Health Care Needed For Rural Children

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Steady progress has been made in improving health conditions in recent decades, but chances for good health as adults continue to be less for rural than urban children. Poverty, lack of education, and scarce medical resources are more prevalent in rural areas. Gaps in Government assistance also contribute to reduced opportunities for needed health care among the Nation’s 22 million rural youth.

How Healthy Are Rural Children?

One frequently used indicator of the health environment is the infant mortality rate, the number of deaths of infants less than 1 year old per 1,000 live births. Although the 1976 infant mortality rate was only slightly higher in rural areas (15.7) than in urban areas (15.0), the rate was considerably higher for nonwhite infants (figure 1).

Long-range effects of environment and use of health services on child health are not always immediately obvious. Nevertheless, they play an important role in the child’s emotional, intellectual, and physical development to adulthood. For example, rural and urban youth do not differ in the extent of limitations of activity due to chronic conditions. For older age groups, this is not the case. The 45- to 64-year-olds in rural areas have a 20 percent higher chance to incur limitations of activity due to chronic conditions than urban residents.

Income and Education Impact

Higher levels of poverty and low education in rural areas lead to poor health that, in turn, promotes continued poverty and inadequate education. Therefore, a vicious cycle is set in motion and perpetuated from generation to generation.

In general, children in low-income families are more likely than other children to be in poor health but less likely to receive medical attention. Low-income families have difficulty both in paying for medical services and in obtaining health insurance. High transportation costs also become a major deterrent to obtain adequate care.

Poor children are more likely than other children to develop communicable diseases, which may result in functional disabilities if medical care is not obtained.

Other damaging effects of poverty on health are through poor nutrition, inadequate housing, and sanitation. The nutrients an infant receives affect the structure and functioning of the brain and central nervous system. The most rapid growth in the brain occurs between 3 months before and 6 months after birth. By 3 years of age, 90 percent of the brain’s growth has occurred.
Educational attainment is linked to an individual's use of health resources, including prenatal care. The importance of prenatal care is its role in the prevention of low birth weights and shortened gestational periods, factors associated with increased infant illness and mortality.

Women with limited education are less likely to obtain prenatal care as early in their pregnancy as those with more schooling. For example, 14 percent of women having completed 8 years of school or less sought prenatal care only in the last 2 months of pregnancy or received no prenatal care. This was far above the 2 percent among women having 12 or more years of schooling. This relationship between education and prenatal care suggests that, particularly in rural areas where the educational attainment is lower, a health educational outreach program is of importance.

Adolescent pregnancy has become a prime concern in today's society. When place of residence of the adolescent mother is considered, isolated rural and semi-rural areas experience the highest percent of births to 13- to 17-year-old mothers. For example, from 1971-75, births to this age group were 7.5 percent of all births nationwide. In isolated rural areas, however, 8.6 percent of the births were to 13- to 17-year-old mothers and, in isolated semi-rural areas, 8.8 percent of the births were to mothers in this age group.

Adolescent mothers face a greater risk of both maternal mortality and medical complications (figure 2). Infants of these mothers also face greater health risks. Infants of teenage mothers under 15 years old have a higher rate of low birth weights than any other age group. Low birth weights are associated with almost half the infant deaths and substantially increase the likelihood of birth defects. Adolescents also receive less prenatal care and less pediatric prevention services after the birth of their infants than postadolescents.

Another concern about teenage pregnancy is its impact on the education and future income potential of the mother. More than half of the female dropouts from high school quit because of pregnancy. This often results in low incomes, perpetuating the cycle of poverty, poor health, and low educational attainment.

Medical Services Used Less

Because of the physician's central role in the medical care system, use of physician services is a good indicator of access to medical attention. Children in urban areas have more physician visits per year than rural children. In 1975, metro children under 5 years old averaged 7.2 physician visits compared with 6.2 visits for rural nonfarm children and 3.8 for farm children. Figure 3 shows a similar trend for 5- to 14-year-olds and 15- to 24-year-olds.

The amount of care a pregnant woman receives is also related to her residence (table 1). Women in rural areas consistently have fewer visits than urban women at every educational level. Furthermore, black women have fewer prenatal visits than white women, perhaps reflected in a higher infant mortality rate.

Neglect of dental care in early years may mean lifelong damage. However, dental care is often viewed as an elective and so varies greatly. Children and teenagers under 18 years old in rural areas have about 25 percent fewer dental visits than urban children.

Fewer Medical Services

A major contributor to the lower use of primary medical services in rural areas is the lower availability of medical resources. For example, in 1973, there were only 18 obstetricians and gynecologists per 100,000 of access to medical attention. Children in urban areas have more physician visits per year than rural children. In 1975, metro children under 5 years old averaged 7.2 physician visits compared with 6.2 visits for rural nonfarm children and 3.8 for farm children. Figure 3 shows a similar trend for 5- to 14-year-olds and 15- to 24-year-olds.

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women of childbearing age in rural areas, compared with 48 in urban areas. For pediatricians, there were 11 in rural and 35 in urban areas for every 100,000 children under 15 years of age. Likewise, rural hospitals are lacking in specialized facilities for infants. A 1976 survey of about 6,000 hospitals found that only 23 percent of rural hospitals had premature nurseries compared with more than 40 percent of urban hospitals.

In 1977, about one-fourth of the U.S. population lived in rural areas, but more than half of all medically underserved persons (as defined by the Department of Health and Human Services) lived in rural areas. Researchers found that residents in medically underserved rural areas were most deficient in preventive and prenatal care. A costly outcome of the shortage of primary care services is that injuries and illnesses worsen and require hospital care, or that hospital care is used as a substitute for primary care. Data from a 1973-74 survey show that for children under 17 years old in rural areas, there were 78.4 hospital discharges per 1,000 persons compared with 66.7 for urban youths.

**Government’s Response**

The Government response to the issue of child health care has been programs that provide financial reimbursement for medical expenses incurred, that provide medical services directly, and that provide health maintenance services, such as nutrition programs.

Government spends less per person on infants, children, and teenagers than on any age group, largely because younger people require less hospitalization and other expensive institutional care than their elders. Federal, State, and local governments also contribute a smaller share of all medical bills of youth under 19 years of age (26 percent) than for 19- to 64-year-olds (29 percent) and for those 65 and over (67 percent).

More than half of all public spending directed toward the health of youth is through the Medicaid program, a cooperative program between Federal and State Government designed to pay the medical bills of eligible poor.

Several program characteristics limit the benefits for rural children. Because of State variations, a poor person residing in a State with lower eligibility levels and/or benefits may receive fewer services than a poor person in a State with higher levels and more benefits. In fact, studies have shown that poor Southerners, especially those in...
rural areas, receive fewer Medicaid benefits than those in other parts of the country. In 1976, only 30 percent of the rural poor were covered by Medicaid, compared with 59 percent of the urban poor.

Because Medicaid program eligibility is tied to eligibility in the Aid to Families with Dependent Children (AFDC) program, many children are not covered. For example, in many States, families are only eligible for AFDC when the father is absent. Rural children are more likely to live in intact families than urban poor children, thus are less likely to be eligible for Medicaid. In addition, 17 States do not cover prenatal care for women during their first pregnancy. Proposed legislation would expand Medicaid eligibility to include more children and pregnant women in low-income families.

Several Federal programs help finance State health services for children and mothers with the goal of decreasing infant illness and mortality. Two of these programs, the Maternal and Child Health Services and the Crippled Children Services, especially reach children and mothers in rural areas and in areas suffering from severe economic distress. The formula for distributing program funds to the States is based on the number of children in the State, the rurality of the State, and the socioeconomic status of its residents. State plans for distribution must then be approved by the Federal office. In fiscal year 1979, funding for the Maternal and Child Health Services program was $243 million; for the Crippled Children Services program, funding was $102 million.

A nutrition program administered by the Food and Nutrition Service of USDA is the Special Supplemental Food Program for Women, Infants, and Children (WIC). WIC provides nutritious supplemental foods to pregnant, postpartum, and breastfeeding women and to children under 5 years of age. Nutrition education programs are also supported through WIC. To be eligible for services, the mother and child must reside in an approved project area, be at nutritional risk (defined as inadequate nutrition), and have a low income. The supplemental foods are distributed by local agencies such as health departments, Community Health Centers, Migrant Health Centers, and Indian tribes through retail purchases, home delivery, and direct distribution.

Because of low incomes, many of the migrant population have inadequate diets, but their mobile lifestyle has made participation in the WIC program difficult. As a consequence of a demonstration project conducted for USDA, migrants now can receive WIC assistance at sites other than where they were initially certified after being issued a “Verification of Certification” card.

Future Directions

All children will benefit from basic changes in the medical system. Presently, care provided at a doctor’s office is not as well supported by public programs as is institutional care, and children receive most of their care from doctors’ offices. The present system is also directed toward treatment of injury and illness. The scope of services provided and publicly supported should be broadened to include preventive services. Many costly and debilitating ailments of adults could be avoided or controlled if preventive care were available in their childhood.

Proposals for a national health insurance plan are currently being considered. Some contain several provisions of importance to children. These include prenatal care, delivery costs, and all medical care for mother and infant in the first year regardless of income.

To improve the medical system in rural areas for children and all other residents, a primary problem must be addressed: lack of medical resources. Even if medical care is free for everyone, the health of rural children cannot be greatly improved unless adequate personnel and facilities are available. In many communities, achievement of needed medical resources will entail innovative programs such as employment of part-time physicians or midlevel health practitioners.
Suggested Readings


Information Sources
On Health-Related Programs

Director of Maternal and Child Health, State Health Department, (State Capitol City, State, Zip Code)

Food and Nutrition Service, USDA, Deputy Administration for Special Nutrition Programs, 500 12th Street, SW, Washington, D.C. 20250

Office of Adolescent Pregnancy Programs, 725-H Humphrey Building, 200 Independence Avenue, SW, Washington, D.C. 20201