



Rural Public Health

Introduction

Persons residing in rural parts of the United States have poorer access to essential public health services than their urban counterparts. Many rural and frontier areas lack necessary public health infrastructure in the form of district, county, or city public health departments. For those rural regions that do have public health departments, many are understaffed and employ staff with little formal public health training. Rural populations are older, have lower health status, and experience high rates of poverty. In addition, many rural regions are experiencing declining numbers of working adults due to the out-migration of young adults and the in-migration of aging baby boomers upon retirement. This population trend has lowered county tax bases and available social capital needed to fund and staff local public health departments.

The problem of poor access to public health services, including health promotion and disease prevention, is intensified for rural people at multiple levels of delivery. Rural hospital and clinic closures have lessened the availability of community outreach services provided by primary care providers. To heighten this access burden, population-focused health services have also declined amidst deep funding cuts to rural public health agencies.

While it is important to assure individuals have access to primary health care providers in rural areas, the most important determinants of rural health status presently and into the foreseeable future continue to be lifestyle behaviors, particularly diet, exercise, and tobacco use. Lifestyle behaviors are multifaceted, influenced largely by one's environment and social surroundings. Primary health care providers are seldom able to deliver population-focused approaches needed to address health barriers at the interpersonal and community level due to limited resources and structures. Public health can play a key function in collaborating with Accountable Care Organizations (ACOs) to collect performance measurement, health promotion and prevention, and community engagement for the conducting of needs assessments¹. Yet, despite the initiation of effective health programs by rural health departments to improve community-level health behaviors, many more rural areas lack the public health agencies, personnel, and financial resources required to implement these interventions. Access to essential public health services is imperative to achieving an immediate and sustained impact on the health determinants that contribute to rural health disparities.

Table: Essential Public Health Services (Source: Public Health in America, Public Health Functions Steering Committee, Public Health Service, 1994)

- Monitor health status to identify community health problems

- Diagnose and investigate health problems and health hazards in the community
- Inform, educate, and empower people about health issues
- Mobilize community partnerships to identify and solve health problems
- Develop policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and ensure safety
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- Assure a competent public health and personal health care workforce
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- Research for new insights and innovative solutions to health problems

Data and/or Background²

A report was released October 2014 from the Rural Health Reform Policy Research Center. This report examined national trends in rural and urban health and documented baseline rural-urban differences in health status and access to care prior to the Affordable Care Act's (ACA) implementation. Specific findings, listed below, revealed greater disparities in health status and healthcare access for rural citizens compared to their urban counterparts. Specifically:

- Rural teenagers and adults are more likely to smoke;
- Rural adults experience overall higher rates of obesity and physical inactivity;
- Rural children and adults have higher overall death rates, particularly for suicide and respiratory disease;
- Rural adults experience greater private health insurance gaps; and
- Geographic disparities exist across rural locales, with a particular burden of diabetes in the South and suicide in the Upper Midwest.

While all populations have demonstrated improved health status over the past decade, rural residents continue to exhibit a higher prevalence of heart disease, cancer, suicide, injury and stroke, among others. The rural public health system, which is an integral source for improving social and environmental health, is fragile as a result of deep funding cuts. Addressing rural health disparities requires a strong rural public health infrastructure staffed by a well-trained public health workforce.

Infrastructure Issues

Despite the need for a strong rural public health infrastructure, the nation's rural public health system remains ill equipped to respond to the health disparities experienced by its people. Accessibility of public health services varies greatly. Many rural and frontier regions are without local health departments and do not have individuals accessible who provide essential public health services. Potentiating the problem of poor access, is the varied composition of each public health entity. Our nation's public health infrastructure is diverse, with each state's model

independently developed and therefore unique. The dissimilar formation of public health departments has led to problems in defining the boundaries of public health and has consequences on the scope and provision of public health services. Adding further complexity is the interplay of new regulations and funding-reimbursement mechanisms to the rural context, which have influenced or are likely to influence rural public health infrastructure.

In 2012, the Institute of Medicine published a report *For the Public's Health: Investing in a Healthier Future*³. The report outlined a minimum package of public health services and capacities to focus on the core functions of public health: assessment, assurance, and policy development, and away from the delivery of clinical services. These recommendations and other forces, such as funding cuts, have led to decreased direct clinical service delivery by state and local health departments. A study by Hale, Smith, and Hardin⁴, examined the impact of clinical capacity reductions in rural local health departments (LHDs) on community access to care. The findings affirmed that the assurance role was integral for LHDs to maintain during times of transition ensuring clients secured alternative forms of care, as decreased service capacity did interrupt service continuity for rural citizens.

Cross jurisdictional sharing and establishment of new partnerships hold promise for leveraging the strengths of governmental and nongovernmental public health entities to generate needed resources⁵. Partnerships include a broad range of entities, such as federally qualified health centers, rural health clinics, non-profit hospitals, EMS, and charitable clinics. The collaborations among the partners also serve a number of purposes to include cross-training of employees, co-locations of operation, and blending of funding streams. A study⁶ comparing the resources and partnerships across rural, suburban, and urban LHDs found that service delivery, partnerships, and resources varied significantly across locales. Rural and suburban LHDs provide markedly fewer health services on average to their citizens than do urban LHDs, even when controlling for staffing and funding levels. Urban LHDs also have more partnerships with NGOs than rural LHDs. Resources influenced service provision both directly and through the partnerships, indicating that in scarce resource environments, partnerships between LHDs and NGOs may hold positive influence on service provision, in addition to staffing and funding. With the range of issues surrounding our rural public health infrastructure, there is opportunity to strengthen the rural public health workforce.

Workforce Issues

Ensuring trained professionals is imperative to monitoring rural public health. *Healthy People 2020*⁷, *Public Health Workforce Interests and Needs Survey (PH/WINS)*⁸ and numerous other public health reports have identified the need for strengthening the public health workforce as a critical component of infrastructure development. The public health workforce is defined as those persons making up the public health system, inclusive of local boards of health, other governance bodies, and non-governmental organizations and persons outside of health departments. The public health workforce is made up of many diverse professions that include

physicians, nurses, and many others. Not all agencies define these positions in the same way. Enumeration efforts, however, have found the following to be true^{9,10} :

- 40% of LHDs serve rural populations;
- Rural LHD workers are more likely to be employed part-time and less likely to have a formal background in public health;
- Public health department staff require a broad set of competencies- particularly budget management, cross-jurisdictional sharing of resources, and the Health-in-All Policies approach to partnership development;
- Public health training programs remain primarily based in urban environments, drawing and retaining young, geographically mobile rural adults to urban agencies after completing their professional training; and
- Analysis of workforce trends is difficult due to lack of concise national policy on definitions.

A 2015 report by the National Association of County and City Health Officials entitled *Forces of Change Survey*¹¹, detailed the influences and challenges that leaders of LHDs face in response to the evolving public health and clinical environments. Notably, analyses were conducted by comparing across health department population size served, which does not equate to rural. However, important distinctions and similarities were noted between small LHDs and middle-large LHDs:

- Small LHD leaders rated their staff competencies lower than those at middle and large LHDs which may reflect the wide range of roles performed by staff in small LHDs;
- Small LHDs are less likely to have formal workforce development plans in place;
- LHD leaders and staff agree that communication skills are important, but rate policy development relatively low in importance; and
- LHD staff and leaders agree that the Core Competencies for Public Health Professionals are integral for the future LHD workforce¹².

The implications for rural public health workforce training and development are substantial. As the current public health workforce nears retirement, critical leadership and institutional experience are lost. Young adults from diverse backgrounds are needed to comprise a future workforce that will be representative of population demographics, exhibit underrepresented skills, and demonstrate innovative thinking amidst a transformed rural public health environment. A great need exists for increased investment in public health educational programs directed toward the current rural public health workforce to assure a competent workforce into the future. Grow-your-own education models that support on-site learning through both formal and informal training are needed to encourage recruitment and retention of workers who are both public health proficient and culturally-oriented to rural public health practice.

Policy Recommendations

- The NRHA supports enhanced collaboration across local health departments, tribal governments, and non-governmental organizations for the improvement of rural public health.
- The NRHA believes that all citizens and all communities should have comparable access to agencies and individuals that assure the provision of the essential public health services. Whether provided by federal, state, tribal, and/or local governments or the private sector, every citizen has the right to expect access to the full complement of essential public health services in their community.
- The NRHA recognizes that health equity is a common good and that current governmental aims need to be broadened to include geography, in addition to race, ethnicity, disability, gender, and sexual orientation.
- The NRHA supports enhanced training and continuing education of the rural public health workforce that is accessible to them in their rural communities, and appropriate for their current level of training and experience. A key ingredient to assuring adequate public health services is a competent, adequately staffed workforce.
- The NRHA supports strengthening communication systems and technology capacities within the rural public health system in order to effectively foster timely response to public health threats, enhance public health workforce training, and support intersectoral organization collaboration.
- The NRHA supports greater engagement with other national public health-focused organizations (American Public Health Association, National Association of County and City Health Officials, Association of State and Territorial Health Officials, National Network of Public Health Institutes, and National Association for Local Boards of Health) in addressing rural public health.

Conclusions

Advocacy for improved access to the complete range of public health services for rural residents is needed. Local rural public health services are an integral component of comprehensive rural health service access that NRHA continues to fight to fund and preserve. Rural public health services hold particular value amidst our current era when preventable health behavior risks continue to function as the most important determinant of future health status and overall well-being for rural Americans.

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