportunities for rural minorities, additional health care funding alone may not change the imbalances shaped by "race and place."

Questions:
1. Are there concrete examples of how overt racism documented 82 years ago in Indian Country, and 40 years ago in Alabama, still impact the delivery of health care services in rural America?
2. Is it realistic to assume that there can ever be parity in health care delivery for all groups in a geographically, racially diverse country like the United States? What is the line separating acceptable unequal care and unacceptable unequal care?

REFERENCES:

1. Roberts LW, Johnson ME, Brems C, Warner TD. Ethical disparities: challenges encountered by multidisciplinary providers in fulfilling ethical standards in the care of rural and minority people. *J Rural Health.* 2007 Fall;23 Suppl:89-97.

2. Probst JC, Moore CG, Glover SH, Samuels ME. Person and place: the compounding effects of race/ethnicity and rurality on health. *Am J Public Health.* 2004;94(10):1695-1703.

3. The problem of Indian Administration: report of a survey made at the request of Honorable Hubert Work, Secretary of the Interior, and submitted to him, February 21, 1928. *The Institute for Government Research Studies in Administration Baltimore*: The Johns Hopkins Press; 1928.

4. Marshall CL. Racism and health in Greene County, Alabama. *J Natl Med Assoc.* Mar 1970;62(2):109-114.

5. James C, Thomas M, Lillie-Blanton M, Garfield R. Key facts: race, ethnicity and medical care. *Kaiser Family Foundation*. January 2007; http://www.kff.org.offcampus.lib.washington.edu/minorityhealth/upload/6069-02.pdf. Accessed November 24, 2010.

6. Gramm L, Hutchison L, Dabney B, Dorsey A. Rural healthy people 2010: a companion document to healthy people 2010 Vol. 2. *The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center.* 2003; http://www.srph.tamhsc.edu/centers/rhp2010/Volume2.pdf. Accessed November 24, 2010.

7. Coburn A, MacKinney A, McBride T, Mueller K, Slifkin R, Wakefield M. Choosing rural definitions: implications for health policy. *Rural Policy Research Institute.* March 2007; http://www.rupri.org/Forms/RuralDefinitionsBrief.pdf. November 25, 2010.

8. Rural Assistance Center. February 2010; http://www.raconline.org/info_guides/minority_health/minorityhealthfaq.php#rural. Accessed November 24, 2010.

9. Hartley D. Rural health disparities, population health, and rural culture. *Am J Public Health.* 2004 Oct;94(10):1675-8.

10. Gamm L, Hutchison L. Rural healthy people 2010-evolving interactive practice. *Am J Public Health.* 2004 Oct;94(10):1711-2.

11. The rain don't fall to the ground here: the status of human rights for Southern black women. *The Southern Rural Black Women's Initiative for Economic and Social Justice*. June 2007; http://www.srbwi.org/Programs/StatusHRSRBWnew.pdf. Accessed November 25, 2010.

12. Erwin PC, Fitzhugh EC, Brown KC, Looney S, Forde T. Health disparities in rural areas: the interaction of race, socioeconomic status, and geography. *J Health Care Poor Underserved*. 2010 Aug;21(3):931-45.

13. The American community—American Indians and Alaska Natives: 2004. *U.S. Census Bureau*. May 2007; http://www.census.gov.offcampus.lib.washington.edu/prod/2007pubs/acs-07.pdf. Accessed November 28, 2010.

14. Nostrand JV. Health disparities: a rural-urban chartbook. *South Carolina Rural Health Research Center.* June 2008;

http://rhr.sph.sc.edu.offcampus.lib.washington.edu/report/(7-3)%20Health%20Disparities%20A%20Rural%20Urban%20Chartbook%20-%20Distribution%20Copy.pdf. Accessed November 24, 2010.

15. U.S. Indian Health Service. 2010; http://www.ihs.gov/PublicInfo/PublicAffairs/Welcome_Info/IHSintro.asp. Accessed November 25, 2010.

16. Persistent primary care health professional shortage areas (HPSAs) and health care access in rural America. *Rural Health Research & Policy Center.* September 2009; http://www.raconline.org/pdf/research_compendium.pdf. November 27, 2010.

17. Alabama Department of Public Health. 2010; http://www.adph.org/ruralhealth/, November 26, 2010.

18. U.S. Department of Health and Human Services, Health Resources and Services Administration. 2010; http://www.hrsa.gov/. Accessed November 27, 2010.

19. HHS announces the availability of up to $335 million to boost access to primary health care. *U.S. Department of Health and Human Services, Health Resources and Services Administration*. October 26, 2010; http://www.hhs.gov/news/press/2010pres/10/20101026a.html. Accessed November 27, 2010.

20. Designated health professional shortage areas (HPSA) statistics. *U.S. Department of Health and Human Services, Health Resources and Services Administration.* November 28, 2010; http://ersrs.hrsa.gov.offcampus.lib.washington.edu/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry&rs:Format=HTML3.2. November 28, 2010.

21. Alabama health center fact sheet. *National Association of Community Health Centers*. 2008; http://www.nachc.com/client/documents/research/2009-State-Fact-Sheets/ALFS08.pdf. Accessed November 27, 2010.

22. Alaska Department of Health and Social Services. 2010; http://www.hss.state.ak.us/. Accessed November 27, 2010.

23. 2009 Alaska health workforce vacancy study. *Alaska Center for Rural Health-Alaska's AHEC, Institute of Social and Economic Research, University of Alaska Anchorage*. December 2009; http://acrh-ahec.uaa.alaska.edu.offcampus.lib.washington.edu/projects/pdf/2009workforce09.pdf. November 28, 2010.

24. Guidotti TL. Health care for a rural minority. Lessons from the Modoc Indian country in California. *Calif Med.* 1973 Apr;118(4):98-104.

25. A sketch of community health centers chart book 2009. *National Association of Community Health Centers.* 2009; http://www.nachc.com/client/documents/Chartbook%20FINAL%202009.pdf. Accessed November 28, 2010.

26. Phillips CD, McLeroy KR. Health in rural America: remembering the importance of place. *Am J Public Health.* 2004 Oct;94(10):1661-3.

27. Private health insurance in rural areas: challenges and opportunities. *Maine Rural Health Research Center*. April 2009; http://www.raconline.org/pdf/research_compendium.pdf. Accessed November 27, 2010.

KEY REFERENCES:

1. Gramm L, Hutchison L, Dabney B, Dorsey A. Rural healthy people 2010: a companion document to healthy people 2010 Vol. 2. *The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center.* 2003; http://www.srph.tamhsc.edu/centers/rhp2010/Volume2.pdf. Accessed November 24, 2010.

2. Marshall CL. Racism and health in Greene County, Alabama. *J Natl Med Assoc.* Mar 1970;62(2):109-114.

3. Probst JC, Moore CG, Glover SH, Samuels ME. Person and place: the compounding effects of race/ethnicity and rurality on health. *Am J Public Health.* 2004;94(10):1695-1703.