INVITED EDITORIAL

The two Georgias: Disparities in rural health and healthcare

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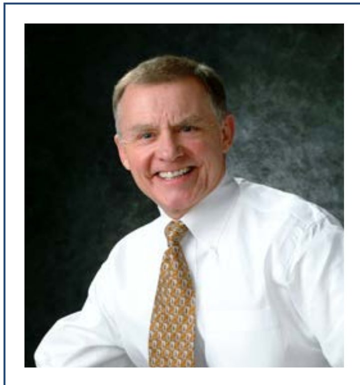
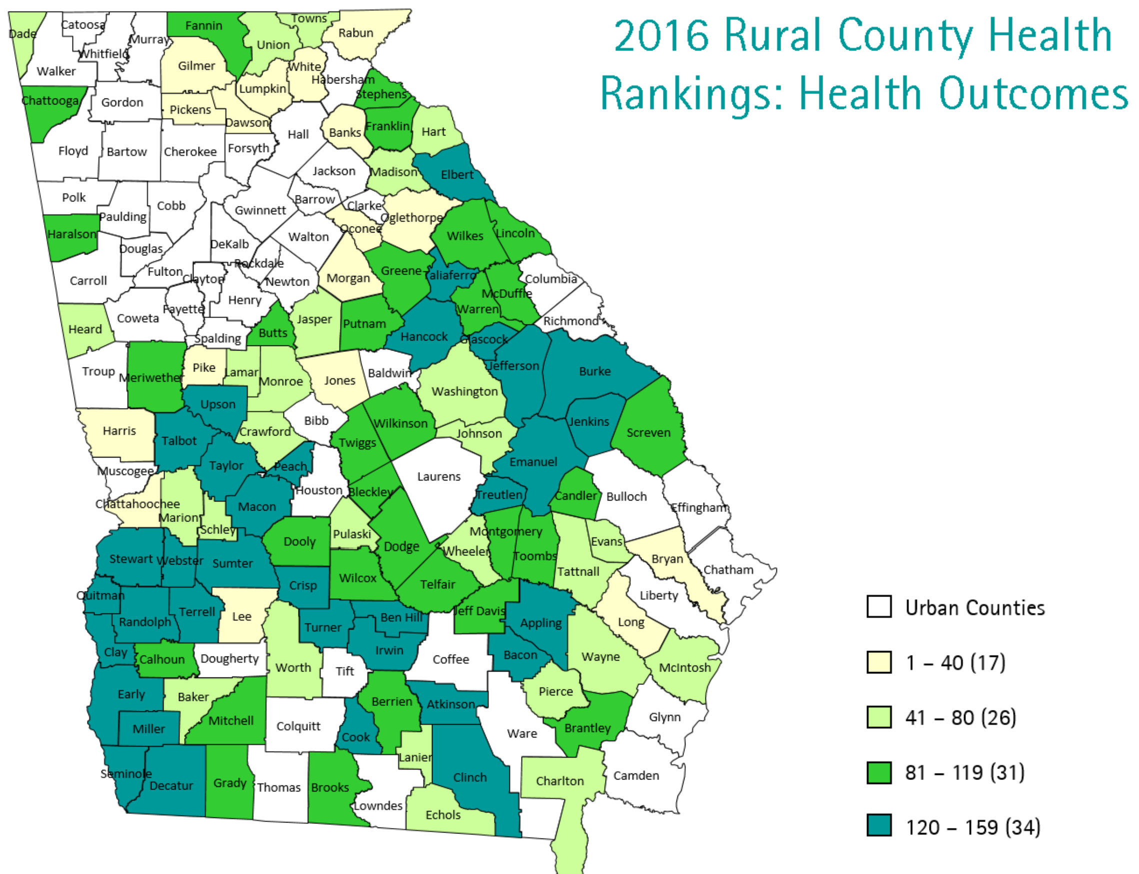
doi: 10.21663/jgpha.5.401



Some years ago, in reference to our state's economy, the claim was made of the existence of two Georgias: one, the vibrant metropolitan areas of our state; the other rural Georgia—its poor economic cousin. Today, this *Two Georgias* distinction applies to the growing disparities in health and healthcare between our metropolitan areas and our rural communities, home to nearly 2 million Georgians. According to the National Institutes of Health (2002), disparities are differences in the incidence, prevalence, morbidity, mortality, and burden of diseases, and other adverse health-related conditions that exist among specific populations. Traveling through the backroads of rural Georgia, a windshield survey reveals challenges in community infrastructure compromised by poverty, unemployment, education, transportation, and a changing demography. The data confirm what is observed: *there is a significant health penalty for living in rural Georgia.*

The 2016 County Health Rankings in Georgia measure health outcomes and health factors among Georgia's 159 counties, of which 108 are defined as rural (Georgia State Office of Rural Health). Among the lowest ranked 120-159 counties, 34 rural counties reported the worst health outcomes. Rural counties comprised 9 of the bottom 10 counties on measures of length and quality of life (University of Wisconsin Population Health Institute, 2016). For 101 rural counties, death rates are above the state average (OASIS, 2014), and 96 rural counties report years of productive life lost above the state average (University of Wisconsin Population Health Institute, 2016) (Figure 1). Addressing health disparities evident in rural Georgia is substantially a *place-based* issue.

Figure 1. 2016 Rural County Health Rankings: Health Outcomes



One's health should not be determined by place of residence or zip code. Yet, rural Georgians represent a population disproportionately experiencing poor health outcomes—higher death rates due to heart disease, stroke, cancer, and motor vehicle accidents; higher rates of smoking; increased prevalence of chronic conditions such as diabetes; and an epidemic of adverse maternal and child health outcomes, including teen births and low birthweight babies.

Rural Georgians report low participation on 8 measures of healthcare access and receipt of preventive services, with rural blacks disproportionately comprising the underserved (South Carolina Rural Health Research Center, 2008). Rural Georgians are deeply entrenched in the conditions that earn them the recognition of living in a *disparity belt*.

Many rural Georgians reside in "medical deserts," where access to affordable, quality healthcare is severely compromised. Since 2001, more than 8 rural hospitals have closed. There are now approximately 54 rural hospitals in our state, and, according to iVantage Health Analytics (2016), it is estimated that 35 rural hospitals are financially vulnerable. If these hospitals were to close, the impact would be the loss of 5,450 healthcare jobs, 600,000 patient visits, and 7,521 community jobs, as well as a loss of $15.3 billion in gross domestic product. Beyond hospitals and the state's 18 public health districts, Georgia's rural health capacity includes 72 rural counties served by federally qualified health centers (Georgia Association for Primary Health Care, 2015), 11 rural counties served by free and charitable clinics (Georgia Charitable Care Network, 2015), and 50 rural counties served by rural health clinics (Centers for Medicare and Medicaid Services, 2015).

Rural Georgia communities are increasingly losing their capacity to *deliver the right care, at the right time, and at the right place*. The traditional models of rural healthcare made possible through legislation decades ago are no longer sustainable. Compromising the delivery of rural healthcare is a growing base of uninsured patients, with 55 rural counties having uninsured rates above the state average (Enroll America, 2016). The shifting healthcare landscape under the Affordable Care Act, coupled with a disruption in payer mix, has essentially eliminated any margin of error for local healthcare providers, who already encounter decreasing rates of reimbursement. Compounding these changes is a rural population in which approximately 60% of residents report experiencing issues with the affordability of health insurance, and 53% directly experience issues with the cost of healthcare (Healthcare Georgia Foundation, 2015).

Shortages in the healthcare workforce across multiple disciplines is endemic. Threatening the potential for a patient-centered medical home are a variety of factors, including the composition, distribution, retention, compensation, continuing education, and retirement of rural healthcare providers. Statewide survey results indicate that 78% of rural Georgians consider their local healthcare workforce shortages as severe (Healthcare Georgia Foundation, 2015). Reflecting this shortage, 93 rural counties are defined as areas with shortages in primary care health professionals; 92 with shortages in dental healthcare professionals, and 98 with shortages in mental health professionals (Georgia Department of Community Health, 2015). A question is: how long will Georgia's healthcare workforce serve as an equalizer as it faces the persistent inequities in health that penalize rural Georgians?

If ignored, our system of delivery of rural healthcare is at risk of collapsing on the shoulders of frail rural communities. With each hospital or rural clinic that closes, or with the departure of a community's only healthcare provider, there are devastating and potentially irreversible consequences for the community. More than 60% of rural Georgians indicate that the impact would be severe in terms of jobs, the community's economic health, and the community's quality of life (Healthcare Georgia Foundation, 2015). These are losses for which there may be no recovery. This delicate relationship between health and economic development is a widely held concern among rural business leaders, representatives of rural chambers of commerce, and rural county commissioners (Healthcare Georgia Foundation, 2016).

Among rural Georgians, there is a prevailing belief "that we can take care of our own." Historically, the social conditions that threaten the health of rural residents have repeatedly generated spontaneous acts of charity. Yet, today this "rugged individualism" and resiliency has been put to the test. Rural Georgians experience higher rates of poverty and persistent poverty, with 44 rural counties being defined as those with persistent poverty (U.S. Census Bureau, American Community Survey 5-Year Estimates, 2007-2011). Rural Georgians experience higher rates of unemployment, with more than 79% of rural counties exceeding the state unemployment rate (U.S. Bureau of Labor Statistics, 2014). Rates of illiteracy are higher in rural Georgia counties (University of Wisconsin Population Health Institute, 2016). This is a reminder that the conditions in which people live, work, and play are determinants of their health and well-being.

Rural Georgia faces many challenges. Foremost among them is the need to create a culture of health and healthcare that eliminates disparities and promotes greater health equity. Nevertheless, rural Georgia is positioned to demonstrate what can be achieved by being an incubator of promising new policies, programs, and collaborative relationships. In the midst of this difficulty lies an opportunity—addressing the role of the social determinants of health. The *Two Georgias Initiative* has identified health disparities as a place-based issue requiring organizational and community leadership capacity, patience, and small steps with a long-term cadence. For Public Health, it's a call for action and efficient adaptions through:

- Recognizing the need for short-term results and having the stamina for long-term impact;
- Holding onto our autonomy, yet looking for strategic opportunities to coordinate and align with others;

- Demanding rigor, insisting on evidence and taking risks despite uncertainty;
- Maintaining some top-down strategy and direction and being willing to let go enough to harness bottom-up opportunities; and
- Embracing what works, recognizing that execution trumps strategy, but looking for creativity and innovation because what we know and do is never enough (Monitor Institute, 2010).

References

Centers for Medicare and Medicaid Services (2015). *Rural health clinics by provider name.* Accessible at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/rhclistbyprovidername.pdf

Enroll America (2016). *Changing uninsured rates by county – from 2013 to 2015.* Accessible at https://www.enrollamerica.org/research-maps/maps/changes-in-uninsured-rates-by-county/

Georgia Charitable Care Network (2015). *Find a clinic.* Accessible at http://charitablecarenetwork.com/?page_id=731

Georgia Department of Community Health (2015). *Health Professional Shortage Area (HPSA) Designations*. Accessible at https://dch.georgia.gov/health-professional-shortage-area-hpsa-designations

Georgia State Office of Rural Health, Georgia Department of Community Health, 2 Peachtree Street NW, Atlanta, GA. Accessible at https://dch.georgia.gov/state-office-rural-health

Healthcare Georgia Foundation (2016). *Listening Tour 2016: Business leader Perspectives on the Relationship between Economics and Health in 22 rural Georgia Counties*. Conducted by Mary Eleanor Wickersham; Publication #98, February 2016.

Healthcare Georgia Foundation (2015). *HealthVoices: Rural Health and Healthcare: 2015 Georgia Poll Results*. Conducted by Matthew Towery, Opinion Savvy LLC; Issue 1, Publication #92, June 2015. Accessible at http://www.healthcaregeorgia.org/uploads/publications/HealthVoices_RuralHealthandHealthcare_2015_poll.pdf

iVantage Health Analytics (2016). *Hospital strength index: State snapshot: Georgia.* Accessible at http://www.ivantageindex.com/georgia/

Monitor Institute (2010). *What's Next for Philanthropy: Acting Bigger and Adapting Better in a Networked World*. Accessible at http://www.monitorinstitute.com/downloads/what-we-think/whats-next/Whats_Next_for_Philanthropy_Snapshot.pdf

National Institutes of Health (2002). *Strategic research plan and budget to reduce and ultimately eliminate health disparities, volume I, fiscal years 2002–2006.* Washington (DC): US Department of Health and Human Services. Accessible at http://www.ncmhd.nih.gov/our_programs/strategic/pubs/VolumeI_031003EDrev.pdf. Accessed February 28, 2013.

Online Analytical Statistical Information System (OASIS) (2014). Georgia Department of Public Health, 2 Peachtree Street NW Atlanta, GA. Accessible at https://oasis.state.ga.us/

South Carolina Rural Health Research Center (2008). *Health Disparities: A Rural-Urban Chartbook*. Accessible at http://rhr.sph.sc.edu/report/(7-3)%20Health%20Disparities%20A%20Rural%20Urban%20Chartbook%20-%20Distribution%20Copy.pdf

The Georgia Association for Primary Health Care (2015). *Counties Served by Community Health Centers*. Accessible at http://www.gaphc.org/health-centers

University of Wisconsin Population Health Institute (2016). *County Health Rankings and Roadmaps*. Accessible at www.countyhealthrankings.org

U.S. Bureau of Labor Statistics (2014). *Local area unemployment statistics – county annual averages*. Accessible at http://www.bls.gov/lau/#cntyaa

U.S. Census Bureau, American Community Survey 5-year estimates (2007-2011). *Rural poverty and well-being.* Accessible at http://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/geography-of-poverty.aspx

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