1986

8601: Frontier and Rural Health: Agenda for Action

The American Public Health Association,

Recognizing that rural populations in the United States continue to experience shortages of health practitioners, and that there is a diversity in rural health care needs; and

Noting that health policies do not take into account the wide range of diversity among rural communities, so that the term "rural" is used to describe both suburban areas adjacent to major cities as well as totally isolated areas with small populations located 100-200 miles from urban areas; and

Observing that in the 1980 Census, there were 143 counties with fewer than two persons per spare mile, and that 394 counties may be defined as frontier areas having six or fewer persons per square mile and located more than 45 miles from the next level of care, and that frontier areas comprise 45 percent of the United States land area; [1], [2] and

Affirming that the facts do not support the reasoning or conclusion that an aggregate surplus of health care providers results in an adequate supply in rural areas; and

Finding that a large number of researchers are unanimous in casting doubt on the notion that physicians will diffuse to rural areas when urban areas become too competitive, and that, even if the diffusion theory were operative, the cost of training seven to ten physicians to assure that one will diffuse to a non-metropolitan county is too high; [3], [4], [5], [6], [7] and

Acknowledging that among nonmetropolitan counties which did gain in health care providers and providers-to-population ratios, the larger numbers were those which enjoyed economic and geographic advantages and were already well endowec with health care providers; and

Noting that many studies have documented the exclusion of many rural areas, especially frontier areas, from changes in the health care environment, such as health maintenance organization (HMO) development, increasing numbers of health care providers and alternative health care delivery systems; [8], [9], [10] and

Understanding that many major health care developments are not occurring in rural and frontier areas because of low population density, high levels of poverty, and limited financial support for health services, so that less primary care is accessible and available to the people in rural and frontier areas, and gaps in health care are increasing; and

Affirming that diffusion and competition theories will not assure an adequate supply of health care providers in rural areas; and

Concluding that health care provider shortages continue in rural and frontier underserved areas; therefore

Recommends the provision of financial incentives for an integrated approach to health services resources in rural and frontier areas, including public health departments, community health centers, and programs that serve populations with unique needs such as migrants, Indians, and veterans;

Renounces the notion of a diffusion-based rural health policy as the sole basis for providing underserved areas with appropriately trained physicians and other health personnel;

Endorses a policy and the maintenance of adequate funding for training programs that encourage health care providers to locate in rural and frontier areas, thus increasing provider-to-population ratios to levels that will ensure access to adequate health care. Examples of these primary care training programs include:

Primary care medical recruitment, education, and training programs such as Area Health Education Centers; and

Scholarship, loan and loan forgiveness programs with provisions for service in rural, underserved, and frontier areas, such as the National Health Service Corps

Encourages equitable health programs and policies which reflect the diversity of rural areas and specifically the needs and rights of people living in frontier areas. For example: the development of reimbursement schedules for Medicare, Medicaid, and other third party sources which eliminate discrimination against the rural and frontier providers and offer incentives for rural practice.

[1] Frontier Health, Rural Primary Care, National Rural Health Care Association, November/De
1984.
[2] Draft Defining Characteristics, Frontier Task Force, National Rural Health Care Association and Region VII, US Public Health Service.

[3] Health Resources Administration, US Public Health Service: Summary Report of the Graduate Medical Education National Advisory Committee, DHHS Pub. No. (HRA) 81-651, April 1981.
[4] Ahearn MD, Pryar MD: Physicians in Nonmetro Areas during the Seventies. Washington, DC: USDA, March 1985 (Rural Development Research Report, No. 46).
[5] Cordes SM, Eisele TW: Changes in Pennsylvania's physician supply. Pennsylvania Med 1985; 88:55-8. _
[6] Cordes SM, Eisele TW: Another look at the Rand studies on physician diffusion. Rural Primary Care, NRHCA, May/June 1984.
[7] Freun MA, Cantwell JR: Geographic distribution of physicians: Past trends and future influences. Inquiry 1982; 19:44-50.
[8] Hicks LL: Social policy implications of physician shortage areas in Missouri. Am J Public Health 1984; 74:1316-1321.
[9] Ellwood Proposes Rural Supermed. Rural Primary Care, NRHCA, May/June 1985.
[10] Ricketts TC, Guild PA, Sheps CG, Wagner EH: An evaluation of subsidized rural primary care programs: III. Stress and survival. Am J Public Health 1984; 74:816-819,