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Analysis: Rural healthcare below par

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WASHINGTON, July 18 (UPI) -- Rural healthcare systems don't measure up when compared to their urban counterparts, several health-sector experts say.

"We have an inequitable system across the country," said Michael Meit, co-director of the Walsh Center for Rural Health Analysis, a division of the National Opinion Research Center, a non-profit organization affiliated with the University of Chicago.

The disparity arises out of history, ironically caused by efforts to bring the health of urban citizens up to par with country dwellers. In the 1800s, government officials began implementing programs to help quell yellow fever and cholera in the cities of the day, where crammed, unsanitary housing conditions fueled the spread of infections.

These diseases weren't a concern in rural areas, were families lived farther apart, so those areas were largely overlooked in the public health initiative.

"It took a lot longer for public health to develop in rural areas, and in some areas I don't think it ever developed," Meit told United Press International Wednesday at a panel discussion on the topic hosted by the **Public Health Congress**, a conference for health officials and practitioners. "Now, the urban citizens tend to be healthier overall than rural citizens."

Although some rural areas have good health systems, others have virtually no public health infrastructure, and the availability of care for rural residents, about 20 percent of the total population, varies widely, as each state has its own system. The disparity between rural and urban areas could be decreased if states had to meet some minimum requirements for the allocation of resources, Meit said.

"I think the federal government needs to provide more guidance or requirements on basic public health capacities that must be met," he said.

Many of the inequalities between rural and urban areas parallel the disparities between minority and white populations, including lack of access to care, lack of healthcare professionals and lower quality of care, said Garth Graham, the deputy assistant secretary

for the Office of Minority Health, a division of the U.S. Department of Health and Human Services.

"We see (these problems) not just looking at racial and ethnic populations, but also when we look at rural populations," Graham said.

Some ethnic groups have high rates of concentration in rural areas, highlighting the overlap between the two demographics, said Charles Grim, director of the Indian Health Service program with the U.S. Department of Health and Human Services.

"The American Indian has been called the most rural population in America," said Grim.

Although Grim's department has found ways to collaborate with other public and private entities to increase the availability and quality of care for American Indians, the lack of healthcare in many rural areas reflects deeper problems, he said.

"It's not just a health issue that creates these disparities," he said. "There are other social issues: unsafe housing, unsafe roads ... (few) economic opportunities."

The IHS started addressing these problems through scholarship and student loan repayment programs as well as sanitation initiatives. Officials found when more safe drinking water and sewage systems were installed on reservations, neonatal mortality rates dropped, among other positive outcomes.

Emergency situations also pose a problem for rural communities, which generally lack the resources to deal with large-scale disasters. Even if the disaster itself occurs elsewhere, most rural communities would be unable to cope with an influx of evacuees from urban areas, according to an analysis of the situation conducted by the Walsh Center.

"In the event of an evacuation, rural hospitals will need to discharge patients to accommodate evacuees," the authors warn in the paper.

The researchers recommended rural communities coordinate with nearby urban centers and other communities in the region to plan for emergency situations.

Nebraska, a state with a large rural population, has attempted to address this problem by pooling the state's resources, said David Palm, administrator for the Office of Public Health with the Nebraska Department of Health and Human Services.

"Within the larger system, we've created six medical response systems," Palm said.

Each system brings several critical access hospitals, one or two regional hospitals and the local health departments together "to try and figure out how we can move people, resources and equipment to the places they might be needed," he said.

However, the large distances between communities within Nebraska, up to four hours in places, has created an obstacle that could delay aid to rural areas in times of crisis, Palm said.

New York has also turned to a collaborative approach for dealing with emergencies, but the number of available personnel presents a greater difficulty in that state than geographic barriers, said Karen Madden, director of the New York State Office of Rural Health.

"The problem could be, especially in rural areas, trying to get enough people in there to treat these patients," she said.