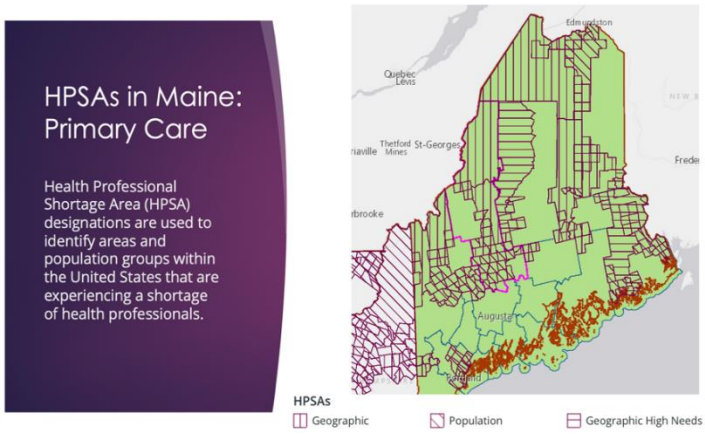
Health Disparities in Maine: "It's Where You Live and What You Do"

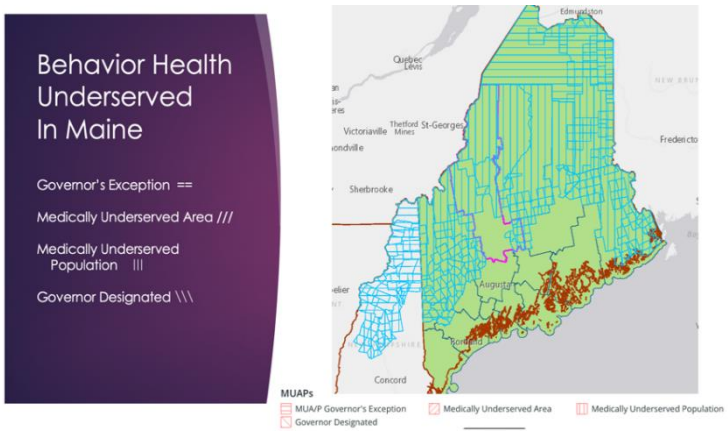
By far, most disparities in Maine health care exist between urban and rural communities.
--61% (66%) of Maine residents live in rural areas
--11 of Maine's 16 counties are rural
--Maine's rural counties tend to have lower education status, lower income, less insurance, and a longer distance to medical care.
-- Maine's rural residents tended to be older, with fewer under age 50 (43% versus 51%) and a greater proportion age 65 and older (26% versus 22%).[1]
--28% of rural Maine hospitals are at risk of closing, including four at immediate risk.

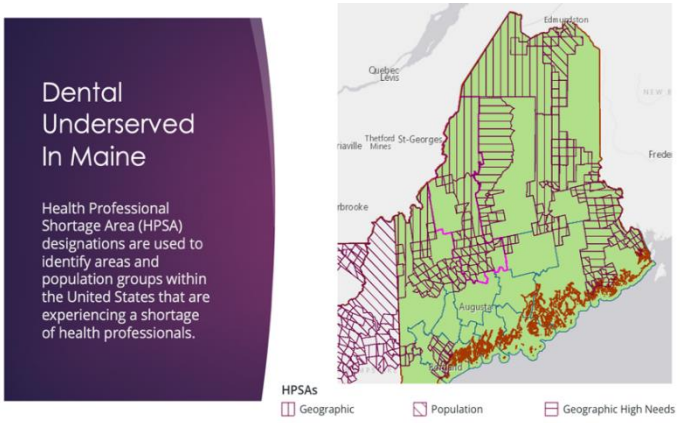
HPSAs[2] are health professions service areas designated by the federal government. Rural Maine doesn't have enough primary care physicians, dentists and behavioral health workers.

Maine people in rural areas are 50% more likely to be uninsured, and with fewer privately insured. The number of people who are underinsured is unknown. The disparities are less significant after 65 years old because of Medicare.

Maine is 15th in the US for spending on primary care – just 5.66% of health dollars are spent in primary care. With a broader definition of primary care, Maine is 19th, spending just 9.18%.







Rural Communities have:

--2 times the poverty
--50% more uninsured
--76% more enrolled in Maine Care
--70% more kids enrolled in MaineCare
--24% more overdose deaths
--3 times the number of drug-affected births
--55% higher rate of Lung Cancer
--44% higher rate of Esophageal Cancer
--30% higher rate of Bladder Cancer
--49% higher rate of Leukemia
--5% higher rate of Pancreatic Cancer
--20% higher rate of self-rated poor or fair health
--19% higher all cancer deaths
--20% higher lung cancer deaths
--16% higher coronary heart deaths
--46% higher stroke deaths
--52% higher rates of heart attack hospitalizations
--10% higher rates of diabetes related death
--33% higher rate of ER visits for asthma
--49% higher rates of COPD
--23% lower rate of Liver/Bile Duct Cancer--
--56% higher rate of Kidney Cancer [3][4]

[1] MEHAF https://mehaf.org/wp-content/uploads/2022_BRFSS-Rural-Brief_FINAL.pdf
[2] https://maps.healthlandscape.org/
[3] Health in Maine: Rurality
https://www.maine.gov/dhhs/mecdc/phdata/MaineCHNA/documents/Rurality%20HE%20Data%20Sheet%206.27.2022.pdf
[4] Based on a comparison of Washington, Aroostook, Piscataquis compared to York and Cumberland Counties in CHNA

How do we get a system that can address rural health inequities?

A unified state health care program provides better care to more people for less money, making the system more responsive to the patients it serves, without compromising provider payment. (Maine Center for Economic Policy fiscal study, 2019: maineallcare.org/fiscal-study-2019/)

- It is a public good; like schools, libraries, and fire departments.
- It is affordable because the middleman cut of money is taken out.
- It can pay a fair amount to hospitals, rural clinics, dental offices and drug treatment centers.
- It is responsible for quality and fairness.
- It can be innovative in reimbursement.
- It can be innovative in education and educational partnerships

How do we support hospitals in rural Maine?

Establish global budgets: A hospital global budget is a predetermined amount of money that a hospital is allocated to spend on its operations for a given period, usually a year. This budget covers all hospital services, including salaries, equipment, and supplies. The hospital is expected to operate within this budget and manage its resources efficiently to ensure that it can provide quality care to patients while staying within its financial means.

How do we get more providers in rural Maine?

1.) **Pay them:** fee-for-service, time-based model, FQHC look-alikes, rural health clinics, and hybrid models.

2.) **Grow them:** Develop In-State Programs to increase the number of primary care physicians in rural Maine.

James Herbert, PhD., president of University of New England testified to the Senate Committee on Health, Education, Labor, and Pensions (Feb 17, 2023), offering potential strategies to combat the shortage of health care workers:

1. **Increase the number of doctors, nurses, and other health care professionals we educate** by expanding partnerships between universities and community health care settings to develop additional training opportunities, revise out-of-date policies, provide targeted one-time adjustments to expand health care training infrastructure, and develop strategic scholarship and loan-repayment programs.
2. **Intentionally recruit more students who look like the communities we need to serve**, as individuals from underrepresented groups are more likely to seek out practitioners who share their identities and background.
3. **Use a variety of tools to encourage health care providers to practice in underserved areas**, including rural, tribal and medically underserved urban communities.
4. **Leverage the power of technology, including telehealth and digital medicine**, to reach underserved communities and integrate robust telehealth training for all of our health profession students in close partnership with our various training sites.

Take action:

- **Recognize that the current situation is unacceptable.**
- **Consider alternatives to incremental solutions**. (We all support lower insulin costs…but really?)
    - Begin the ground work NOW – **Access, Finance and Quality Exploratory Commissions for the State**
- **Don't put the fox in charge of the hen house**. *(For-profit companies have succeeded in transferring wealth to their shareholders, but little else.)*

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Additional Charts and References:

Shared Maine Community Health Needs Assessment								
Cancer per 100,000 persons	Washington	Aroostook	Piscataquis	Average Rural	York	Cumberland	Average Urban	Ratio; Rural to Urban
Lung Cancer	153	128	158	146	109	79.3	94	1.55
Esophageal Cancer	18	10	14	14	11	8.5	10	1.44
Bladder Cancer	46	44	57	49	42	32.9	37	1.30
Kidney Cancer	31	31	32	31	22	18.6	20	1.56
Laryngeal Cancer	7	8	11	8	4	4.2	4	2.06
Leukemia all types	30	24	31	29	18	20.7	19	1.49
Pancreatic Cancer	20	21	20	20	22	17.3	19	1.05
Liver/Bile Duct Cancer	9	7	7	8	11	8.7	10	0.77

Maine Shared Community Health Needs Assessment Report 2022

https://www.maine.gov/dhhs/mecdc/phdata/MaineCHNA/documents/State%20Report%207.12.2022revision.pdf

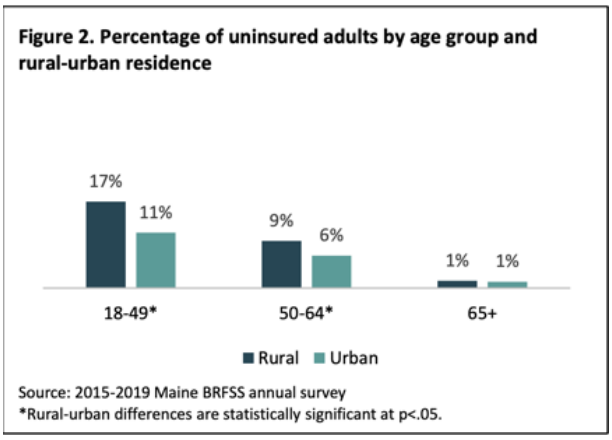
	Maine	Washington	Aroostook	Piscataquis	Oxford	Somerset	Average Rural	York	Cumberland	Average Urban	**Ratio; Rural to Urban**
Median Income	57,918	41,347	41,123	40,890	49,204	44,256	45,790	67,830	73,072	70,451	**1.54**
Unemployment	5.4	6.2	5.5	5.5	6.7	6.6	6.0	5.4	5.3	5.4	1.12
Uninsured	7.9	12.1	8.4	10.2	8.8	9.4	9.5	6.7	5.8	6.3	**1.51**
Individuals in Poverty	11.8	18.9	16.1	18.5	15.1	20.4	16.8	7.4	9	8.2	**2.05**
Children in Poverty <19 yrs.)	13.8	24.6	20.2	23.8	17.6	22.6	20.4	9.9	9.2	9.6	**2.14**
Persons with Disabilities	16	22.5	22.3	26.3	18.5	21.7	21.2	15	11.4	13.2	**1.61**
Veterans	9.6	11.8	11	12.6	10.2	10.6	11.0	10.2	7.2	8.7	**1.26**
Access to Broad Band	88.6	76.3		41.8	87.6	58.6	70.6	99.3	99.4	99.4	0.71
Ratio; Populations to PCP	1,332	2672	1481				1,828	1704	1018	1,361.0	**1.34**
Usual Prumary Care Provider	87.9	82.4	86.5*		89.1	90.7*	86.5	90.4	87.9	89.2	0.97
Percent over 30 miles to Visit	20	31.9	17.7	33.1	42.2	36	30.2	18.8	12.8	15.8	**1.91**
Visit to PCP last 12 months	87.9. 72.0 (2017)	82.4	74.1	71.8	73.2	75.2	75.3	73.1	89.5	81.3	0.93
Maine Care Total Enrollement	29.1	42.9	40.1	38.2	36.4	39.3	37.7	22	20.9	21.5	**1.76**
Maine Care Child Enrollement	43.8	62.6	56.2	61	56.3	56.8	56.1	34.7	31.5	33.1	**1.70**
Cost Barriers	10.6	13	12.9	11.2	11.6	8	11.2	8.6	9.1	8.9	**1.27**
Rate Seeking Mental Health Care in ER/100,000	181.5	195.5	193	188.2	199.3	183.5	190.2	152.7	160.7	156.7	1.21
Ratio; Population to Psychiatrist	12,985	60,664	64,856	NA	173,148	191,140	100,559	20,812	5,419	13,115.5	**7.67**
Percent HS students sad or hopeless for over 2 weeks	23.7	23.7	11.4	19.8	22.7	21.4	20.5	22.8	8.5	15.7	**1.31**
Overdose Deaths / 100,000	37.3	63.5	25.4	58.8	25.8	25.7*	42.2	35.4	32.5	34.0	1.24
Drug Affected Infants / 1,000	73.7	139.2	124.1	99.6	121.1	140.5	116.4	41	29.4	35.2	**3.31**
Binge Drinking (HS)	8.2	11.4	8.6	9.5	8.1	8.6	9.1	8.2	8.8	8.5	1.07
Alcohol Impared Death (Driving) /100,000	3.8	6.4	4.5	6.0*	10.3	4	5.8	1.4	1.7	1.6	**3.74**

https://www.maine.gov/dhhs/mecdc/phdata/MaineCHNA/final-CHNA-reports.shtml

These average rates and differences are weighted based on populations of 33.8% metro, 35.9% large rural, 24.3% small rural, and 6.0% isolated rural residents of Maine and come from the *Maine Shared Community Health Needs Assessment* www.mainechna.org

If you are interested in health disparities between the US and other first nations you can find them in the Commonwealth Fund report. *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes*

https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022



Rural vs Urban Uninsured

An Example of an In-State Program to increase the number of primary care physicians in rural Maine:

Thomas Jefferson University developed the PSAP in 1974. The Physician Shortage Area Program (PSAP) is an admissions and educational program designed to increase the supply and retention of physicians in rural areas and small towns, with a focus on Primary Care doctors for Pennsylvania and Delaware. The Program recruits, trains and supports medical students who have grown up or spent a substantial part of their lives in a rural area or small towns.

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https://maps.healthlandscape.org/

Health in Maine: Rurality
https://www.maine.gov/dhhs/mecdc/phdata/MaineCHNA/documents/Rurality%20HE%20Data%20Sheet%206.27.2022.pdf

Assessing the Costs and Impacts of a State-Level Universal Health Care System in Maine, by James Myall, Policy Analyst
www.maineallcare.org/fiscal-study-2019/

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ADVOCATING FOR COMPREHENSIVE, HIGH-QUALITY AND AFFORDABLE HEALTH CARE FOR ALL MAINE PEOPLE

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