



Rural Minority Health: *How do we respond to a voice of audacious and unjustified hope?*

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This is a particularly tough topic. Beyond the basic challenges of rural health, we must face disproportionate poverty complicated by our racial and ethnic attitudes; we have a history of interventions that have often fallen short, and most of us are neither a minority nor poor. We need more and better dialogue, however awkward, if we are to see significant improvement in documented poor health outcomes. Until then, rural minority health remains the weakest link in American health care.

As providers, educators and advocates, we have a responsibility to do all of our work as well as we can, including work related to minority health. However, this is a topic that quickly takes many of us into conflicting and strong undercurrents. How do those of us who are not minorities, who are not poor become part of a solution and avoid falling into the extremes of either paternalism or avoidance? I don't know, but for me one place to begin is to consider what I may have to gain from trying.

The following is from a recent lecture by Tim Tyson, a friend (albeit professor) in the Afro-American Studies Department at the University of Wisconsin-Madison. While in the context of Afro-American history and presented in the very finest tradition of southern oratory, I believe he offers one answer to the question of what all of us have to gain in struggling with the challenge of rural minority health:

"There also are those of you, no doubt, who do not think that African American history can speak to you in any deep personal sense. For four hundred years they have struggled for their humanity--and for yours and mine--and we must treat them with respect, and not pretend that their story is our own, or that its primary function is to speak to us. They had their own purposes. But if we acknowledge that the story belongs to them, that it emerges from a specific people and a specific location in history, then we can permit it to speak to us wherever we are."

"The collision with the absurd that black people experienced on these shores, the ongoing struggle for freedom and humanity, this is only a powerful distillation for freedom and humanity, this is a powerful distillation of the eternal human struggle always and everywhere. It speaks to us in a voice of audacious and unjustified hope--daring and unjustified hope."

It is a hope we all need, to feel and experience, regardless of our personal circumstances or history.

Policy discussions frequently misuse racial or ethnic status as a proxy for social-economic status. Ironically, there is something in our tradition that makes it easier for us to acknowledge racial/ethnic differences than the reality of socioeconomic divisions. Maybe it is to say the obvious but I believe there are issues of poverty independent of minority status and issues of minority status independent of poverty. As we work to improve minority health outcomes, we need to be conscious of both the independent and interdependent

effects of race, ethnicity and poverty on health. At the same time, we need to keep in front of us experienced reality--a mother who is poor, who is Hispanic, wants/needs good pediatric services and could care less about talk on whether it was her being Hispanic, poor or both that triggered a barrier to care.

Many of you are familiar with the ongoing toll of negative rural minority health indicators that continually lay claim to our attention but I needed a refresher. The following sample of current research findings is taken from Research Activities, the on-line newsletter of the Agency for Health Care Policy & Research at <www.ahcpr.gov:80/research/>:

Minority children receive fewer medications than white children--"Compared with white children, black and Hispanic children are less likely to receive a prescribed medication for a specific condition and to receive fewer overall prescribed medications, even after accounting for other factors that affect the use of prescription medicines, such as health condition, number of physician visits, and socioeconomic status." (Oct '95)

Wide variations found in hospitalization patterns for blacks and whites--"Whites are hospitalized more often than blacks, and the types of conditions for which black and white patients are hospitalized vary considerably. Black patients were hospitalized more frequently for conditions that often can be avoided by adequate primary care, such as asthma, epilepsy/convulsions, fluid and electrolyte disorders, problem pregnancies, and chronic skin ulcers." (Nov/Dec '96)

High levels of functional disability found among Mexican-American nursing home residents--"Mexican-American nursing home residents are more functionally disabled than non-Hispanic white residents, chiefly because elderly Mexican Americans are burdened by more chronic and acute medical conditions that impair their ability to function." (Jul/Aug '96)

However not all data about racial and ethnic differences reinforce the prevalent findings of lower utilization and higher morbidity/mortality rates. Some "non-intuitive" findings require us to continue to think outside of our conventional wisdom; two examples:

Racial variations found in use of community services by elderly rural residents--The most widely used services are senior centers (13 percent) and places that serve group meals (9 percent). Elderly blacks use both types of services to a larger extent than more economically advantaged whites, who may view these services as a "handout" and the centers as the domain of black people. (Oct '95)

Ethnicity affects individual and family roles in terminal illness--"In France, Spain, Japan, and Eastern Europe, physicians rarely tell patients with cancer their diagnosis or prognosis, usually informing the family instead. In stark contrast, physicians in the United States tell patients the truth about terminal illnesses and involve them in decisions about withholding life support. Korean-Americans (47 percent) and Mexican-Americans (65 percent) are significantly less likely than European Americans (87 percent) and African-Americans (88 percent) to believe that a patient should be told the diagnosis of metastatic cancer and are less likely to believe that the patient should make decisions about the use of life-supporting technology." (Nov/Dec '95)

One of the many obvious challenges we face as a national rural health community is how little institutional leadership reflects the people we serve. The cover story of the December 15th, 1997 issue of Modern Healthcare, "The unchanging FACE of healthcare," notes that 16.5% of U.S. hospital workers were black and 6.7% Hispanic. "And minorities constitute the major population for many of the country's nearly 6,000 hospitals and healthcare facilities. Yet today, only 1% of presidents and chief executive officers managing health service organizations are minorities themselves." NRHA with support from the Office of Rural

Health Policy and other federal agencies has taken action to try to begin part of this imbalance.

A series of working meetings/conferences, most recently this December in Charleston, South Carolina have aimed at developing a better understanding of and addressing the unique health needs of rural minority populations. Until a family event intervened, I had intended to participate in this, the third annual rural minority health working conference sponsored by the NRHA. Consequently, I am indebted to Rosemary McKenzie on the NRHA staff for her timely synthesis of the national implementation strategies and plan of action developed by the meeting's seventy-five participants.

A three part vision statement was developed by the NRHA Rural Minority Health Work Group in February of 1997; recommendations were then developed at the Charleston meeting for each vision statement. These recommendations will be considered as part of the ongoing strategic planning and work plan development of both the NRHA Trustees and NRHA Health Policy Board during 1998. A summary of each vision statement and a sample of related recommendations are as follows:

Information and Data: Currently, there are sparse and inconsistent health-related data on rural minority communities--by the year 2002, there will be adequate data concerning the health status, health care utilization patterns, health care financing and health outcomes for all rural minority populations. NRHA is asked to support achievement of the following:

- Identify a lead agency to "own" the National Rural Minority Health Agenda and move it forward through the mechanisms to maintain focus and cohesiveness. It is recommended that NRHA serves as this owner and leader.
- Develop networked "task forces" as a mechanism to introduce and develop a coordinated and focused approach to address rural minority needs.
- Determine what data exist and identify additional needs and gaps within these data.
- Understanding of the rural minority cultures.
- Involving communities in all phases of the data collection and analysis process.

Health Policy and Practices: By the year 2002, our nation will have achieved a system of health care that provides for multigenerational, rural minority populations. Comprehensive health services will be measured by the level of quality of care being provided, access to essential services and the offering of services that are affordable to rural minority populations. NRHA is asked to support achievement of the following:

- Develop the mechanisms for use by health care delivery systems to achieve comprehensive health care services for multigenerational, minority populations.
- Identify and review existing legislative policies at all levels in order to evaluate their impact on rural minority health care to facilitate reorganization and formation of complementary health care systems.
- Empower the multigenerational, rural minority community to enter into the legislative process as partners in the development of appropriate community health care systems.
- Promote an environment that improves the public health and maintains the safety of rural minority communities through a holistic focus, inclusive of sustained economic development, education, infrastructure and resource management.

- Rural minority issues should be integrated across NRHA's constituency groups. Establish the Rural Minority Health Advisory Committee as a standing committee of NRHA.

Health Delivery Systems: Health care is a right--not a privilege. Given this premise, health care delivery systems must be developed by the year 2002 that substantially improve the health status of rural minority populations. NRHA is asked to support achievement of the following:

- Health care delivery systems must be developed that improve the health status of rural minority communities and are based upon the assessed needs of the community.
- Establish and strengthen "safety-net" health care providers.
- Increase access to culturally and linguistically appropriate health care services and systems to rural minority communities.
- Empower minority health consumer groups and local leaders to become involved with the development of health care delivery systems in their communities.
- Build bridges between existing health care delivery services and other formal and informal community support systems to maximize the efficacy of the local delivery system.

As a first step, the NRHA Trustees have implemented the conference's recommendation to establish the NRHA Rural Minority Health Work Group as a formal standing committee of the Association. I will be appointing several additional members to this committee; please let me know if you would consider volunteering in this capacity. In addition, those of us representing you on the Board of Trustees and on the Health Policy Board would welcome your thoughts and involvement as we strive to integrate the remaining recommendations into our ongoing work.
