*Chapter Seventeen*

# Rural Areas

## MYTH NO. 17: SINGLE-PAYER NATIONAL HEALTH INSURANCE WOULD BENEFIT RESIDENTS OF RURAL AREAS

What we know about who gets care and who does not under nonprice rationing schemes is incomplete. However, geographical variations in health care resources and health care outcomes exist.[1] Despite extensive efforts to combat geographic disparities in access to medical services, Canada, Britain, New Zealand and Australia all have medically underserved areas.[2]

Waiting times are longer in rural areas, principally because advanced medical equipment is in short supply there. Such technology, which is expensive, is often available only at major hospitals in large cities. In addition, since care is given only to patients who are available when an opening occurs in the surgery schedule, rural patients are at a considerable logistical disadvantage. Urban patients, who live close to medical facilities, benefit most from public provision. Their rural counterparts often have to travel hundreds of miles just to receive treatment. So, in using waiting as a rationing device, public systems indirectly discriminate against rural patients.

Even in urban areas, as we have seen, success in obtaining care often depends on the politics of bureaucracy. A patient treated by a physician in a rural area will tend to be at a disadvantage vis-à-vis a patient represented by a physician who lives nearby and is a colleague of the hospital staff. Urban patients also have access to political and personal relationships that may be important in dealing with bureaucratic obstacles—relationships rural patients seldom have.

## RURAL PATIENTS IN BRITAIN

Britain is one of the few countries that publishes hospital waiting lists by region and for the country as a whole. Yet, in Britain, as in other countries with single-payer systems, rationing decisions are made by doctors and hospital personnel at the local level. No national procedures guarantee that those in greater need move to the front of the waiting lines.

The most important philosophical principle set forth by those who established the British NHS was equal access to health care. Yet, as we noted above, inequalities across England persist and may even have grown worse since the NHS was founded in 1948. The British government tends to spend the most in metropolitan areas—especially the wealthier urban districts—where private sector alternatives are most abundant. For example, the NHS spends 20 percent of its annual budget on the greater London area, although the 15 percent of the population living there has access to the most private sector services. Nonetheless, there are persistent pleas to allocate even more resources to the London area.[3]

Overall, the quantities of resources allocated to different regions of the country are vastly different.[4]

- The North East Thames region (near London) has 27 percent more doctors and dentists per person, 15 percent more hospital beds and 12 percent more total health spending than the Trent region (in the more rural northern part of the country).
- There are 63 doctors per 100 beds at University College Hospital Trust in London, compared to 11 doctors per 100 beds at the hospital in Northern Devon, a rural area in southern England.
- At Chelsea and Westminster Healthcare Trust, located in one of London's most prosperous districts, there are 64 doctors per 100 beds, compared to only 18 doctors per 100 beds at Pinderfields Hospital in rural West Yorkshire.

These differences in resources reinforce regional disparities in the levels of care patients receive. To be sure, government reforms of the past two decades have brought some noticeable declines in the waiting list numbers. However, it is significant to note that some areas have seen greater improvement than others. Table 17.1 shows changes in the waiting lists for the three best- and worst-performing health authorities in England:

- Between March 1997 and 1999, the total number of patients waiting for medical treatment in the three London health authorities fell by between 23 and 31 percent.
- Over the same period, the total number of patients waiting for medical treatment in the three rural health authorities increased by between 12 and 19 percent.[5]

**TABLE 17-1**

## Percentage Change in Number of Patients On Waiting Lists between March 1997 and March 1999 for London and Rural Areas

| London Health Authorities | Percentage Change |
|---|---|
| Brent and Harrow | -23.4% |
| Croydon | -24.1% |
| Camden and Islington | -31.6% |
| **Selected Rural Health Authorities** | **Percentage Change** |
| South Staffordshire | +19.9% |
| Wocestershire | +12.9% |
| Warwickshire | +12.8% |

Source: "Hospital Waiting List Statistics: England," *NHS Executive*, 2000.

For individual hospital trusts within London and rural health authorities, the differences in levels of treatment and health outcomes are even more striking.[6]

- At Hamerton Hospital in London, 96 percent of inpatients are admitted within six months, compared to 51 percent of patients at Surrey and Sussex Healthcare Trust in the rural southeast.
- Similarly, at Whittington Hospital in London, 90 percent of inpatients are admitted within six months, compared to 54 percent of patients at Royal Surrey County Hospital in the rural southeast.

These inequalities do not reflect differences in need. Northerners die younger and are less healthy than southerners.[7] Poor urban dwellers live shorter lives and die more frequently from common, treatable illnesses than their wealthier neighbors living only blocks away. For example[8]:

- A person with colon cancer in Herefordshire has a 52.4 percent chance of survival, while a person in the rural northeastern town of Tees has a 24.9 percent chance.
- A woman with breast cancer living in the Hillingdon, Borough of London, has an 80.3 percent chance of surviving five years, compared to a 64.5 percent chance for a woman in rural North Staffordshire.

Clearly, peoples' chances of surviving major illnesses or procedures depend very much on where they live. Although some of the differences in outcomes

may be attributable to regional differences in lifestyle, differences in medical resources must surely matter. The difference in cancer mortality and survival rates, for example, has been attributed to the general shortage of specialists, unavailability of the latest cancer drugs and relative lack of investment in radiotherapy equipment in underserved health regions.[9]

## RURAL PATIENTS IN CANADA

In Canada, too, wide differences exist between the level of care available to citizens who live in the sparsely populated countryside and those who live in metropolitan areas. Although rural residents pay the same high tax rates as urban dwellers, they have less access to care. Recent hospital closings are a serious problem for rural patients. According to the *Canadian Journal of Rural Medicine,* "In Alberta, Saskatchewan and Manitoba rural hospitals have been closed by the dozens."[10]

Not surprisingly, the number of family physicians—as well as the number of specialists—varies widely across the rural and urban centers. In British Columbia, the average family physician in the rural Peace Liard region has 1,316 patients, while his counterpart in urban Vancouver has 606 patients. If specialists are included, there are 1,099 patients per physician in the Peace Liard region compared to 268 in Vancouver.[11] There are also inequalities among the provinces:

- Among Canadian provinces, the number of physicians per 100,000 population varies from a high of 211 in Quebec to a low of 92 in the Northwest Territories, a difference of more than 2 to 1.[12]
- The number of patient beds varies from a high of 22.3 per 1,000 population in Prince Edward Island to 10.6 per 1,000 in Yukon, a difference of more than 2 to 1.[13]

As noted above, health care in Canada tends to be hospital-based, with modern technology restricted to teaching hospitals and outpatient surgery discouraged. Moreover, specialists and major hospitals tend to be in major cities. As in other countries, rural residents often travel to the larger cities for medical care. A major study produced at the University of British Columbia determined the impact this has on the amount of care urban and rural patients receive. As previously noted, this study is unique in that it identified patients based on where they lived and thus was able to accurately determine how much care was delivered to the population of the different health regions. Table 17.2 and figure 17.1 show the following:[14]

- Overall, people living in British Columbia's two largest cities (Vancouver and Victoria) received about 63 percent more physician services per capita than those living in the twenty-seven rural districts of the province.
- Urban residents received 91 percent more services from specialists per capita than rural residents, and for specific specialties the discrepancies were even greater.
- On the average, urban residents were seven times more likely to receive services from a thoracic surgeon, almost four times more likely to receive the services of a psychiatrist, almost three times more likely to receive services from a dermatologist and twice as likely to receive services from a neurologist.

TABLE 17-2

**Spending on Physician Services Per Person in British Columbia[1]**
**(1993-94)**

| Speciality | Urban[2] | Rural[3] | Urban/Rural |
|---|---|---|---|
| All Physician Services | $494.5 | $303.0 | 163% |
| General Practice | 173.2 | 142.3 | 122% |
| Specialists | 321.3 | 168.5 | 191% |
| Anesthesia | 30.0 | 9.6 | 313% |
| Dermatology | 6.5 | 2.4 | 271% |
| General Surgery | 15.9 | 13.8 | 115% |
| Internal Medicine | 39.3 | 21.3 | 185% |
| Neurology | 5.7 | 2.8 | 204% |
| Neurosurgery | 2.5 | 1.3 | 192% |
| OB/GYN | 13.5 | 8.6 | 157% |
| Ophthalmology | 22.9 | 9.7 | 236% |
| Orthopedic Surgery | 9.7 | 7.8 | 124% |
| Ontolaryngology | 7.7 | 3.9 | 197% |
| Pediatrics | 11.5 | 4.7 | 245% |
| Pathology | 59.8 | 39.0 | 153% |
| Plastic Surgery | 4.85 | 2.3 | 211% |
| Psychiatry | 22.6 | 5.7 | 396% |
| Radiology | 44.5 | 26.9 | 165% |
| Thoracic Surgery | 7.1 | 1.0 | 710% |
| Urology | 7.0 | 4.4 | 159% |

[1] Based on fees paid to physicians for rendering services to patients living in the areas indicated, regardless of the area in which the service was performed. All figures are age-sex standardized and expressed in Canadian dollars.

[2] Greater Vancouver and Victoria regional hospital districts.

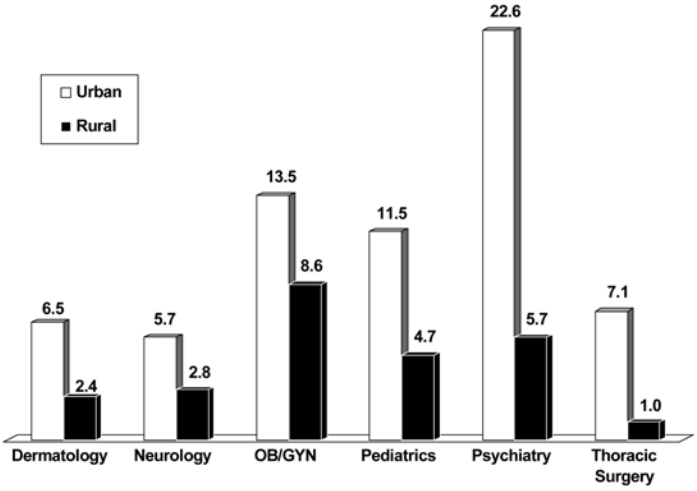
[3] Twenty-seven non-metropolitan hospital districts.

Sources: Arminée Kazanjian et al., "Fee Practice Medical Expenditures per Capita and Full-Time Equivalent Physicians in British Columbia, 1993-94," University of British Columbia, 1995.

**FIGURE 17-1**

**Inequalities in the Use of Physician Services among Urban and Rural Patients in British Columbia**

**(Per capita spending, 1993-94)**




Sources: Arminée Kazanjian et al., "Fee Practice Medical Expenditures Per Capita and Full-Time Equivalent Physicians in British Columbia, 1993-94," University of British Columbia, 1995.

## NOTES

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2. Morris L. Barer, Laura Wood and David G. Schneider, "Toward Improved Access to Medical Services for Relatively Underserved Populations: Canadian Approaches, Foreign Lessons," Centre for Health Services and Policy Research, University of British Columbia, May 1999.

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7. "Dying of Inequality," *The Economist* (April 4, 1987): 52; see also "UK Death Rate Echoes North-South Divide," *Reuters Health,* 2000.

8. "Cancer Rates Reveal Regional Divide," *BBC News,* July 13, 2000; National Health Service, "NHS Postcode Lottery Revealed" and "Quality and Performance in the NHS. Performance Indicators: July 2000," *NHS Executive* (July 2000).

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10. John Wootton, "Rural Hospitals: We Can't Do without Them!" *Canadian Journal of Rural Medicine* 2, no. 2 (Spring 1997): 59.

11. Harvey V. Thommasen et al., "Physician:Population Ratios in British Columbia," *Canadian Journal of Rural Medicine* 4, no. 3 (Summer 1999): 139–45.

12. Southam Medical Database, Canadian Institute for Health Information, 2001.

13. "Health Care Beds, All Institutions, by Type of Care," Statistics Canada, Canadian Institute for Health Information, 1996–97, available at www.statcan.ca/english/Pgdb/People/Health/health32a.htm.

14. Arminée Kazanjian et al., "Fee Practice Medical Expenditures per Capita and Full-Time Equivalent Physicians in British Columbia, 1993–94," University of British Columbia, 1995. Physicians in Canada are paid by the province on a fee-for-service basis. Income data are available by specialty for each region. Consequently, fee-for-service income is a good measure of the value of services actually rendered to patients. By using physician billing data, the researchers determined the regional hospital district in which each patient lived—even if the service was provided in some other district.