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EDITORIAL

The impact of recession on the health care of rural citizens in the northwest United States

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Rural residents in the USA were already at an economic disadvantage before the current recession hit. During the 1980s in states located in the northwest region, specifically Idaho and eastern Oregon, well-paying labor and manufacturing jobs were lost[1], leaving behind higher poverty rates, aging populations, and increased challenges accessing quality health care[2]. This editorial explores needs, quality and access to health care for rural citizens during our current time of economic instability.

In the early 1980s and again in the 1990s, recessions contributed nationally to increased unemployment. Small towns dependent on forestry, mining and agricultural jobs were hit hard with losses due to restructuring and downsizing[1]. As mills and mines closed, loss of income and declines in local tax revenues failed to fund smaller infrastructures. In the current recession, these areas are again losing jobs and there are fewer jobs to lose. Part-time, seasonal, recreation and small independent businesses currently dominate the rural economy[3].

The job losses and lack of new opportunities contributed to population exodus. Recessions forced out young, well-educated families as jobs disappeared, further eroding the social capital of the communities. Current population demographics indicate more citizens living in small towns are over the age of 65 years[4]. In these aging communities, uncontrolled cardiovascular disease, hypertension, and diabetes are less controlled than in their urban counterparts because of challenges such as distance and cost in accessing health care. The young people remaining in small, rural communities suffer higher rates of alcoholism, tobacco use and pregnancy[5,6].

Adding to the disparities made worse by this recession are fewer healthcare personnel living in rural communities. Many physicians, for example, are nearing retirement.

Exacerbating this problem of decreased access to health care is a finding that fewer physicians are training for primary care and fewer physicians and dentists are setting up practice in outlying areas. In the USA, physicians are increasingly turning away public insurance patients (Medicaid and Medicare) due to low reimbursements and excessive paper work. Decreased local access means driving greater distances for healthcare services, thereby increasing costs secondary to gasoline and time. In rural settings, trauma and accidents result in higher morbidities and mortalities due to distances from healthcare facilities, and first responders are generally volunteers[6].

Nurse practitioners (NPs) offer an alternative to physicians for filling gaps in accessing cost-effective provider care. However, barriers identified to full utilization of NPs relate to lack of understanding from the public and other healthcare professionals regarding the role of the NP[7].

Technological innovations also deserve a closer look at filling gaps for healthcare personnel, especially registered nurses[8]. Taking higher education classes to distant residents through visual interactive computer technology may provide a platform to integrate older, distance students into university learning communities without the added expenses of travel and housing. This advantage may contribute to retention of healthcare personnel in their home community upon completion of the degree.

Paying for health care is another obstacle in accessing care. In the US, costs of health care during this economic crisis are increasingly burdensome on personal and public economic stability. This was not always the case. For many years, the US healthcare system has been a major contributor to the economy, as evidenced by the exponential growth of healthcare corporations, commercial insurance companies, and pharmaceutical companies. In the current recession, however, increasing numbers of citizens are losing their health insurance as they lose their jobs. Currently, nearly one in five people living in rural communities are uninsured. Of those who have insurance, one-third purchased it independently from an insurance agent, compared with only 8% nationally. Individual purchase of health insurance costs an average of $2,117 more than the group coverage available through large businesses[3]. The cost of purchasing insurance, however, does not include deductable charges for additional out-of-pocket expenses paid before insurance reimbursements. On average, rural citizens spend 40% more for health care[3]. Finally, Medicaid, the public insurance available for citizens who do not have commercial insurance, does not necessarily provide a safety net because of decreasing acceptance of Medicaid and Medicare by providers.

Rural and remote citizens have enhanced needs in this time of global economic instability. Serious socio-economic inequalities between rural and urban regions, along with limited access to healthcare services, have led to differences in personal health status. Indeed, access and quality are basic aspects of preventive care and maintenance of chronic diseases.

With the expansion of the journal *Rural and Remote Health* to include North America, opportunities exist for increased discussions, research and comparisons regarding rural health care, access, quality, cost, and values. Commonalities, differences and friendships between Canada and the USA provide rich opportunities for research and debate, thereby increasing attention to health needs and quality-of-life issues. Possible questions for future debate might include: What can we learn from each other through focused conversations? How can access and quality be improved for rural residents? Can computer technology impact access to quality health care? Can computer technology expand professional health education opportunities for rural residents? The voice of all citizens must be increased in both state and national forums for the purpose of increasing equitable access to affordable, quality health care.

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