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ORIGINAL RESEARCH

Exploring differences in caseloads of rural and urban healthcare providers in Alaska and New Mexico

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Summary *Objectives:* Although it is commonly accepted that rural healthcare providers face demands that are both qualitatively and quantitatively different from those faced by urban providers, this conclusion is based largely on data from healthcare consumers and relies on qualitative work with small sample sizes, surveys with small sample sizes, theoretical reviews and anecdotal reports. To enhance our knowledge of the demands faced by rural healthcare providers and to gain the perspectives of healthcare providers themselves, this study explored the caseloads of rural providers compared with those of urban providers.
Method: An extensive survey of over 1500 licensed clinicians across eight physical and behavioural healthcare provider groups in Alaska and New Mexico was undertaken to explore differences in caseloads based on community size (small rural, rural, small urban, urban), state (Alaska, New Mexico) and discipline (health, behavioural).
Results: Findings indicated numerous caseload differences between community sizes that were consistent across both states, with complex case presentations being described most commonly by small rural and rural providers. Substance abuse, alcohol use, cultural diversity, economic disadvantage and age diversity were issues faced more often by providers in rural and small rural communities than by providers in small urban and urban communities. Rural, but not small rural, providers faced challenges around work with prisoners and individuals needing involuntary hospitalization. Although some state and discipline differences were noted, the most important findings were based on community size.

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Conclusions: The findings of this study have important implications for provider preparation and training, future research, tailored resource allocation, public health policy, and efforts to prevent 'burnout' of rural providers.

Introduction

Rural and frontier geographic regions make up 75% of the landmass of the USA. According to the 2000 US Census, they are home to approximately 21% of the US population or 59 million people in about 2000 counties (http://factfinder.census.gov). Rural healthcare work brings many challenges for providers, at least partly due to the complexities presented by rural residents who tend to have lower levels of income, greater diversity in age and cultural background,[1–5] and high rates of disease and poor health.[6–8] Rural residents are more likely to be victims of accidental injury,[9–11] exhibit more health-risk behaviours,[12] have higher postnatal death rates for infants,[13] rate their own physical health as poor,[7] report more chronic physical illness[6] and chronic pain,[14] and face greater increases in human immunodeficiency virus[15] than non-rural residents. Research reveals less treatment for rural residents compared with urban residents with equivalent mental health concerns,[16] at least twice the rate of completed suicides among rural men compared with urban men,[17] more self-reported depression and domestic violence among rural women compared with urban women,[18] and higher rates of child abuse.[19] Relatedly, rural users report higher current and lifetime rates of drug use while seeking less treatment,[20] rural residents have higher excessive alcohol use rates and more substance abuse treatment admissions than urban residents,[11] rural adolescents show more risk factors for substance abuse than urban adolescents,[21] and rural youth show more substance use risk behaviours, more substance abuse and higher rates of depression than urban youth.[18]

Given the economics, age, diversity and physical and behavioural health patterns found in rural regions, it is not surprising that rural providers often feel unprepared for the tremendous challenges they face, that their desired scope of work and clientele are often far exceeded by their actual responsibilities,[5,22,23] and that many public health issues tend to remain unattended or poorly managed through urban paradigms with poor fit. Although the role of rural providers is often believed to be significantly different from that of urban providers,[11] few academic programmes acknowledge this issue by providing training specific to rural healthcare delivery and public policy. Most training programmes emphasize specialization, whereas rural healthcare providers must often be generalists. Such training leaves clinicians woefully underprepared for rural work with complex and diverse clienteles.[1,24–26] Rural healthcare providers, of necessity, find that they must use a very broad set of clinical skills, serving both as specialist and generalist depending on the needs of their communities. Those who come to rural areas with generalist training are often called upon to provide specialty services that exceed their training experience. Also, although not as common, those who come to rural areas from specialty training may be challenged by having to provide generalist services beyond their specialty areas.[27] Either way, rural clinicians are often called upon to work outside the scope of their intended practice[10,28–30] and training,[1,31,32] especially given the dearth of specialists in rural areas.[33] The limitations in the preparation of rural healthcare providers for the complex caseloads that they seem to face in rural areas result in significant threats to the public health of rural communities. Not surprisingly, health and healthcare disparities are being documented regularly for rural communities.[23,34,35]

Although it is commonly accepted that rural healthcare providers face significant caseload demands, as described above, the literature upon which these conclusions are drawn is based largely on qualitative work with small sample sizes, surveys with small sample sizes, theoretical reviews and anecdotal reports. Indeed, despite the existing evidence of differential patterns in the physical and behavioural health of rural residents compared with urban residents, and despite assertions in the literature about the overwhelming and stressful demands of rural practice, no study can be found in the peer-reviewed literature (represented in PsycInfo and MEDLINE) that has attempted an objective, quantitative comparison of the types of caseloads encountered by small rural versus rural versus urban clinicians.

This study sought to remedy this gap in the literature by surveying over 1500 licensed clinicians