

Location, Location, Location: Rural Areas and Health

By Linda S. Lowe

Location, location, location. This often-repeated realtors' description of the three major determinants of property values might well apply to predicting the health status of populations and their local medical systems. As with real estate values, location can tell us something about health status because it can serve as shorthand for a variety of factors such as geography, demographics, economics, social norms, and even politics. Access to quality health care also varies with the level of urbanization. In assisting clients with health issues in rural areas, the new legal services attorney needs to be knowledgeable about these differences.

Health Status

In the United States one finds significant health-status differences between urban and rural populations and among geographic regions. These observable variations present distinct challenges. Regardless of location, legal services attorneys learn that many of their clients' legal problems are connected in some way to health problems. Clients may be too ill or disabled to work; clients may seek help with evictions or bankruptcies due to the gar-

nishment of their wages by creditor hospitals or doctors; clients with Medicaid, Medicare, or other insurance may have problems with coverage or payment denials or with inadequate managed care networks; or uninsured clients with little or no access to health care may experience a crisis when they become ill. Although low-income people in all settings face these problems, attorneys in rural areas may find it especially difficult to help clients address them. This difficulty is due to shortages of quality health care resources, fewer choices for patients, fewer choices for workers employed in hazardous occupations; travel distances, limited tax bases, and pressures on local health care providers that threaten their viability and thus their ability or willingness to respond.

The U.S. Department of Health and Human Services publishes a report detailing the variation in health status among areas of the nation.¹ It divides the country into four geographic regions with subregions, classifying counties from most urban to most rural as metropolitan (large central, large fringe, or small), or non-metropolitan (with or without a city of

¹ MARK S. EBERHARDT ET AL., HEALTH, UNITED STATES, 2001: URBAN AND RURAL HEALTH CHARTBOOK (Nat'l Ctr. for Health Statistics, HHS (U.S. Department of Health and Human Services) 2001).

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10,000 or more).² About 80 percent of the population live in the one-quarter of U.S. counties that are classified as metropolitan. The *Urban and Rural Health Chartbook* highlights some of the characteristics and problems of the rest (some 60 million people) who live in rural areas, particularly those living in certain regions:

- People in nonmetropolitan areas tend to be older, especially in the South and Midwest.³
- Populations in central counties of large metropolitan areas are more racially and ethnically diverse than populations in less urbanized areas.⁴
- The poverty rate is much higher in southern rural counties and in the northeastern and midwestern central counties than in the fringe counties of any region.⁵
- Nonelderly people in the most rural areas are even more likely than their counterparts in the most urban areas to be uninsured.⁶ At least one study shows rural residents also are likely to be uninsured three times longer than urban dwellers.⁷
- Both adolescents and adults in rural areas are more likely than others to smoke, and obesity rates are higher in rural areas.⁸
- Limitations in activity due to chronic health conditions are more prevalent in nonmetropolitan counties than in large metropolitan counties, especially in the

Northeast and South, and tooth loss among seniors is highest in rural areas.⁹

- Within the South and West, rural areas have the highest infant death rates, whereas the rates are higher in the large central counties of the Northeast and Midwest.¹⁰
- Death rates in the South for working-age adults (25–64) are highest in nonmetropolitan areas.¹¹
- Death rates for children and young adults (ages 1–24) and seniors (age 65 and over) are highest in nonmetropolitan areas.¹²
- Death rates from unintentional injuries (including motor vehicle accidents) are over 80 percent higher in most rural counties than in fringe counties and are especially high in the nonmetropolitan counties of the South and West.¹³
- Although homicide rates tend to be lower in nonmetropolitan counties, male suicide rates tend to be higher.¹⁴

Health Care

Access to quality health care varies substantially with the level of urbanization. Rural areas have the smallest number of physicians per 100,000 population. The rate of general and family practitioners is actually higher in small metropolitan and rural areas than in large metropolitan counties, but the availability of specialists

² “Large central counties” are those in large (one million or more population) metropolitan areas that contain all or part of the largest central city. “Large fringe counties” are the remaining counties in those metropolitan areas. “Small counties” are those counties in metropolitan areas with a population of less than one million.

³ EBERHARDT ET AL., *supra* note 1, at 3.

⁴ *Id.* at 3.

⁵ *Id.*

⁶ *Id.* at 112.

⁷ Keith J. Mueller et al., *Lengthening Spells of Uninsurance and Their Consequences*, 13 J. RURAL HEALTH 29 (1997).

⁸ EBERHARDT ET AL., *supra* note 1, at 3.

⁹ *Id.* at 4.

¹⁰ *Id.*

¹¹ *Id.* at 5.

¹² *Id.* at 6.

¹³ *Id.* at 4.

¹⁴ *Id.*

and dentists is starkly lower.¹⁵ Rural physicians tend to be older and are more likely to practice alone. Rural physicians are more likely to provide care outside their specialty area than are those in urban areas—a practice that can compromise patient care unless physicians receive adequate training.¹⁶

Studies have shown that rural physicians also are more likely to lack ready access to up-to-date information that they need for patient care because of their isolation, inadequate equipment, lack of time, inadequate access to the Internet or library research service. Many also lack the training to evaluate the scientific merit of information. Like most physicians, notably primary care practitioners, they prefer to rely on colleagues, textbooks, and their personal libraries instead of journals and online databases.¹⁷

Telemedicine (the use of telecommunications and information technology to provide health services to persons at some distance from the provider) has been considered a promising method of disseminating information and delivering care in remote areas. However, early failures due to high costs and awkward technology, insurer and policy maker pressure to prove effectiveness, clinician concerns about economic competition, and other factors have resulted in slow diffusion of innovations.¹⁸

On the positive side, at least one study suggests that rural family practice clinics may provide more preventive services than their urban and suburban counterparts. This may result in part from doctors knowing their patients better, rural residents' willingness to accept longer

Web Sites to Consult on Rural Health and Health Care Issues Generally

- Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, www.ahrq.gov.
- National Academy Press, www.nap.edu
- PubMed Central, www.pubmedcentral.nih.gov.
- The Commonwealth Fund, www.cmwf.org.
- The Kaiser Family Foundation, www.kff.org.
- Families USA, www.familiesusa.org.
- The National Health Law Program, www.healthlaw.org
- American Public Health Association, www.apha.org
- National Rural Health Association, www.nrharural.org

waits if they had more time with the doctor, and the lesser likelihood that rural practices are part of networks that emphasize efficiency.¹⁹

Rural hospital services are the focus of special concern. Hospitalization rates for adults, 18–64, excluding maternity stays, are higher in nonmetropolitan areas, but lengths of stay are shorter. Researchers suggest that the greater use of hospitals in rural areas may result from barriers leading to delays in accessing outpatient care for treatable conditions.²⁰ Rural hospitals are struggling to survive largely because of high levels of uncompensated care for uninsured people, loss of patients to larger facilities outside the area, reimbursement changes at the federal and state levels and within managed care plans, and staffing deficiencies. Over 300 rural hospitals have closed in the last few years. Others are adjusting their mission by focus-

¹⁵ *Id.* at 114–15.

¹⁶ AGENCY FOR HEALTH RESEARCH & QUALITY, HHS, AHRQ PUBLICATION NO. 02-M015, AHRQ FOCUS ON RESEARCH: RURAL HEALTH CARE (2002).

¹⁷ Josephine L. Dorsch, *Information Needs of Rural Health Professionals: A Review of the Literature*, 88 BULL. MED. LIBR. ASS'N 346 (2000).

¹⁸ INST. OF MED., A GUIDE TO ASSESSING TELECOMMUNICATIONS FOR HEALTH CARE (1996). See also www.ahrq.gov, the U.S. Department of Health and Human Services' Agency for Health Research and Quality Web site, for information on ongoing research about telemedicine.

¹⁹ Louis G. Pol et al., *Rural, Urban, and Suburban Comparisons of Preventive Services in Family Practice Clinics*, 17 J. RURAL HEALTH 114 (2001).

²⁰ EBERHARDT ET AL., *supra* note 1, at 74, 116.

ing more on primary care services, long-term care, and limited-use hospital beds.²¹

Health-Related Issues and Advocacy

Other special health-related issues require attention in rural areas. Migrant farmworker populations' mobility challenges the creativity of service delivery, and their working and living conditions put them at risk of accidents, chemical exposure, and other hazards. They are very likely to be uninsured and, absent specially targeted programs, have to rely on episodic hospital care at hospitals. Moreover, rural residents may experience more stigma and related barriers to diagnosis and treatment of certain conditions. There is evidence that rural people with HIV (human immunodeficiency virus) report lower general satisfaction with life; perceive less social support from family and friends and less access to care, are lonelier, more fearful about disclosure of their HIV status, and have more maladaptive coping behavior.²² At least one study also shows that rates of arrest and incarceration of people with serious mental illness have increased with declining access to inpatient mental health care and lack of alternatives and that rural residents face significantly greater risk of such incarceration without criminal charges than urban residents.²³

Rural legal services attorneys find a variety of ways to address clients' health

care concerns. At the most essential level they familiarize themselves with clients' needs and the resources available to meet them. They learn about Medicaid; Medicare; public or private, free or low-cost programs that help clients receive care or pay medical bills; and state or local legal requirements for access to services. They master the legal underpinnings and practical operations of programs. Legal services attorneys often are the only help available to clients who want to assure that health-related programs comply with the law and benefit them. The help takes many forms—always community education, sometimes defending collection actions or challenging coverage or service denials, and other times helping clients monitor programs and conduct advocacy or file lawsuits. By being engaged in their communities, legal services attorneys find other ways to improve services. They have helped file applications to obtain funding for new health centers. They sometimes are asked to serve on local task forces or to speak at local forums. Simply being persistent in making policymakers and the public aware of the situations that clients face can generate action. Local and state legislators often seek legal services attorneys' guidance on health issues. Assisting these officials can advance clients' interests in attaining good health and equal access to services.

²¹ See Robert W. Broyles et al., *Networks and the Fiscal Performance of Rural Hospitals in Oklahoma: Are They Associated?* 14 J. RURAL HEALTH 327 (1998); Ira Moscovice & Roger Rosenblatt, *Quality-of-Care Challenges for Rural Health*, 16 *id.* 168 (2000); Jeffrey A. Alexander et al., *Determinants of Profound Organizational Change: Choice of Conversion or Closure Among Rural Hospitals*, 37 J. HEALTH & SOC. BEHAV. 238 (1996).

²² Timothy G. Heckman et al., *Psychosocial Differences Between Urban and Rural People Living with HIV/AIDS*, 14 J. RURAL HEALTH 138 (1998).

²³ Greer Sullivan & Karen Spritzer, *The Criminalization of Persons with Serious Mental Illness Living in Rural Areas*, 13 J. RURAL HEALTH 6 (1997).