Access and Issues of Equity in Remote/Rural Areas

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ABSTRACT: *This article reports on a workshop in which the major focus was a review of the barriers that prevent access to the array of community-based services available to the rural elderly. The demographics of the elderly were outlined and key components of the service system described. Attention was given to access hospital-based care, the closing of hospitals and the reasons for bypassing rural hospitals for those in large towns or cities. Special emphasis also was given to mental health services and their uneven accessibility. A review of the policy implications closed the workshop.*

The four speakers in this workshop made informal presentations rather than reading formal papers, thus ensuring maximum feedback from the participants as well as allowing them to introduce specific service variations with which they were familiar. C. Neil Bull, Ph.D., opened the workshop by outlining the major trends that will impact the rural elderly. Changes in the economy of rural areas, especially the transition from manufacturing, small farms and extractive industries to service jobs, have brought about both a decrease in work and an exodus of the younger population. Also, farming and extractive industries have become more vulnerable to global competition and the economic bust and boom cycles have been amplified. Members of the baby boom generation have spent most of their working lives in two-income families, and their expectations with respect to services have increased (Bull, 1998).

Even when social needs are met by the government or marketplace, the need for voluntary or nongovernmental associations is growing. Such organizations as churches, the welfare and not-for-profit sectors, and even private foundations, have increased in importance. These institutions, which are growing in number, most often reside in and represent their community and the elderly who live there. A final point bears on the continued lack of advocacy for the rural elderly. The rural elderly, due to their geographic, racial and low socioeconomic backgrounds, are often overlooked and have little, if any, organized political advocacy (Bull, et al., 1991).

The major barriers to the provision of services to the rural elderly were outlined in the workshop. The most obvious is isolation with respect to distance, hostile terrain, lack of good roads and little, if any, choice of transportation other than the automobile. Economic resources are limited, not only with respect to personal income but also due to a fragile tax base and a lack of corporate or private giving. There has been and continues to be a breakdown of the infrastructure, especially in the health area with the reduction of hospitals, doctors, nurses and other health professionals. There are also few economies of scale and often a single provider can dictate both the cost and quality of a service. The lack of a trained labor pool means that the introduction of new technologies is slowed due to a lack of training in how to maintain and repair the ever more sophisticated machines. Finally, there is still some carry-over of what has been termed a rural "cul-

ture" based on the need for independence and the suspicion of the introduction of change from the outside—most often attached to government agencies that are seen as hostile to rural ways and more prone to use rules that favor urban areas (Bull, et al., 1991).

The workshop presentation by John A. Krout, Ph.D., first focused on demographics of the rural elderly. One-quarter of the nation's older adults live in rural (nonmetropolitan) areas. In many states one-half or more of the older population is rural and, generally, the smaller the community the larger the percentage of population that is age 65 and over. While significant differences are found between rural and urban elders, the rural older population also is very heterogeneous. It varies not only by region but also by community size and type. While only a small percentage of rural elders currently live on farms, some of the biggest differences among rural older populations are those of farm versus non-farm dwellers.

Many myths and stereotypes of rural living suggest that rural older adults would be healthier and happier and with fewer unmet needs than urban elders. This picture does not fit with reality. Overall, rural elders compared to their urban counterparts are somewhat older, are less educated, have lower incomes, are more likely to live in substandard housing, and are less healthy. Rural elders do not have greater contact or receive more assistance from family, friends and neighbors. Thus, rural elders face a "double jeopardy" of being both old and rural. It is very clear that rural elders have fewer health and social services available to them. Low population densities, lack of public transportation and the cost of services create significant barriers to accessing the services that do exist. Other challenges include lower levels of service awareness among older adults, a lack of trained service professionals, and the paucity of effective models for providing appropriate and acceptable services in rural areas. Overall, the existence of considerable gaps in the continuum of community-based service systems illustrates the rural service disadvantage (Krout, 1998). Area Agencies on Aging (AAAs) play essential roles in the planning, coordination, delivery and funding of services for older adults. Rural, compared to urban, AAAs are responsible for much larger service areas with lower population densities and less robust service systems. The demographics increase the amount of resources that must be spent on transportation, and the less developed service systems limits service options and availability. Rural AAAs have smaller budgets and support fewer services than urban AAAs while at the same time they are charged with meeting the needs of rural elders who are poorer and sicker. A similar scenario is found for senior centers, a highly visible and important component of aging services in rural communities. Nationwide, rural senior centers have much smaller budgets and staffs and thus provide fewer services. However, rural senior center users tend to be older, sicker, and poorer than urban users (Krout, 1994).

Additional funding is a key to better meeting the unmet service needs of rural elders. More emphasis should be given to training service professionals about these needs and to developing program approaches that work in rural areas. Simply "scaling down" urban models has not proven to be effective. Practitioners, policy-makers, and planners need to consider the distinctive characteristics and needs of rural elders as well as the unique features of rural social and physical environments as they develop programs to serve this population.

The workshop presentation by Jean Shreffler, Ph.D., focused on access to "formal" health care services, particularly access to hospital-based care for the elderly living in rural areas. Formal health care services that are available locally and are acceptable to the rural elderly can provide an important support service when used to supplement or substitute for traveling for health care. While acute or hospital-based care is not often considered among the array of community-based care options, small rural hospitals and community-based services have many of the same characteristics and problems. Also in many small rural communities, "traditional" community-based services and rural hospital services are interdependent (Shreffler, 1996). For example, the hospital may offer or facilitate community-based services that would not exist if the hospital were not there. Rural community-based services and hospitals are also often mutually dependent on one another financially.

Access to acute health care services for many rural Americans of all ages declined significantly during the past two decades due to record numbers of rural hospital closures. During the 1980s, 10 percent of the rural hospitals in the United States closed, and this high closure rate continued in the 1990s. Closure of a rural hospital may result in loss of reasonable access to acute and emergency care for residents when there are no other local alternatives. An exodus of health care

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providers and loss of some community-based services, particularly those offered by the hospital, often accompany the hospital closure, leaving rural dwellers with few local health care resources. The older age of many rural residents, as well as poverty, distance, geography, weather and lack of public transportation, all complicate access when travel to distant communities for care is required.

Factors contributing to rural hospital closures have been well documented in the literature. National/regional forces such as Medicare reimbursement levels, a declining rural economy and provider shortages have usually been blamed for the closures. Local factors have also been implicated (Shreffler, et al., 1999). Economic conditions such as rural poverty, unemployment and underemployment, as well as lack of health insurance and an aging population result in not only increased health care needs of community residents but also a reduced tax base to support the hospital and an increase in uncompensated care. Other research has found that underutilization of the local hospital by rural residents who bypass it to seek care in larger towns or urban areas and lack of community support may also be major contributing factors to closures.

The extent to which older rural residents rely on local acute or hospital-based care for their health care is not clear and the research evidence is somewhat contradictory. Advancing age is generally associated with an increase in health problems that tend to become more complex and the services and/or types of providers best suited to treat these complex problems may not be available in small rural communities. Some studies have found that older residents are as likely or more likely to travel to larger towns or cities for their health care as compared to younger residents. Other research has found, however, that elders are more likely to use and/or depend on local health care, particularly if their health and/or mobility declines to the point that they are less able to travel for care. Still other investigators have found that a lack of—or limitations in—local health services have contributed to rural elders' decisions to move from rural areas to be closer to the health care available in larger towns or cities.

Assuming quality of care is taken into account, maintaining or restoring access to at least basic local health care services may contribute to the health and well-being of rural residents of all ages, particularly of the youngest and the oldest residents who may not as easily travel for care. Having access to local health care may also mean as much to the social and emotional quality of rural residents' lives as it does for the health care aspects. Maintaining or restoring access to certain "security blanket" services, such as health care, also may contribute to what it means to be a "community." If one believes that quality of life and maintenance of community identity contribute to health, then there is a compelling need to address the barriers that limit access to rural health care.

Lee Rathbone-McCuan, Ph.D., focused her attention on rural mental health services. The first federal government social program to introduce a window of mental health service delivery opportunity was the 1965 Community Mental Health Act. Both urban and rural mental health centers were established under the act, and the elderly were a "target" population for prevention, education, mental health treatment, consultation and related services.

Throughout rural America, there was a very uneven rate of development of mental health centers and different levels of emphasis placed on the needs of elderly people in the geographical catchment areas designated for each center. One of the most effective approaches used by community mental health centers to build a foundation for serving elderly people in the catchment was through collaboration with an AAA. Given that AAA programs were also in the early stages of development through funding under the Older Americans Act, local cooperation with mental health centers was a great opportunity for some mental health centers. When it was possible to establish collaboration between the two programs, outreach was more effective, programs were more collaborative and service expertise was exchanged between them. Other mental health services have operated in rural communities to help close the mental health service gap of the rural elderly. State mental hospitals, long-term care settings, Veteran's Affairs services, private therapists, and individual and group-practice physicians offer assistance to rural older people and their families. On the other hand, these resources are very limited, unevenly accessible throughout rural areas, uncoordinated, and often too short term (Rathbone-McCuan, 1993).

There is no rural mental health continuum for any of the highest-risk populations. Those individuals with severe and persistent mental illness now receive the most attention from community mental health centers. Neither children nor the elderly with mental health and psychiatric care needs receive adequate mental health services. Five important factors must be resolved if there is to be major improvement for rural mental health delivery to rural elderly. First, there must be adequate funding to establish and support in-

novative programs for reaching rural elderly in various areas.

Second, elderly people and their families must be supported to move beyond the stigma of mental health service utilization that lingers throughout rural America. The third factor involves the need of adult protective services operating in rural areas to have access to better mental health consultation in order to effectively serve cases of abuse and neglect. The fourth factor deals with giving priority to the continuous efforts to build outreach programs for the isolated rural elderly. The fifth factor is that all facets of rural health care must be better integrated with mental health and psychiatric services (Rathbone-McCuan, 2001).

Upon reviewing the four speakers' presentations, policy implications were discussed and it was felt that most of the successful rural programs were homegrown and based on local interest and local talent (Bull, 1993; Bull and Bane, 2001). Therefore, wherever possible, funds for rural programs should be administered at the lowest level possible. The heterogeneity of rural communities means that local adaptation of programs is necessary, and the need for reducing duplication of services is of vital importance and can be best achieved through cooperation. One of the main needs identified was to stabilize the infrastructure. The role of keeping a local hospital open was seen as a top priority.

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