PRIMARY HEALTH CARE IN URBAN COMMUNITIES pdf

1: Primary healthcare - Wikipedia

Written by academics and community leaders alike, Primary Health Care in Urban Communities details partnerships formed between health professionals, institutions, local governments, and organizations in an effort to provide accessible, acceptable, and affordable health services to underserved populations.

Health Status and Health Care Access of Farm and Rural Populations , states that both farm and rural populations experience lower access to health care along the dimensions of affordability, proximity, and quality, compared with their nonfarm and urban counterparts. Nonmetropolitan households are more likely to report that the cost of healthcare limits their ability to receive medical care. In more remote counties, patients have to travel long distances for specialized treatment. These patients may substitute local primary care providers for specialists or they may decide to postpone or forego care from a specialist due to the burdens of cost and long travel times. According to the report, Access to Rural Health Care - A Literature Review and New Synthesis , barriers to healthcare result in unmet healthcare needs including lack of preventive and screening services, treatment of illnesses, and preventing patients from needing costly hospital care. A vital rural community is dependent on the health of its population. The challenges that rural residents face in accessing healthcare services contribute to health disparities. What are barriers to healthcare access in rural areas? Health Insurance Coverage Individuals who do not have health insurance have reduced access to healthcare services. Uninsured people face barriers to care compared to people with health insurance coverage. Rural uninsured are more likely to delay or forgo medical care because of the cost of care compared to those with insurance. A issue brief from the Kaiser Family Foundation points out that the rural uninsured, when compared to their urban counterparts, face greater difficulty accessing care due to the limited supply of rural healthcare providers who offer low-cost or charity healthcare. The affordability of health insurance is a concern for rural areas. Premium increases tend to be higher where there is less competition among insurers. Workforce Shortages Healthcare workforce shortages have an impact on access to care in rural communities. One measure of healthcare access is having a usual source of care. Having an adequate health workforce is necessary to providing that usual source of care. Some health researchers have argued that determining access by simply measuring provider availability is not adequate to fully understand healthcare access. They contend that access measures should include healthcare service use and nonuse. For example, counting people who could not find an appropriate provider of care. A shortage of healthcare professionals in rural America can limit access to care by limiting the supply of available services. As of September , Primary Care HPSAs are scored on a range from , with higher scores indicating greater need for primary care providers. This November map highlights nonmetropolitan areas with primary care workforce shortages, with areas in darker green indicating higher nonmetro HPSA scores: Distance and Transportation People in rural areas are more likely to have to travel long distances to access healthcare services, particularly specialist services. This can be a significant burden in terms of both time and money. In addition, the lack of reliable transportation is a barrier to care. In urban areas, public transit is generally an option for patients to get to medical appointments; however, these transportation services are often lacking in rural areas. Rural communities also have more elderly residents who have chronic conditions requiring multiple visits to outpatient healthcare facilities. This becomes challenging without available public or private transportation. Social Stigma and Privacy Issues In rural areas, where there is little anonymity, social stigma and privacy concerns are more likely to act as barriers to healthcare access. Residents may be concerned about seeking care for issues related to mental health, substance abuse, sexual health, pregnancy, or even common chronic illnesses due to unease or privacy concerns. This may be caused by personal relationships with their healthcare provider or others that work within the healthcare facility. In addition, concerns about other residents noticing them utilizing services such as mental healthcare can be a concern. Co-location or integration of behavioral health services with primary care can help. This is a particular concern in rural communities, where lower educational levels and higher incidents of poverty often impact residents. To learn more about low health literacy in rural America, see What are the roles of literacy, health literacy, and educational attainment in the health of rural residents? Why

is primary care access important for rural residents? Primary care is the most basic and, along with emergency services, the most vital service needed in rural communities. Primary care providers offer a broad range of services and treat a wide spectrum of medical issues. The American Academy of Family Physicians characterizes primary care as: Some benefits of primary care access are: Preventive services, including early disease detection Coordination of care Lower all-cause, cancer, and heart disease mortality rates Reduction in low birth weight Improved health behaviors Access to Quality Health Services in Rural Areas â€" Primary Care: A Companion Document to Healthy People , Volume 1 , provides an overview of the impact primary care access has on rural health. Rural residents may not get the preventive screening that can lead to early detection and treatment of disease. Limited rural access to primary care is also related to poor health outcomes due to chronic conditions such as diabetes and heart disease. The report also identifies rural primary care access for children as a challenge. What types of healthcare services are frequently difficult to access in rural areas? The committee opinion from the American College of Obstetricians and Gynecologists, Health Disparities in Rural Women , reports that prenatal care initiation in the first trimester was lower for mothers in more rural areas compared with suburban areas. Access to delivery and related services is also a concern with the authors reporting that less than one half of rural women live within a minute drive to the nearest hospital offering perinatal services. Obstetric Services and Quality among Critical Access, Rural, and Urban Hospitals in Nine States , a report on the results of a study to assess the quality of childbirth-related care in different hospital settings, concluded that Critical Access Hospitals performed favorably on obstetric care quality measures when compared to urban hospitals, with some variation across states. Mental Health Services Access to mental health providers and services is a challenge in rural areas. As a result, primary care doctors often provide mental health services while facing barriers such as lack of time with patients and adequate financial reimbursement. Due to the lack of mental health providers in rural communities, telehealth is increasingly being used to provide services. Mental health services delivered via telehealth has been shown to be effective, as reported in a June technical brief from the Agency for Healthcare Research and Quality. By using telehealth delivery systems, mental health services can be provided in a variety of local community settings including rural clinics, schools, residential programs, and nursing homes. A shortage of mental health and substance abuse providers in rural communities has led to new models for providing services using allied behavioral health workers. According to the report, Behavioral Health Aides: Some models of care include: Behavioral health aides as care coordinators Behavioral health aides as support workers Peer counselors and peer specialists Promotoras or community health workers with supplemental training in mental health Oral Health Services Oral health affects physical health, emotional health, and the ability to get a job, both in urban and rural areas. Despite its importance, access to dental services is very limited or difficult in many rural and remote communities. One barrier to oral health access is the fact that most health insurance plans do not cover dental services. According to the National Academies report, Advancing Oral Health in America , a smaller proportion of rural residents have dental insurance compared to urban residents. Another issue limiting access to dental services is the lack of dental health professionals in rural areas. Residents , reports that rural adults used dental services less and had more permanent tooth loss that urban adults, which may be related to the lower supply of dentists in rural areas. The per capita supply of generalist dentists per , population, based on data, was Providing rural training tracks during dental education. Admitting dental students who have a background in rural areas and who are more likely to practice in a rural community. Providing dental students the opportunities to obtain a broad range of dental skills which will be needed in a rural practice. Helping rural communities recruit and retain oral health providers through local community development programs. Substance Abuse Services Despite great need, there is a definite lack of substance abuse services offered in many rural communities. An Assessment of Treatment Quality by Location , reports that rural substance abuse treatment centers, compared to urban centers, had a lower proportion of highly educated counselors. Rural treatment centers also offered fewer wraparound services and specialized treatment tracks. Detoxification is an initial step in treatment of substance abuse that focuses on withdrawal from the substance, minimizing medical complications that may result. The authors of Few and Far Away: This geographic distance is a barrier to care that results in patients who might forgo or delay the treatment that they need. In addition, if a rural area does

not have a detox provider, that service is often delegated to the local emergency room or the local jail which are not the most appropriate location for detoxification services. Access to medication-assisted treatment is also limited in rural communities. Buprenorphine is used to treat opioid use disorder and can be prescribed and monitored in an office-based setting. How do rural healthcare facility and service closures impact access to care? The closure of rural healthcare facilities or the discontinuation of services can have a negative impact on the access to care in the community. Local rural health systems are fragile; when one provider closes, it can impact care and access across the community. For example, if a surgeon leaves, C-section access declines and obstetric care is jeopardized. If a hospital closes, it may be harder to recruit physicians. Factors affecting the severity of the impact of a closure may include: Distance to the next closest provider Availability of alternative services Availability of transportation services Socioeconomic and health status of individuals in the community Traveling to receive services places burden on patients including cost and time. For people with low incomes, no paid time off of their jobs, physical limitations, or acute conditions, these burdens can significantly affect their ability to access care. A significant concern for rural communities losing their hospital is the loss of emergency services. In emergency situations, any delay in receiving care can have serious adverse consequences. Rural health experts believe that rural hospital closures are likely to continue because many rural hospitals have tight operating budgets with little room for financial loss. The report, Change in Profitability and Financial Distress of Critical Access Hospitals from Loss of Cost-Based Reimbursement , discusses how changes in reimbursement to Critical Access Hospitals could have a large negative effect on their profitability and financial stability. If more Critical Access Hospitals across the United States close, rural residents will need to travel longer distances to receive care. The absence of a pharmacy may be disproportionately felt by the rural elderly, who often have a greater need for access to medications and medication management servicesâ€¦Increased distance to the nearest pharmacy may result in decreased access to pharmacy services for this population. Access to medications may be maintained through mail-order, delivery, or telepharmacy; however, providing clinical and in-person consultative services to remote populations may be a challenge. Many strategies are being used to improve access to healthcare in rural areas:

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2: Rural health around the world: challenges and solutions1 | Family Practice | Oxford Academic

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Advanced Search Abstract Despite the huge differences between developing and developed countries, access is the major issue in rural health around the world. Even in the countries where the majority of the population lives in rural areas, the resources are concentrated in the cities. All countries have difficulties with transport and communication, and they all face the challenge of shortages of doctors and other health professionals in rural and remote areas. Many rural people are caught in the povertyâ€" ill healthâ€"low productivity downward spiral, particularly in developing countries. This conference addressed the immense challenges for improving the health of people of rural and remote areas of the world and initiated a specific action plan: The Global Initiative on Rural Health. Rural health around the world: Family Practice ; Introduction The year has passed and clearly we have not attained Health for All. This article begins by outlining some of the challenges facing rural health around the world before reviewing the Health for All target, reflecting on its non-achievement and on the potential role of family practice. Rural health status Around the world, the health status of people in rural areas is generally worse than in urban areas. In South Africa, infant mortality rates in rural areas are 1. This tends to encourage migration from rural areas to the cities. At times, it seems to be assumed that eventually everyone will move to the cities. It does raise the notion that there should be programmes which actively seek to reverse the ruralâ€"urban drift. With the concentration of poverty, low health status and high burden of disease in rural areas, there is a need to focus specifically on improving the health of people in rural and remote areas, particularly if the urban drift is to be reversed. The WHO International Development Programme has highlighted this, with specific objectives for policies and action which promote sustainable livelihoods including access for people to land, resources and markets, as well as better education, health and opportunities for rural people. These objectives seek to contribute to lowering child and maternal mortality, and to improve basic health care for all, including reproductive services. Achievement of this is linked to protection and better management of the natural and physical environment. The emphasis on poverty as well as other social and economic factors has led to a tendency to focus on those issues rather than directly addressing health issues. It results in a greater sense of wellbeing and contributes to increased social and economic productivity. The low health status and variable patterns of illness and injury in rural areas are related not only to poverty. In general, the rates of avoidable deaths in rural and remote areas are higher than in the cities. In countries with established highway systems, country people spend a lot of time driving at high speed and tend to have more serious injuries from motor vehicle accidents. The specifics differ from country to country; however, there are always some illnesses which are peculiar to living and working in rural areas. These include zoonoses, such as hydatids and leptospirosis, as well as other illnesses with animal vectors such as mosquitoes. As a generalization, lifestyle-related illnesses are more common in the rural areas. The peaks and troughs of the economic cycle tend to impinge more directly on rural communities, with economic downturns often placing severe pressure on these communities. Consequently, there are significant levels of stress in a situation where generally counselling, support groups and other mental health services are limited if available at all. Commonly, in rural areas, there is a higher alcohol and tobacco consumption, and standards of nutrition vary when compared with the cities. Rural cultures There tend to be clear cultural differences between rural communities and urban centres and, in many countries, there are significant cultural differences from community to community in rural areas. There is a strong feeling in rural communities that they are different from, and have special qualities not found in the cities. Relationships are seen as personal and enduring; unlimited and unspecified in their demands and imbued with a strong sense of loyalty not only to friends and relatives, but to the community and its members. The city is seen in many respects as bad and inferior, while the small rural community is good and superior. Another aspect of the sociology and psychology of rural communities is the clear sense of behavioural norms which translate into community views of social roles and functions of various members of the community. In many countries, the social roles

and functions are supported by a long tradition and specific religious practices. People in rural communities often value very highly self-sufficiency, self-reliance and independence, coupled with a stoicism which comes primarily from the farming culture. There is very much a focus on getting the job done. Consequently, health is given a very low priority which often translates into the view that medical services and hospitals really are the last resort. In most developing countries, the vast majority of the people are in rural areas, whereas in mostly developed countries the rural population is a relative minority. In all countries, accessibility to rural and remote communities is affected by the physical topography, with mountains, deserts and jungles creating difficulties for transportation, at times complicated by varying climatic conditions. Consequently, in some areas, at least some of the time, there is no means of transportation, and evacuation of critically ill or injured patients is impossible. The standard and quality of communications between different rural and remote areas and between those communities and the urban centres is also very variable. Rural health services Despite the substantial differences between developing and developed countries, the key themes in rural health are the same around the world. Access is the major rural health issue. Even in countries where the majority of the population lives in rural areas, the resources are concentrated in the cities. Generally speaking, in the cities where there are hospital emergency departments and ambulance services, this emergency response is assumed to occur. In rural and remote areas, this cannot be taken for granted, and people tend to be focused on their security need. The provision of health services in rural and remote areas is significantly affected by limited funding and other resource constraints. As mentioned already, in developing countries, there is considerable poverty and limited facilities and resources available for health care. In many developed countries, there has been a trend towards the reduction of funding and infrastructure support for health services in rural and remote communities. Many rural and remote communities bear the cost of global change without the commensurate benefits. Sustainability of these services is dependent on adequate health service infrastructure and availability of specialist support. Drawing together the various aspects of rural morbidity and mortality patterns, and the rural context, it is clear that the development and delivery of health services in rural areas must be specific to the rural context and different from that in the cities. Unfortunately, urban-based policy makers and health service planners often seem to think that the country is just like the city but with a different population distribution, and that it is possible simply to transplant modified urban health services to rural areas. Primary Health Care is the key to attaining this target as part of development in the spirit of social justice. Primary Health Care is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first level of a continuing health care process. The Declaration of Alma Ata outlined a grand vision of primary health care which has not yet been achieved. It clearly has a strong public health emphasis and is much more than primary medical care. In retrospect, there have been a series of problems with the interpretation and implementation of primary health care. The first problem relates to the bureaucratic context. This was well outlined by Judith Justice in her paper: Often primary health care is interpreted differently in different bureaucratic settings and adapted to bureaucratic needs, but not necessarily adapted to the village cultures and conditions. Selective vertical programmes enable the International Aid Agencies to measure results and protect their investments from complicated long-term multisectoral and interdepartmental implementation. Also, they comment that non-government organizations NGOs and religious groups have found that holistic community-based health programmes are generally undermined by narrowly selective interventions and that the sustainability of people-owned initiatives can be put in jeopardy. So clearly this approach of selective vertical programmes often focused on particular diseases has been another problem with the implementation of primary health care. A third problem is the tendency of primary health care programmes to dismiss curative interventions and ignore the desire people have for some help with their immediate health problems. A programme in Nepal, the Nutrition Education Intervention Programme which was evaluated some years ago, did involve some curative intervention. The evaluators found that the inclusion of curative activities in the programme seemed to be a key factor in increasing the motivation of participants and acceptance by the community, so contributing to the success of the programme. As the notions of primary health care were developed, the strong emphasis was on disease prevention and health promotion. That dichotomy and the tension itself has created difficulties. Family

practice In most of the WHO and the other primary health care programmes around the world, there has been little medical involvement in planning other than by specialists in public health or in specific diseases. Implementation in the field has tended not to involve clinicians and particularly not to involve doctors. Family physicians or GPs are the key providers of primary medical care and so essential to successful primary health care. This is true for developed and developing countries alike. She wrote a paper describing how she sees the commonality in family practice in her experience in Nepal with the USA. In , the World Health Assembly could see coming and made new commitments to Health for All Policy for the 21st century. The commitment included in part: It is also important to have the full health team. There is a need not only for doctors but also for nurses and other health professionals, including medical assistants and village health workers who are part of the health team responding to the health care needs of the community. In fact, for the vision of primary health care to be achieved, there needs to be strong and active community involvement. Health systems work best where there is active community participation. This community development approach supports and encourages sustainability of the small rural community, as well as facilitating improvements in health status and outcomes. Dr Neethia Naidoo, local family physician and district medical officer, has a key role in encouraging and facilitating the project. Specific activities are developed in response to demonstrated local needs. In addition, community involvement extends to an active role for the other sectors of the economy in health and development activities. Since , specific achievements include: A school water and sanitation project at 10 of the most needy schools in four villages. A district water reticulation scheme. District Social Welfare and Pension Services. This consists of 22 creches. A Child and Family Welfare Society. At that conference, the rural delegates met to discuss matters related to rural practice. It had a particular focus on rural health in the developing world. The Declaration calls for a combined effort to address the historical inequities facing rural and disadvantaged communities. It recommends that targets be set in stages until the year to reduce substantially all aspects of global poverty, social, cultural, economic, education, nutritional and health. The document calls for affirmative action policies by Government structures at national and regional levels which address the needs of underserved rural areas. It calls for research to inform rural health initiatives and to monitor progress in rural health care. Each conference has been much more than just an International Conference.

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3: Why Primary Care Matters -- Choosing Family Medicine

Primary health care for urban school children: developing comprehensive school health programs for inner-city children--Primary health care curriculum for urban school children: grades KHealth care and community health in the current environment--Transformational leadership development in primary health care--Lessons learned.

Print Friendly The availability of accessible and efficient primary care in rural America is a substantial and growing concern that is heightened by a combination of demographic trends. Physician supply in rural areas is already low, compared to non-rural areas of the country. These areas may be substantially underserved by hospitals and other health care facilities. Demographic shifts, such as the aging rural physician workforce and the growth in the rural elderly and near-elderly population will increase demand for primary care services. One approach to meeting this increased demand that is under consideration in many state legislatures is a redefinition, and often expansion, of the scope and standards of practice for non-physician practitioners. A recent survey found that 41 percent of rural Medicare beneficiaries saw a physician assistant or nurse practitioner for all 17 percent or some 24 percent of their primary care in Scope of practice regulations vary by state. The American Academy of Physician Assistants defines a physician assistant as a graduate of an accredited PA educational program who is nationally certified and state-licensed to practice medicine with the supervision of a physician. Scope of practice is an important issue for all health professionals because it affects their revenue and potential client base. For example, state Medicaid programs pay providers based on the scope of practice standards for that profession. This brief examines the legislative role, provides an overview of existing research, and describes state activity relating to scope of practice. The Problem Estimates of the scope of the provider shortage in rural America vary, but what is generally agreed upon is that thousands of additional primary care providers PCPs are needed to meet the current demand in rural America and that, during the coming decade, tens of thousands of additional PCPs will be needed to meet the growing rural population. Those who obtain regular primary care receive more preventive services, are more likely to comply with their prescribed treatments, and have lower rates of illness and premature death, according to research. Research shows that financial, professional and cultural factors affect where young doctors choose to practice. Another factor compounding the shortage of physicians is that the number of medical graduates who choose to practice rural primary care is insufficient to replace the rural doctors who are retiring. A recent study found nearly 30 percent of rural primary care physicians are at or nearing retirement age, while younger doctors those under age 40 account for only 20 percent of the current workforce. The rural population of those ages 55 to 75 is estimated to grow 30 percent between and due, in part, to retiring baby boomers migrating from urban areas. In addition, the Patient Protection and Affordable Care Act requirement that most people have health insurance will increase demand for health care services, especially for primary care. Some estimates projected an additional 8 million to 9 million rural individuals would be eligible for coverage through Medicaid as a result of the expansion of coverage for those with incomes up to percent of the federal poverty guidelines. For these reasons, states have been working to find ways to increase the number of primary care providers in rural areas. One option under consideration is to expand the scopes of practice for certain non-physician practitioners, thereby permitting these professionals to furnish a greater array of diagnostic and therapeutic services to patients. The Research Studies suggest that access to and the quality of primary care services can be improved and certain costs can be reduced with targeted expansions of scope of practice for non-physician practitioners. However, research also identifies the need for increased educational and licensure standards for providers with expanded scopes of practice, as well as improved data collection in order to increase accountability and ensure quality of care. Here are some brief findings from the research. The IOM also found that nurses working as care coordinators and primary care clinicians can reduce hospitalization and rehospitalization rates for elderly patients. In certain studies, for example, nurse practitioners were found to spend more time in consultation with patients and generate greater overall levels of patient satisfaction. As rural and frontier areas increasingly rely on non-physician practitioners to deliver primary care services, research indicates that these providers need to attain higher levels of training and

education over the course of their careers. In addition, the IOM recommends creating systems for collecting and analyzing workforce data and that future decisions about the scope and standards of practice for non-physician practitioners be based upon the data collected. Physician Assistant Dispensing Authority State Actions Many states have taken steps to increase the procedures, treatments, actions, processes and authority that are permitted by law, regulation and licensure for non-physician primary care providers. For instance, physician assistants may prescribe medication in all 50 states and, according to the National Association of Boards of Pharmacy, 40 states have given physician assistants varying degrees of authority to dispense give or supply to a patient medications to patients; this can be helpful for people who live in rural areas where the closest pharmacist may be many miles away. Another eight states allow nurse practitioners to independently diagnose and treat patients, but not to prescribe medications. The remaining 27 states require either direct or indirect physician supervision of nurse practitioners to diagnose, treat and prescribe. In addition, according to the American Nurses Association, federal law requires that all 50 states provide payment for services furnished by pediatric nurse practitioners, family nurse practitioners and certified nurse midwives for medical services provided under their Medicaid fee-for-service or Medicaid managed care programs. Nurse Practitioner Scope of Practice Authority, Legislative Considerations For states with large rural and frontier areas, finding an appropriate balance between expanding scope of practice for non-physician practitioners while ensuring patient safety, the quality of care and provider accountability are a challenge. Physician groups generally support collaborative or supervisory arrangements with non-physician practitioners. However, these groups generally oppose efforts that allow non-physicians to practice independently. As policymakers grapple with increasing access to quality primary health care, they may wish to examine or re-examine the following issues. Can they practice without direct physician supervision, and under what circumstances? Should the requirements related to the distance between a supervisory physician and a non-physician practitioner be examined for providers practicing in rural areas? If so, what classes of prescription drugs should they be allowed to dispense? Should non-physician primary care providers in remote areas where there is no physician or pharmacist be given broader authority to dispense medications? Should educational and licensing standards for non-physician practitioners be increased in order to meet the growing demands placed upon these professionals in rural areas? Should non-physician practitioners receive lower payment than physicians for comparable services? Should rural providers be reimbursed differently for practicing in underserved areas? State Examples States have taken a number of actions in recent years to expand the scope and standards of practice for non-physician primary care providers, many of which are too recent to see results or properly evaluate. This section includes policy examples from Pennsylvania and Connecticut. Prescription for Pennsylvania Between and , the Pennsylvania General Assembly enacted a large package of health reforms, referred to as the Prescription for Pennsylvania, which included numerous provisions related to the scopes of practice for health professionals such as certified registered nurse practitioners, clinical nurse specialists, physician assistants, nurse midwives and independent dental hygienist practitioners. One law gave physician assistants working under the supervision of a physician the authority to order durable medical equipment and physical therapy, dietician, respiratory and occupational therapy referrals; perform disability assessments for the federal Temporary Assistance for Needy Families TANF program; issue homebound schooling certifications; and perform and sign for the assessment of methadone treatment evaluation. Walk-in clinics, which were then growing in numbers in Pennsylvania and often are operated by nurse practitioners, were the impetus for this expanded scope. This can make legislative decisions very difficult, even for the most informed legislator. Five scope-of-practice changes were reviewed under the new process for the legislative session and one, eliminating a face-to-face supervision requirement for physician assistants, became law. Consequently, many states continue to look at ways non-physician providers can play a larger role in providing primary care in rural areas. Research suggests that, by expanding scopes of practice for non-physician primary care providers such as physician assistants and nurse practitioners, access to primary care services can be improved and the quality of those services will be comparable to that provided by physicians. Expanded scope of practice for non-physician practitioners also could potentially result in decreased costs, although more research is needed in this area to determine whether cost-savings can be

achieved in rural areas. States also will want to develop better ways to measure the effects of expanded scopes of practice on cost, quality and access to care. By attempting to find a balance between using non-physician primary care providers to the fullest extent of their education and ensuring that patients can seek treatment in a safe and cost-effective environment, states can potentially work toward meeting the growing health care needs of their rural populations. Bloniarz, , January Physician and other health professional services Washington, D. What Does the Evidence Tell Us? Are Rural Locations Vulnerable? Department of Agriculture Economic Research Service, Center for Rural Affairs, Leading Change, Advancing Health Washington,. National Academies Press, Naylor and Ellen T. Leading Change, Advancing Health. National Association of Boards of Pharmacy, American Academy of Physician Assistants. American Medical Association, Swankin, Reforming Scopes of Practice: A White Paper Washington, D. Citizen Advocacy Center, July State of Connecticut, State of Connecticut, Nov.

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4: Primary health care - Department of Health

Community participation is seen as the key to Primary Health Care (PHC) but to date is the most difficult and least understood principle. To assist health planners to implement PHC programmes, three simple questions can be asked: why participate? who participates? how do they participate?

March 27, DOI: METHODS In , semistructured interviews were conducted with 19 rural primary care physicians in central Pennsylvania regarding their experiences in two domains of preventive reproductive healthâ€”contraceptive care and preconception care. Major themes were identified using a modified grounded theory approach. RESULTS Physicians perceived that they had a greater role in providing contraceptive care than did nonrural physicians and that contraceptives were widely accessible to patients in their communities; however, the scope of contraceptive services they provided varied widely. Participants were aware of the importance of optimal health prior to pregnancy, but most did not routinely initiate preconception counseling. Physicians perceived rural community norms of unintended pregnancies, large families, and indifference toward career and educational goals for young women as the biggest barriers to both contraceptive and preconception care, as these attitudes resulted in a lack of patient interest in family planning. Lack of time and resources were identified as additional barriers to providing preconception care. Efforts to motivate rural women to engage in reproductive life planning, including more proactive counseling by providers, merit examination as ways to improve use of services. Women in rural areas are less likely than urban women to receive contraceptive services 1,2 and Pap smears. Challenges to providing reproductive services in rural areas include relatively high rates of poverty, 6,7 difficulties related to the long distances that many women have to travel to access services, 8 lack of privacy in small communities with few providers, 9,10 and community attitudes such as conservatism and stigma associated with sexuality. On the other hand, given scarce health-related resources, they may view their role as important for promoting preventive reproductive health care. Our goal is to identify strategies for improving preventive reproductive health care for rural women. We focus on two types of services for women of reproductive age: The need for contraceptive services to prevent unintended pregnancy is well established. In , an estimated 36 million U. However, in our previous work, women in rural central Pennsylvania were significantly less likely than their urban counterparts to report having received birth control information or counseling in the past year. On the other hand, the majority of rural primary care providers are family practitioners and received obstetric training during their residencies, 17 which could make them comfortable delivering preconception and other pregnancy-related care. This study was approved by the institutional review board at the Penn State College of Medicine. Rural central Pennsylvania consists of a range of communities from midsize and small towns to isolated rural areas. We included obstetrician-gynecologists with no subspecialty who identified themselves as primary care providers, because in many locations, women of reproductive age obtain primary care from their obstetrician-gynecologist; 20 physicians in Veterans Affairs practices were excluded. Our sample was limited to practices located in rural zip codes or in zip codes immediately adjacent to rural ones on the assumption that women in most rural areas travel to adjacent areas for their health care. We based our definition of rural zip codes on the Rural Urban Commuting Area RUCA codes, census tractâ€”based classifications that take into account measures of population density, urbanization and patterns of daily commuting flow. We considered RUCA codes 7â€”10 to be rural zip codes and 4â€”6 to be adjacent ones. Using these definitions, 85 physicians from rural zip codes and physicians from zip codes adjacent to rural ones met the inclusion criteria. In response to this letter, 12 physicians contacted us to volunteer to be interviewed and were enrolled in the study. We then telephoned eligible physicians who had not responded to the initial mailing, giving priority to those in the rural zip codes. We did not call all physicians who had not responded to the mailing, as we reached thematic saturation at the completion of 19 interviews. No physicians outright refused to participate. All interviews were audio-recorded and professionally transcribed. The physicians were then asked questions covering four main topic areasâ€”cancer screening, preventive reproductive health, intimate partner violence and mental healthâ€”and were asked to focus their responses on their experiences providing primary care for

adult rural women. In this article, we present data from the preventive reproductive health section, which addressed contraceptive and preconception care. Analysis We calculated frequencies for demographic characteristics of the primary care providers. For the qualitative analysis, two members of the research team independently analyzed each transcript using a modified grounded theory approach to identify themes related to the topics discussed. Grounded theory is a systematic approach to qualitative analysis emphasizing the formation of concepts and theories that are grounded in empirical observations in the data. The team then jointly decided on the major themes, for which there was full agreement. We present representative quotes from the participants to illustrate the themes. The NVivo8 software package for qualitative data was used to group the responses into appropriate theme categories. RESULTS Of the 19 participants, 12 were trained in family practice, five in internal medicine, one in general practice and one in obstetrics and gynecology. The sample comprised 10 men and nine women. Practices ranged from solo private practices to hospital-owned multispecialty groups and were located in 15 of the 28 counties in the target region; eight were in rural zip codes, and 11 in areas adjacent to rural zip codes. The median number of years in practice was 21 range, 1â€” Most participants had been in the same practice for their entire career, and only two had worked in urban locations. The predominant reason physicians gave for practicing in a rural area, cited by 11 participants, was that they had grown up in a rural area, often the one where they currently practiced. Other reasons were that physicians were fulfilling a visa requirement or a commitment to the National Health Service Corps or a loan repayment program. Furthermore, the telephone and in-person interviews yielded the same amount of data, and the same themes were identified in both, so we concluded that the data quality was the same for both types of interview. Overall, participants perceived that their patients were more likely to seek contraceptive care from primary care providers than were patients in urban settings. For example, a female internist, who had previously worked in an urban area, stated: I was used to any contraceptive issues always went to the gynecologist. However, the amount of contraceptive care they provided varied widely. One physician provided no contraceptive services because of lack of comfort and interest; others were willing to provide oral contraceptive prescriptions to women already using the method, but were not comfortable giving a prescription to a new user. Still others provided more comprehensive contraceptive care e. Providers acknowledged the importance of optimal health prior to pregnancy and were aware that women may benefit from guidance in planning for pregnancy, but they tended to focus on contraceptive or prenatal care. Physicians who provided these components of care expressed that doing so is an important way to inform women about how pregnancy can affect their health. A male family practitioner explained: About half reported trying to initiate conversations about preconception care in certain situations, most commonly when performing routine Pap smears or when discussing contraception with younger women. None reported providing dedicated preconception care visits. Physicians did not consistently initiate preconception counseling because they did not prioritize it, they did not feel it was their role to do so or, in some cases, they were uncertain what they could offer. Overall, physicians felt that, given their own practices and local family planning clinics, access to contraceptive care was not a problem in their communities. One female family physician commented: I think more the barrier is probably just not understanding the importance. The physicians perceived an overall shortage of obstetrician-gynecologists in their communities, and only one participant an obstetrician-gynecologist provided IUD and sterilization services. Nevertheless, they did not think it was difficult for women to obtain referrals for these services, although they acknowledged that some women might have to travel considerable distances for them and that access to sterilization was particularly limited for patients without insurance or on medical assistance. Participants all agreed that pharmacy access to contraceptives was adequate in their communities. Notably, none brought up emergency contraception availability when discussing pharmacy access. This perception is illustrated in comments from a female family practitioner: A female internist said: They are not looking for a career. This perceived lack of interest in life planning was also described as a barrier to preconception care. They just think that it happens, just like that. The second most optimal place would be in the schools. Primary care physicians tended to report that patients preferred to obtain contraceptive services from gynecologists, female physicians or family planning clinics, rather than from male primary care providers. One male internist reflected that he had been providing less and

less contraceptive care over the years, and he cited three reasons for this shift: Specifically, physicians described lack of access to obstetricians with training in managing high-risk pregnancies who may assist with preconception care, or endocrinologists who may assist with management of diabetes. A male family practitioner remarked: They commonly cited diabetes, hypertension, seizure disorders and depression as conditions that would need particular attention. Comments from one male family practitioner illustrate this perspective: But to be honest, I would probably just limit [preconception counseling to those situations]. Or if they have risk factors for pregnancy, [those risk factors] should be eliminated before. However, only one participant specifically mentioned congenital malformations as an important adverse consequence of poorly controlled diabetes during pregnancy, which she routinely counseled diabetic reproductive-age women about as part of preconception care. DISCUSSION In this sample of primary care physicians practicing in rural central Pennsylvania, the greatest perceived barrier to providing preventive reproductive health care was community norms that do not support family planning. Several physicians described low community expectations for young women to pursue higher education or careers, which they felt resulted in low prioritization of family planning. While physicians expressed disapproval of these norms, they did not see it as their role to confront them or try to empower women with regard to their reproductive options. Rather, they took a passive stance with regard to their role as providers of contraceptive and pregnancy planning services, and did not engage in more active counseling methods that can be effective in promoting reproductive health. The key implication of these findings is that the traditional focus on increasing access to contraceptive and pregnancy planning services would not improve the use of contraceptive services or preconception care in communities where such attitudes predominate. Rather, overcoming attitudes such as indifference to family planning and perceptions that one cannot control pregnancy outcomes is essential to improving use of services. In our sample, physicians uniformly believed that access to contraceptive services in their rural communities, either through their own practices or through family planning clinics, was sufficient. This was surprising, given that several participants reported not providing comprehensive contraceptive care themselves, and most rural communities suffer from a shortage of obstetrician-gynecologists. While preconception care clearly is not yet a routine part of preventive primary care in these rural communities, it is unclear whether this finding is specific to rural areas. Limitations Our study has certain limitations. Although we interviewed a diverse group of primary care physicians in our target rural region and believe that we reached thematic saturation, the 19 study participants may not represent the experiences or opinions of all primary care physicians in the region, and the small sample size did not permit formal comparisons across specialty areas. Additionally, the findings may not be generalizable beyond this particular rural area, which has a largely non-Hispanic white population. Conclusions Previous efforts to increase contraceptive use and reduce unintended pregnancies have largely focused on improving access to care by increasing availability of providers and reducing financial barriers to services. Raising public awareness of the importance of pregnancy planning and good preconception health is needed. Our findings point to the importance of encouraging primary care physicians to take a more proactive role in promoting preventive reproductive health care. This could be accomplished through continuing education programs and skills-building workshops to increase provider knowledge about and self-efficacy for reproductive health counseling in rural communities. Chandra A et al. Coughlin SS et al. Bird K et al. Chronic Poverty Research Centre, , No.

PRIMARY HEALTH CARE IN URBAN COMMUNITIES pdf

5: Primary health care delivery models in rural and remote Australia â€“ a systematic review

Why is primary care access important for rural residents? Primary care is the most basic and, along with emergency services, the most vital service needed in rural communities. Primary care providers offer a broad range of services and treat a wide spect.

Residency Program Solutions Why Primary Care Matters The evidence shows that access to primary care helps people live longer, healthier lives. Studies suggest that as many as , deaths per year www. What is primary care? The Institute of Medicine www. Patients with access to a regular primary care physician have lower overall health care costs than those without one, and health outcomes improve. Better Health Care Primary care is the backbone of the health care system. Utilizing primary care physicians puts an emphasis on the physician-patient relationship by shifting the focus from physician-centered care to patient-centered care. An increase of one primary care doctor per 10, people has been shown to result in: Evidence shows that primary care, in contrast to specialty care, is associated with a more equitable distribution of health in populations--a finding that hold in both national and international studies. Lowering the Cost of Health Care A primary care-based system may cost less because patients experience fewer hospitalizations, less duplication of treatment, and more appropriate use of technology. Medicare spending is lower in states with more primary care physicians, and these states also report more effective, higher-quality care. At the Center of Primary Care Family medicine aims to reintegrate and personalize health care for patients, who are increasingly frustrated with the fragmented and complex health care system. It is a deviation from physician-centered traditional models of care, such as specialist care. The family medicine model of care seeks to provide patients with a personal medical home through which they receive a full range of services within the context of a continuing relationship with their family physician. Family physicians deliver acute, chronic, and preventive care, either directly or indirectly through established relationships with clinicians outside their practice. What Family Physicians Do Care for patients regardless of age or health condition, sustaining an enduring and trusting relationship. Navigate the health care system with patients, including specialist and hospital care coordination and follow-up. Use data and technology to prioritize and coordinate services, enhancing access, continuity, and relationships. Care for patients in the context of their family and the ways in which the health of each family member affects the others. Understand the effects of community-level factors and social determinants of health, helping patients to identify community resources available.

PRIMARY HEALTH CARE IN URBAN COMMUNITIES pdf

6: Community Health Center Overview

CAHS Primary Health Care Branch provides comprehensive primary health care to urban and remote Central Australian communities. Services are provided with support from town-based and visiting allied health professionals, public health nurses, diabetes and chronic disease educators, child health nurses and wound specialists.

This article has been cited by other articles in PMC. Abstract Background One third of all Australians live outside of its major cities. Access to health services and health outcomes are generally poorer in rural and remote areas relative to metropolitan areas. In order to improve access to services, many new programs and models of service delivery have been trialled since the first National Rural Health Strategy in Inadequate evaluation of these initiatives has resulted in failure to garner knowledge, which would facilitate the establishment of evidence-based service models, sustain and systematise them over time and facilitate transfer of successful programs. This is the first study to systematically review the available published literature describing innovative models of comprehensive primary health care PHC in rural and remote Australia since the development of the first National Rural Health Strategy â€" The study aimed to describe what health service models were reported to work, where they worked and why. Methods A reference group of experts in rural health assisted in the development and implementation of the study. Peer-reviewed publications were identified from the relevant electronic databases. Data were extracted and synthesised from papers meeting inclusion criteria. Results A total of abstracts were reviewed. Synthesis of extracted data resulted in a typology of models with five broad groupings: Different model types assume prominence with increasing remoteness and decreasing population density. Conclusion Synthesised data suggest that, moving away from Australian coastal population centres, sustainable models are able to address diseconomies of scale which result from large distances and small dispersed populations. Based on the service requirements and enablers derived from analysis of reported successful PHC service models, we have developed a conceptual framework that is particularly useful in underpinning the development of sustainable PHC models in rural and remote communities. Of this non-metropolitan population, almost twenty percent is dispersed across more than 1, rural and remote communities with fewer than 5, residents. Almost three-quarters of these small communities lie in the rural and remote areas furthest from large population centres [2]. More than one-third of these small communities are losing population and experiencing economic hardship [3 - 5]. People living in small rural and remote communities of Australia face significant health disadvantage. Generally, mortality and illness levels increase with distance from major cities [1]. Moreover, these communities are characterised by higher hospitalization rates and higher prevalence of health risk factors compared with metropolitan areas [1 , 6 , 7]. These rural and remote communities are further disadvantaged by reduced access to primary health care PHC providers and health services in part a function of health and medical workforce shortages , leading in turn to lower utilisation rates than in urban areas and consequent poorer health status for rural residents [1]. Often these isolated rural and remote communities are too small to support traditional models of health delivery locally, so residents must access care from larger urban centres. Unfortunately, access to health services provided in larger centres remains a problem for many residents of isolated settlements. In many cases, their inability to access health services when required results in health needs not being adequately met, lack of continuity of care and an absence of monitoring of the effectiveness of services in terms of health outcomes [1]. In order to address these access and service problems, specific measures targeting rural health featured in annual national government budgets from the early s. Since the Commonwealth has made two major budgetary commitments to rural health: These initiatives constitute a series of workforce enhancement measures, principally targeting the medical workforce. Policy-makers are under increasing pressure to strengthen the link between evidence, policy development and program implementation. Although numerous approaches and models of service delivery have been trialled in rural and remote areas since the first National Rural Health Strategy, inadequate evaluation of these initiatives has resulted in failure to garner knowledge, which would facilitate the establishment of evidence-based service models, sustain and systematise them over time and facilitate transfer of successful programs to other jurisdictions [12 - 14]. The objective of this

research was therefore to systematically review the available published literature describing innovative models of comprehensive primary health care in rural and remote Australia since the development and publication of the first National Rural Health Strategy in order to identify what rural and remote primary health care models work well, where and why. Methods Whilst systematic reviews of mixed qualitative and quantitative papers aimed at informing policy can be complex and do not always accord with a pure methodological approach, our experience shows how they can still be conducted rigorously and effectively within constraining circumstances [15]. To assist in the development and implementation of the study a Reference Group was formed, comprising eleven recognised experts in rural and remote health, health economics, consumer issues, evaluation, PHC service provision and government policy making. Two international health services researchers were included in the Reference Group. This paper addresses two key aspects of the systematic review. What were the key remote and rural PHC models in Australia since the first National Rural Health Strategy, and what specific structural or financial issues did they address? Secondly, what are the characteristics of appropriate PHC service models for rural and remote Australia? The research questions and relevant search terms were developed iteratively, in consultation with the Reference Group, and refined during the literature search process. The search for and review of literature was divided across two research sites â€” one rural and one remote â€” based on familiarity with specific literature.

7: Primary Health Care in Urban Communities

Note: Citations are based on reference standards. However, formatting rules can vary widely between applications and fields of interest or study. The specific requirements or preferences of your reviewing publisher, classroom teacher, institution or organization should be applied.

Specifically, considering what is fair and reasonable in a relatively wealthy country such as Australia, what PHC services should residents of different-sized communities, located in different geographical locations, be able to access from resident health workers as opposed to some alternative means of delivery such as visiting or tele-health services? While this is difficult and relatively uncharted research, answers to this question can assist policy makers and service planners to plan PHC service provision more equitably, thereby improving access to core PHC services for residents of rural and remote communities. In the absence of comprehensive national data or evidence relating to the health and cost-effectiveness of different modalities of providing PHC services, answers to this key question may be subjective. Responses are likely to vary according to the perspective of different stakeholders. Nonetheless, it is important to ascertain the extent to which some common agreement can be obtained about which core PHC services residents of different sized communities should be able to expect to be available locally. Method A Delphi method was used to determine consensus among rural and remote health experts in relation to differing population thresholds at which each of the core PHC services should be provided by resident health workers. Based on successive iterations, email surveys were used, thereby allowing the participation of a wide range of experts from across Australia without them having to meet face-to-face [18 , 19]. Email surveys are quick and easy to administer, provide simple means to communicate with panellists and can result in high quality data collection [20]. Importantly, too, email surveys allow the ready participation of many different stakeholders who are widely dispersed across large geographical areas, in contrast to the high costs and sometime reluctance to travel associated with engaging them face-to-face. Researchers collated and returned the results allowing panellists to re-evaluate and adjust their previous responses in light of those of their peers. Iterations continued until the group reached some consensus or level of saturation. Resulting anonymity prevented dominance by any individual and allowed all opinions to be considered [21]. In pursuing this research, the Delphi method was considered the most appropriate as the subject is complex, opinions are varied and there is a scarcity of published literature on the topic. The 28 member Delphi group used here was a subset of a larger Delphi group of 39 experts that had been engaged in previous research on the core PHC services [17]. Selection of individuals was based on their knowledge, experience and length of time working in the field of rural or remote health. Attention was paid to ensuring wide representation from areas of policy, the academic community, clinical practice and consumer representation. All states and territories were represented and members of key rural and remote health organisations were included. Potential panellists received a participant information statement with a letter of invitation. Informed consent was implied as panellists completed the first survey. Population cut-offs, based on previous research measuring access to PHC services [22 , 23], were deemed sufficiently sensitive to enable participants to differentiate population thresholds in relation to need for, and requirements of, different PHC services. Communities with populations more than were not included as it was assumed that in Australia these have access to resident health workers for all core PHC services. Participants were asked to consider PHC services for both rural and remote settings. There exists a vast literature distinguishing rural and remote. For the purpose of this study, remote communities were described as communities with small populations, located at a considerable distance from larger centres, usually in sparsely populated regions. These communities often have a high proportion of resident Indigenous Australians and a high degree of isolation ASGC categories 4 and 5. Panellists answered separately for both rural and remote communities. In the absence of firm rules for defining a consensus [25], this study adopted the following: Secondly, discussion focussed on reaching a consensus on population thresholds for resident service providers for each of the illustrative core PHC services in both rural and remote communities of different sizes. During the face-to-face meeting notes were taken by three research facilitators. Emerging themes were individually developed and

compared for consistency. Results Twenty eight experts were invited to participate in the first round of the Delphi group. Two survey rounds were completed between October and March

PRIMARY HEALTH CARE IN URBAN COMMUNITIES pdf

8: Urban Versus Rural Health - Global Health University

Australians in rural and remote areas experience poorer health status compared with many metropolitan residents, due partly to inequitable access to primary health care (PHC) services. Building on recent research that identified PHC services which all Australians should be able to access regardless.

Consulting Urban Versus Rural Health In recent years there has been a renewal of interest in geographic characteristics within public health, particularly in the areas of international health and community development. Past research has documented a difference between urban and rural health care, usually expressed in terms of healthcare access and utilization, cost, and geographic distribution of providers and services. By utilizing a framework that examines determinants of health, researchers can identify environment-specific factors that may contribute to different health outcomes for urban and rural residents. This focus on the environmental and social determinants of health has accompanied a rapid change in rates of urban populations across the world. The rapid urbanization of the 20th century reflects changes in global political, economic, and social forces. As more people worldwide live in cities, it is imperative to understand how urban living affects population health. Does urban living negatively affect health? Can urban living enhance population health and well-being? This article first examines determinants of heath in urban versus rural contexts and then outlines several emerging problems caused by rapid urbanization. Urban Context The social environment: Urban environments are more likely to see large disparities in socioeconomic status, higher rates of crime and violence, the presence of marginalized populations e. In densely populated urban areas, there is often a lack of facilities and outdoor areas for exercise and recreation. In addition, air quality is often lower in urban environments which can contribute to chronic diseases such as asthma. Lack of basic infrastructure can exacerbate rates of infectious disease and further perpetuate the cycle of poverty. Access to health and social service: Persons of lower socioeconomic status and minority populations are more likely to live in urban areas and are more likely to lack health insurance 7. Thus, these populations face barriers to care, receive poorer quality care, and disproportionately use emergency systems. Other commonly represented populations in cities are undocumented immigrants and transient populations. The high prevalence of individuals without health insurance or citizenship creates a greater burden on available systems. Rural Context The social environment: In the United States, rural elders have significantly poorer health status than urban elders. Instead, these challenges call for a social perspective with a focus on prevention and a healthy lifestyle. Despite negative health behaviors, many aspects of rural social life contribute to positive health outcomes. Similar issues exist in the developing world. The problem of youth pregnancy stems from the larger issues of rural versus urban access to education, health services, and employment. Rural women in the United States, especially less educated women, are more sedentary than urban women. While poor air quality and crime rates are likely to be less of an issue in rural areas, insufficiencies in the built environment make it difficult for rural residents to exercise and maintain healthy habits. Evidence indicates that rural residents have limited access to health care 14 and that rural areas are underserved by primary care physicians. However, this is rarely true. Research about the features of urban areas that influence health has been relatively sparse but often indicates increased health hazards. With the onset of modernization it was thought that the burden of disease would shift from infectious to chronic causes. In the past, most deaths were caused by infectious diseases, degenerative diseases, and violence; thus, people did not often live long enough to be afflicted by chronic causes of death such as heart disease and diabetes. This double burden is often present in areas that have experienced rapid urbanization. Throughout most of human history, populations were not large enough to sustain highly transmissible infectious diseases for long periods of time. Now, however, this is no longer the case. Because people are living closer to one another in often unsanitary environments, the potential for infectious disease transmission is much higher. In addition to higher rates of infectious diseases, rapid urbanization has led to poor living and working conditions, and thus more chronic diseases. For example, poor urban individuals who live in moldy apartments are more likely to be afflicted with asthma. Furthermore, overworked factory employees are more likely to suffer from work-related injuries and environmental

pollution. To understand urban health and the phenomenon of urbanization, we must shift our focus away from disease outcomes and toward urban exposures, namely, the characteristics of the urban context that influence health and well-being. This can include methods relevant to the study of urban health including epidemiology, health policy, and urban planning. In addition, practical issues for developing healthy cities should be addressed, such as preventive strategies, the provision of health services, and education. Footnotes 1 Hartley DA. Rural health disparities, population health, and rural culture. Am J Public Health. The City in History: Harcourt, Brace and Company; Qualifying urban areas for census Federal Register Part 7. Time for a national agenda to improve the health of urban populations. To mitigate, resist, or undo: Acute effects of summer air pollution on respiratory symptom reporting in children. Gender differences in health care access indicators in an urban, low-income community. A comparison of health status between rural and urban adults. A national call to action: Health in rural America: Remembering the importance of place. American Journal of Public Health. Urban Access to Health Services. Accessed September 14, Journal of Epidemiology and Community Health. Health Resources and Service Administration, A projection of the primary care physician population in metropolitan and nonmetropolitan areas. Agency for Health Care Policy and Research; Common beliefs about the rural elderly: Vital Health Stat 3; Urban and rural differences in health insurance and access to care. Journal of Rural Health. United Nations Population Fund, Urbanization and human health. High prevalence disorders in urban and rural communities. Aust N Z J Psychiatry.

9: Meeting the Primary Care Needs of Rural America: Examining the Role of Non-Physician Providers

National Health Service Corps Loan Repayment Program ($ million) provides 3, new awards and 2, one-year continuation awards to fully trained, licensed primary care clinicians in exchange for providing primary health care services in an area of greatest need.

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