Barriers to Preventive Health Services for Minority Households in the Rural South

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ABSTRACT: *Health values, behaviors, and status are shaped by place of residence, region, race, and socio-economic status, among other social factors. Consequently, this article examines barriers to preventive health services for lower-income blacks in five rural counties in Georgia. Qualitative and quantitative data were collected through 281 household, 51 community leader, and six focus group interviews. Female respondents who had been pregnant were most likely to have received pregnancy-related services and all respondents least likely to have received vision and dental screenings. Six of the seven types of services inquired about were most likely to have been received in a private practice setting. Primary barriers to preventive service utilization included ability to pay, perception of need, service availability, accessibility of services, and the perception of racism. The relationship between structural and nonstructural barriers, their impact on preventive service utilization, and research recommendations also were developed and presented.*

"Regional diversity is an essential consideration when identifying rural health care needs.... In studying rural health problems, there is no homogeneous rural America and...it is reasonable to expect that health differences among various rural areas and subgroups may be pronounced" (Weinert & Long, 1990, pp. 61-62).

The "rediscovery of rural health care by policy-makers" has been accompanied by a wealth of relevant research (Patton, 1989, p. 1005). However, additional attention needs to be given to "special populations" within rural America (Department of Health and Human Services [DHHSJ, 1991). An examination of the preventive health beliefs and behaviors of lower-income black households in the rural South is important for three reasons. First, black Americans comprise a needy population in terms of health and health care (Alcena, 1992; Blendon, Aiken, Freeman, & Corey, 1989; Braithwaite & Lythcott, 1989; DHHS, 1991). Even after controlling for income, racial disparities in health status are still evident (Council on Ethical and Judicial Affairs, 1990; Williams, Lavizzo-Mourey, & Warren, 1994). Second, although they are more likely to suffer from many chronic conditions, minority, poor, and rural individuals are less likely to receive preventive health screenings than are nonminority, nonpoor, and urban individuals (DHHS, 1991; Office of Technology Assessment [OTA], 1990a). Third, although extensive racial comparisons have been made of crude health indicators, insurance status, and use patterns using national samples, limited attention has been given to the experiences of minorities who reside in specific rural areas. To more fully understand health and health behavior, it is necessary

to examine cultural factors related to race within this context of rurality, region, and socioeconomic status (DeFriese & Ricketts, 1989; DHHS, 1991; Green, 1978; Patton, 1989; Weinert & Long, 1990). As observed by DeFriese and Ricketts (1989, p. 932), "a complex web of social, cultural, and economic values can have enormous influence on the way in which health care needs are expressed as expectations (or as patterns of health services use) by persons in different communities."

This article focuses on barriers to preventive health services for lower-income black households in rural Georgia. The first section of the article identifies general barriers to preventive service use for black, lower-income, and rural individuals. The second section examines patterns of preventive service utilization as well as reasons services were not received for a convenience sample of 790 black individuals in 281 households. Lastly, structural and nonstructural barriers, their impact on preventive service use, and research directions are presented based on data collected from household, community leader, and focus group interviews.

Rural, Minority, or Poor

Research indicates that minorities, lower-income individuals, and rural residents often have difficulty accessing health services. Critical factors include the availability of providers, ability to pay, health values, and quality of health services, all of which have influenced preventive service utilization for lower-income blacks in rural Georgia.

Health Service Availability. Although the number of rural physicians has increased during the past 20 years, the urban-rural disparity in medical personnel has also increased. Overall, rural areas across the country have one half as many physicians per capita as urban areas, and "in 1988, all of the 111 counties (with a total resident population of 325,100) with no MD or DO were rural" (OTA, 1990a, p. 8). The proportion of nonphysician providers and registered nurses to licensed practical and vocational nurses, already lowest in the South, continues to decline (OTA, 1990a) with 74.7 percent of Georgia's nonphysician providers employed in urban counties (Center for Rural Health and Research, 1995). The recent demand for primary care physicians in urban areas is expected to exacerbate this shortage (OTA, 1990a).

The lack of medical personnel in rural areas is partly due to differential funding at the federal level, community demographics, and provider preference (Cordes, 1989; DeLeon, Wakefield, Schultz, Williams, & VandenBos, 1989; National Association of Community Health Centers [NACHC] & National Rural Health Association [NRHA], 1989; OTA, 1990a). At the federal level, "public funding for health care [in rural areas] has consistently lagged behind the U.S. national average," with rural areas receiving 42 percent fewer health service dollars and 50 percent fewer social service dollars per capita than the U.S. average (NACHC & NRHA, 1989, p. 10). At the community level, rural providers must contend with a limited client base, "aging physical plants, difficulty in hiring and retaining technical staff, lower proportions of private-pay patients, local and regional competition, and perceived (or actual) deficits in quality of care" (Bronstein & Morrisey, 1991, p. 88).

Personnel, facility, and funding limitations have direct consequences for preventive service availability and accessibility. For example, rural areas have fewer preventive and health promotion programs than urban areas (Bushy, 1990; Weinert & Long, 1990), increasing numbers of rural women must travel outside the county or rely on general practitioners for obstetric services (Nesbitt, Connell, Hart, & Rosenblatt, 1990), and three fourths of Georgia's rural counties lack obstetric services (Ryan, 1993). Davis and Rowland (1983, pp. 169-170) reflect that "the effort involved in such a search for care may discourage the use of preventive services, resulting in the uninsured only seeking care for serious illness or in crisis." Even when health services are available, "rural populations are unique in the extent of physical barriers they may encounter when obtaining health care. Even in relatively well-populated rural areas, the lack of a public transportation system and the existence of few local providers to choose from can make it difficult for many rural residents to reach facilities where they can receive care" (OTA, 1990a, p. 6).

The fact that high percentage black counties in the rural South have substantially lower levels of

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public infrastructure than other counties in the region places minorities at even greater risk (Brown & Warner, 1991).

Ability to Pay. The use of preventive services is directly linked to ability to pay through income, private insurance, and entitlement status. This suggests that rural blacks as a group are at risk on three fronts. First, poverty is associated with rural residence, the South, and minority status in general, and with blacks residing in the rural South in particular (Brown & Warner, 1991; Rowland & Lyons, 1989). Second, blacks in the rural South are one and one half times less likely to be insured than are whites from the South or nonsouthern blacks, and two times less likely to be insured than nonsouthern whites (Korcyzk, 1989). Third, the rural poor are less likely to be covered by entitlement programs than are the urban poor (OTA, 1990a), with "just over a third (36 percent) of the rural poor hav[ing] Medicaid coverage compared to 44 percent of urban residents" (Rowland & Lyons, 1989, p. 986). Rural-related impediments to entitlement coverage are numerous and include functional illiteracy, fear of insensitive treatment by agency employees, family pride, and stigma within the community (Bushy, 1990).

"Two-parent families, which are generally not eligible for Medicaid, are even more prevalent among the rural poor. Rural residents may lack information about eligibility, may be reluctant to apply for a means-tested program, or may have less access to providers who accept Medicaid. Finally, many of the rural poor...may be disqualified by farm or business assets. . . . The Medicaid program is clearly reaching fewer of its intended beneficiaries in rural areas than in the nation's cities" (Korcyzk, 1989, p. 28).

Rural Values and Norms. The social values and norms associated with rural life may discourage the use of preventive services. Studies examining specific rural areas (e.g., Long & Weinert, 1987; Shannon, 1989; Weinert & Long, 1990) suggest that rural people tend to subscribe to the role performance model of health, that is, the assumption that one is healthy as long as she or he is able to "be productive, to work, and to carry out usual role functions" (Weinert & Long, 1990, p. 59). Individuals who subscribe to this model assume they are healthy as long as their performance is not seriously impaired, seek medical attention only when problems are severe, and devalue preventive health services.

Rural residents also may hesitate to seek preventive screenings due to a preference for informal social support networks, provider-patient status differentials, a distrust of outsiders, and a concern for privacy (Hill, 1988; Weinert & Long, 1990). Although some rural residents rely on folk medicine only when formal services are not available (Coward & Cutler, 1989), it is not unusual for relatives and friends to be the primary-and preferred-source of medical information and confidence in home remedies to be high. Perceived social distance and discomfort is exacerbated when providers are white and patients are both black and poor (Hall, Roter, & Katz, 1988; Ventres & Gordon, 1990). The lack of privacy in small towns may lead individuals to reject preventive services associated with "embarrassing" conditions, such as testing for AIDS, venereal disease, or pregnancy outside of marriage. Rounds (1988, p. 362) observed that while "fear, intolerance, and stigma are not problems unique to rural areas,...given the lack of confidentiality and the homogeneous nature of most rural communities, these attitudes are much more pronounced and the impact more strongly felt."

Provider Characteristics. The quality of care that poor and minority rural residents receive can be compromised even when health services are available and accessible. Twenty years ago, Roth (1972) observed that the more patients deviated from white, middle-class appearance and behavior, the less likely they were to receive considerate or extensive treatment, and that up to 30 percent of Medicaid recipients did not seek care at some time because of physician attitudes. In 1988, a meta-analysis of 44 more recent studies confirmed that provider behavior is influenced by the patient's social status (Hall, Roter, & Katz, 1988). Consciously or unconsciously, physicians interact differently with poor and minority patients, both eliciting and providing less medical information and engaging in shorter consultations. Consequently, poor patients are often left confused, uninformed, and "frustrated that their concerns have not been heard" (Ventres & Gordon, 1990, p. 307).

Research Design

To examine barriers to preventive services for lower-income black households in rural Georgia, quantitative and qualitative data were collected in 1992 through household, community leader, and focus group interviews. Although many types of preventive services are important, this study limited

its focus to six categories of formal services:

1. physical examinations for infants, children, and adults;
2. dental examinations for school-age children and adults;
3. vision examinations for school-age children and adults;
4. gynecological examinations for women aged 18 and older;
5. four or more prenatal visits during pregnancy; and
6. medical supervision during childbirth.

These services were selected for several reasons. First, general health screenings are critical for detecting the chronic conditions prevalent among rural and minority individuals. Second, not only are urban residents more likely to have dental examinations than are rural residents but "11 percent of rural residents have never visited a dentist" (OTA, 1990a, p. 48). Third, the role performance model of health suggests that routine vision and dental screenings will be given low priority. Last, gynecological and pregnancy-related services were included because rural women are less likely to receive gynecological examinations than are urban women (OTA, 1990a), Georgia's teen pregnancy rate is among the highest in the nation (Ryan, 1993), and "Georgia and South Carolina are among the states with high black infant mortality in rural areas" (OTA, 1990a, p. 379).

Household Interviews

Sampling Procedures. Data presented in this article were collected in the course of a broader study on the health attitudes and behaviors of lower-income black households in rural Georgia. The goal of the broader study was to identify the most salient factors associated with health service utilization as a foundation for future research. Because the study's overall purpose was exploratory in nature, a nonprobability sample was used and findings cannot be generalized in the same manner as a random, population-based sample. However, the value of these data can be found in the dearth of existing data on rural, minority subpopulations. As noted by the DHHS (1991, p. 29), data pertaining to broader categories of "special populations"-such as poor, minority, or disabled individuals-are "limited; sometimes, and for some groups, the data may be severely limited."

Data pertaining to subpopulations within these categories are even more scarce, and researchers are "challenge[d] to refine our knowledge and understanding even further, especially as basic health policies are translated into community-based prevention programs and clinical preventive services" (DHHS, 1991, p. 29).

Sampling for household interviews involved five steps. First, the southern portion of Georgia was targeted because socioeconomic and health indicators are worse in the southern half of the state (Bachtel & Boatright, 1993). Second, Bulloch, Burke, Stewart, Telfair, and Ware counties were selected by the research team through quota sampling. Selection criteria included rural status (no cities of greater than 50,000 population) and high minority population. The percent of black population ranged from 26.0 to 63.3; median black household income ranged from $10,898 to $13,260; and percent blacks in poverty ranged from 41.2 to 45.8 for these counties (Bachtel & Boatright, 1993). Household income was derived primarily from service occupations and secondarily from manufacturing, agriculture, and public assistance.

In the third step, data collection was conducted in county seats to examine households that were a similar distance from county health facilities. Fourth, community leaders identified predominantly lower-income neighborhoods within these communities. This was a relatively effective means of identifying minority households because of the high degree of residential segregation in Georgia. Because many of the target households lack telephone service, door-to-door interviews were conducted with adult members of 300 black households residing in subsidized and nonsubsidized housing. Fifth, households with an annual income at or below 185 percent of federal poverty level were classified "lower income" and retained for analysis.

Characteristics of the Sample. The final data set consisted of 281 households, comprised of 133 men, 311 women, and 344 children. More than four fifths (81%) of these households were at or below federal poverty level, and the remaining households were between 101 and 185 percent of the federal poverty line. Almost one third (32.1%) of the individuals lacked any form of health insurance. Nonelderly adults were covered as follows: private insurance only (23.9%), Medicaid only (43.1%), and both private insurance and Medicaid (0.9%). Adults 65 years and older were more likely to be insured: private insurance only (32.7%), Medicaid only (6.1%), Medicare only (24.7%), and coverage by two programs (20.2%).

However, it should be noted that these figures may overestimate health benefits for two reasons. First, private policies held by rural residents tend to be less comprehensive than private policies held by urban individuals (Rowland & Lyons, 1989), and Medicare does not cover most types of preventive services (OTA, 1990b).

Data Collection and Instrumentation. In-depth interviews were conducted with knowledgeable adult members from each household. Interviews addressed a range of health issues and took about 45 minutes each to complete. Relevant interview items included: (1) Did members of your household receive the following [six types of] preventive services at any time during the past year? (2) If "yes," did family members receive this type of service in a family practice, clinic/health department, or hospital setting? (3) If "no," what was the primary reason family members did not receive this type of service? Household members constituted the unit of analysis for item (1), and the household constituted the unit of analysis for items (2) and (3). Items were open-ended, and probes were used to encourage respondents to more fully describe their perceptions and experiences.

Community Leader and Focus Group Interviews

Sampling Procedures. Community leader interviews were conducted with individuals who were familiar with black health issues in their communities, and focus group interviews were conducted with a range of interest groups and service recipients. Community leaders and focus group members were selected from each of the five target counties through "snowball" sampling techniques. The research team first identified and interviewed medical personnel in each county who provided services to lower-income black households and/or who were familiar with the public health system. At the conclusion of each interview, respondents were asked to recommend other key informants and/or interest groups that were familiar with these issues and might be willing to be interviewed.

Characteristics of the Sample. Individual interviews were conducted with 51 community leaders: director of social welfare program (19); health department or emergency room nurse (11); case worker or other social work personnel (seven); clergy (five); general community leader, including National Association for the Advancement of Colored People (NAACP) officers (three); mental health professional (two); educator (two), and attorney (two). Interviews were conducted with six focus groups, including a local NAACP chapter (25 members), two Senior Companion support groups (13 members each), a black businesswomen's association (12 members), a community service group for men (10 members), and a support group for single teenage mothers (four members). All focus group members were black.

Data Collection and Instrunientation. Community leader and focus group interviews were semi-structured to elicit discussion and identify issues that were important to the respondents. Items designed to assess health needs included: (1) What kinds of health problems do black people in this community have most often? (2) What kinds of problems do black people in this community have in getting good health care? (3) What kinds of problems do black people have in maintaining good health? (4) Do you think black and white people in this community have the same opportunity for getting good health care? Items designed to assess existing health resources included: (1) Where do you think black people in this community are most likely to go when they need health care? (2) Is there any place you would not send a black friend who is visiting here? Please explain. Interviewers followed specifications to probe for information about barriers to preventive services, and references to preventive services were analyzed for this study.

In general, data provided by community leaders differed from information provided by household respondents in three ways. First, community leaders were more aware of patterns of health service access and utilization across their counties. Second, community leaders appeared more knowledgeable of community organization, including structural barriers to health services. Third, although it was not uncommon for household respondents to refer to race- and class-based biases in health settings, community leaders and focus group members were specifically asked about and were more likely to describe these dynamics.

Findings

Quantitative data describing preventive service utilization and the reasons services were not received

Table 1. Individuals Receiving Services and Distribution of Settings by Household.

	Individuals Received		Setting: Health Department		Private Practice		Emergency Room		Other Hospital	
	N	%	N	%	N	%	N	%	N	%
Physical										
Infant/child	261	75.9	48	37.5	72	56.3	2	1.6	6	4.7
Adult	292	65.8	48	22.5	148	69.5	1	0.5	16	7.5
Vision	248	38.5	26	18.3	112	78.9	0	0.0	4	2.8
Dental	245	38.0	11	8.7	113	89.7	0	0.0	2	1.6
Gynecological										
Pap smear	166	53.4								
Breast exam	154	49.5	48	32.9	91	62.3	0	0.0	7	4.8
Both	147	47.3								
Prenatal	35	81.4	8	22.2	24	66.7	0	0.0	4	11.1
Childbirth	34	100.0	0	0.0	1	2.9	0	0.0	33	97.1

Note: Percentages of individuals receiving specific services were calculated using number of relevant individuals as the denominator, including: 344 infants and children, 444 adults, 644 school-age children and adults, 311 women, 43 pregnant women, and 34 deliveries.

were derived exclusively from household interviews. Qualitative discussions of barriers to preventive services are based on household, community leader, and focus group interview data.

Patterns of Preventive Service Utilization. The percentage of individuals who received each type of preventive service and distribution of service settings is presented in Table 1. Sample utilization of specific types of services ranged from 38.5 to 100 percent. Pregnant women were most likely to have received pregnancy-related care, including four or more prenatal examinations (81.4%) and medical supervision during childbirth (100%). Children were more likely to have received physical examinations than were adults (75.9% and 65.8%, respectively). Slightly more than one half (53.4%) of the adult women received Pap smears, and 49.5 percent had received breast examinations. In 1985, 41.8 percent of rural women nationwide had received Pap smears, and 45.4 percent had received breast examinations (OTA, 1990a). Likewise, 46.8 percent of urban women had received Pap smears and 51.8 percent had received breast examinations (OTA, 1990a).

With the exception of medical supervision during childbirth, each type of service was most likely to have been obtained in a private practice setting. However, almost one third (32.9%) of gynecological examinations were performed by health department personnel, as were about one fifth of the general physical, vision, and prenatal examinations. With the exception of childbirth, use of emergency room and inpatient hospital settings for preventive services was infrequent, ranging from 1.6 percent for dental examinations to 11.1 percent for prenatal examinations. Less than one tenth of the general physical examinations were conducted in a hospital setting. Non-obstetrical services were often received in the course of treatment for an acute or chronic condition that warranted medical attention, especially if the

Table 2. Primary Reason Services Were Not Received, by Household.

	Not Needed		Preference		Service Availability		cost		Time		Transportation		Child Care		Treatment	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Physical																
Infant/child	10	58.8	0	0.0	0	0.0	5	29.4	1	5.9	1	5.9	0	0.0	0	0.0
Adult	35	46.1	9	11.8	0	0.0	34	31.6	5	6.6	1	1.3	1	1.3	1	1.3
Vision	88	55.3	11	6.9	0	0.0	54	34.0	3	1.9	2	1.3	0	0.0	1	0.6
Dental	104	53.6	10	5.2	1	0.5	71	36.6	5	2.6	2	1.0	0	0.0	1	0.5
Gynecological	30	41.1	15	20.5	0	0.0	23	31.5	3	4.1	2	2.7	0	0.0	0	0.0
Prenatal	6	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Childbirth	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Note: Respondents identified the primary reason members had not received specific services during the past year.

screening was a general physical examination and/or treatment was being received in a hospital setting.

Reason Preventive Services Were Not Received. Table 2 presents the primary reason that household members had not received specific preventive services during the past year. Across the board, the most common reason was the perception that health services were not needed. This belief was cited by more than one half of the households in which dental, vision, prenatal, and children's general physical examinations had not been received. The second most common barrier, inability to pay, was cited in about one third of the instances that general physical, gynecological, vision, and dental examinations had not been received.

Preference and lack of time had a greater effect on service use for adults than children. About one fifth (20.5%) of the women had not received gynecological examinations because of personal preference and 4.1 percent due to lack of time. Likewise, 11.8 percent of the adults had not received physical examinations due to personal preference and 6.6 percent due to lack of time. Lack of provider, transportation, and child care and inconsiderate treatment were rarely identified as primary barriers.

Inability to Pay as a Primary Barrier. Household, community leader, and focus group respondents consistently indicated that inability to pay was a primary barrier to preventive services, with more than one half (53.6%) of the households reporting that they could not always afford a physician when treatment was needed for acute and chronic conditions (Strickland & Strickland, 1995). Woven throughout these discussions was the perception that health service access was inextricably linked to Medicaid coverage. Although it may be difficult for households with Medicaid to locate and receive preventive services, it is often impossible for lower-income households without Medicaid coverage. Unfortunately, many of the barriers to preventive services—such as lack of awareness of relevant agencies and programs, lack of telephone and transportation, and functional illiteracy-are also barriers to establishing Medicaid eligibility.

Service providers were particularly cognizant of three groups that "fall through the cracks" of the health system: middle-aged women, men of all ages, and lower-income households with incomes that exceed Medicaid eligibility guidelines. A local department of family and children services director explained that middle-aged women often lack

resources because they no longer qualify for Aid to Families with Dependent Children (AFDC) or Medicaid when their children become adults, lack marketable job skills, and are not yet eligible for Medicare. The director noted that this population is "often really in a bind as far as lots of things go, but especially as far as health care." Similarly, a public health nurse noted that women are much more likely to receive preventive services because, unlike men, they often enter the health department system through family planning, pregnancy, and childhood immunization programs. Community leader and focus group respondents stressed that Medicaid eligibility guidelines are too low and described the problems that community members face when they "make too much for Medicaid but too little for insurance."

Health Service Availability. The fact that household respondents rarely identified "lack of provider" as a primary barrier implies that health service availability was adequate in the five target counties. However, program directors and service providers in both the public and private sectors stated emphatically that services for lower income individuals were grossly underfunded. Directors in each county explained that current health department resources were insufficient to serve all individuals covered by Medicaid, much less all individuals eligible to receive Medicaid, and/or all households "just over the limit for Medicaid eligibility." Case loads were manageable only because many eligible individuals and households did not request services. Providers associated with one unit stated that the only way they could "survive" was to avoid advertising their services and treating only those individuals who located them through word-of-mouth or the telephone directory. Although the health service providers in the five target counties were understaffed and underfunded, other factors prevented lower income individuals from requesting services in the first place.

Program directors concurred that additional resources were needed for services related to pregnancy and childbirth, including family planning, general and at-risk prenatal care, and, obstetrical services. Medicaid patients in each of the five counties were referred to hospitals outside the county, often several hours away, for obstetric services. It was usually easier for women to request emergency medical transportation to the local emergency room and negotiate payment for physician and hospital fees after delivery. Program directors also stated that additional resources were needed for mammograms for women aged 40 years and older, general health education for parents, health services of all types for lower income men, and efforts to link men to the health department system.

Accessing the System. Even when preventive health programs were available, accessing these services could be difficult. In addition to motivational factors, accessing services often involved knowing about relevant entitlement programs, establishing entitlement eligibility, being aware of local preventive health services, scheduling appointments, and keeping appointments. Consequently, structural barriers included inadequate or ineffective advertisement of services, functional illiteracy, exceeding Medicaid eligibility guidelines, lacking telephone service to inquire about services and make appointments, residing in remote parts of the county, full-time employment, and being homebound due to age, infirmity, child care responsibilities, and/or lack of transportation. The sheer complexity of the social and health service system could be daunting even to middle-class individuals who attempted to serve as advocates. A black fourth-grade teacher who was active in community service noted:

> It is difficult to find out how to access care or special help for people without money. Often, you are told to call person "A," who tells you to call person "B," who tells you to contact place "C." By the time you have done this, most people give up and do not want to bother calling anyone else.

Although rarely cited as primary barriers by household respondents, lack of telephone and transportation interfered with establishing entitlement eligibility and receiving health services. More than one fourth of the households interviewed did not have telephone service, more than one half did not own a car, and almost one third stated that transportation for health services was a problem (25.3, 55.6, and 32.8%, respectively). Owning a car did not necessarily eliminate transportation problems when employed members of the household needed the car for work, the car was not safe for long-distance travel, and/or the household could not afford gas. Relying on friends and relatives for transportation was difficult when appointments involved a 15-minute consultation, one hour of driving time, and two hours in the waiting room. Cab fare from the perimeter of the county often was prohibitive. Transportation programs for Medicaid

recipients were excellent in some of the target counties but limited or nonexistent in others.

Lack of confidence in one's ability to negotiate within the health care system in some cases diminished extent and quality of care even further. The activities director of a black owned and operated nursing home observed that many minorities did not receive benefits for which they were eligible because they lacked a sense of empowerment. She emphasized that this differed from knowing whom to call or which office to go to apply for aid.

> If you can imagine that your whole life you worked in a job where you were told to go to one place and not open your mouth or go in that room or ask any questions or say a word when you're not supposed to.... Imagine going from that type of environment to a Social Security office where suddenly you need to speak up and ask what form you need or what person to see next or find out what type of information you need when you come back the second time.

She concluded that "many of our people, especially older women, just will not be able to do that."

Coping with Prejudice and Discrimination. A number of community leaders and focus group members observed that if you are poor, you are treated poorly regardless of race, and that "many doctor's offices do not like Medicaid patients, and Medicaid patients are treated differently." A focus group member explained, "...one woman who **can** pay or who has insurance is treated one way. Another woman who has Medicaid, is treated another way. It's humiliating, so they don't go for preventive services unless they are really sick. They know people look down on them."

Although there were exceptions, complaints about poor treatment tended to focus on entitlement program personnel and office staff in medical offices. A focus group member summarized the sentiments of his group:

> Often the doctor is fine when he sees a Medicaid patient. But the office staff, such as the receptionist and secretary and other people in the office, are the ones who treat you differently.

Focus group members often considered entitlement program office staff rude and unhelpful and believed that policies discriminated against recipients. Several members described how clients who were late to an appointment because of transportation problems and could not call the office ahead of time because they did not have a telephone were penalized. Penalties included having to reschedule appointments, thus delaying benefits and having to take time off work and/or arrange transportation and child care a second time, as well as being chastened by the office staff.

Preference or Access? "People with similar health status do **not** have similar perceptions, nor do they make similar demands for health care because of differences in health beliefs, illness behavior, social networks, willingness or ability to pay for services, and other social psychological, economic, and cultural processes. The assessment of need is not simply a matter of relating health status to resource availability and distribution, but also the social, economic, and political environment of individuals and populations" (Patrick, Stein, Porta, Porter, & Ricketts, 1988, p. 108).

A number of studies suggest that lower-income rural residents prefer home remedies over formal health services (Bushy, 1990; Hill, 1988). At first sight, the assertion of household respondents that services were "not needed" appears to support this notion. However, to enhance the use of preventive services, it is important to understand what respondents meant by this claim. Data collected in the course of this study suggest that perception of need is affected by financial considerations as well as health values.

On one hand, confidence in home remedies and adherence to the role performance model of health may reduce the likelihood that respondents would consider formal services necessary in the absence of discomfort. On the other hand, respondents were acutely aware of their financial limitations. When dealing with household budgets of $2,500 to $5,000 per year, adults prioritized products and services as absolutely needed or not absolutely needed by household members. For this population, food, shelter, and basic clothing were considered "needed," and indoor plumbing, heat, and transportation were often classified as "not needed" (Strickland & Strickland, 1995). Except in the most extreme cases, medical services were considered a luxury. Respondents tended to be pragmatic, stating "if **I can't** afford it, I don't get care." Consequently, health values and poverty were interrelated rather than separate barriers to receiving preventive services. Although confidence in home remedies and the role performance model of health may lead rural residents to eschew formal services, inability to pay reinforced dependence on home remedies and self-treatment. This suggests that preventive services

will be considered "needed" when health education is coupled with ability to pay.

Conclusion

A temporal model of service access for the treatment of acute and chronic conditions was developed for this population (Strickland & Strickland, 1995). However, data addressed in this article preclude developing a temporal model of preventive service access for two reasons. First, household respondents were asked to identify only the single most salient reason they had not received specific types of services rather than the process by which they attempted to obtain services and the range of barriers they encountered. Second, data provided through household, key informant, and focus group interviews indicated that there was significant interaction between categories of barriers.

In light of these constraints, it is useful to examine general relationships between the structural and nonstructural barriers identified by respondents (Table 3) and assess their effect on preventive service utilization.

Structural barriers pertaining to tangible resources included the range of services available within the community and the adequacy of resources within programs. Across the five target counties, the most glaring deficiency was obstetrical services for lower income women, including Medicaid recipients. Relative to other preventive services, program administrators concurred that they were unable to meet the needs of all lower income adults and children in their communities. At the individual level, ability to pay functioned as a primary barrier to service utilization. Although arrangements often could be made to make and keep preventive health appointments, the options for financing services often were limited.

As nonstructural barriers, certain cognitive, attitudinal, and behavioral processes encouraged or discouraged the use of preventive services. Baseline standards for preventive health screenings and other services were disseminated by public schools, public health programs, and other community institutions. Service use was enhanced when entitlement and health programs advertised their services, simplified program access, and treated clients with respect. In addition, individuals who were responsible for their household's health varied in the extent to which they were aware of baseline standards, believed that services were attainable and desirable, were motivated to seek services, sought services, and felt empowered within health care settings.

Table 3. Structural and Nonstructural Barriers to Preventive Service Utilizaiton Identified by Respondents.

	Structural Barriers	Nonstructural Barriers
Community level	Health service availability	Health education: baseline standards
Programmatic level	Health program resources	Health services advertised Procedures for assessing services advertised Quality of provider-patient interaction
Individual level	Ability to pay Transportation Telephone Time Child care	Awareness of baseline standards Awareness of local programs Belief that services are desirable Belief that services are attainable Seeks services Sense of empowerment

Structural and nonstructural barriers interacted to deter lower income black households from using preventive services in several ways. Major patterns associated with the research population include, but are not limited to, the following. First, due to a lack of information about entitlement programs and poor treatment by entitlement personnel, some households hesitated or were unable to apply for means-tested programs that covered preventive services. Second, in order to ration limited resources, some program administrators did not aggressively advertise their services, thus limiting awareness of available opportunities. Third, due to limited personal resources apart from ability to pay, a number of households had difficulty applying for entitlement programs, making preventive health appointments, and keeping preventive health appointments. This was exacerbated when services, such as obstetrical care, were far from home. Fourth, the perception of prejudice and

discrimination on the part of health care providers and support staff affected some households' desire to obtain services. Finally, preventive services were often considered to be "not needed." In part, this reflected a lack of information about baseline standards and the lack of discomfort and urgency associated with some acute and chronic conditions. This assessment also reflected the common belief that other expenses were more important than preventive services when household income was extremely low.

These patterns suggest that enhancing the use of preventive services involves identifying the complex of structural and nonstructural barriers that deter special populations from receiving services and addressing these barriers at the community, programmatic, and individual levels. Consequently, research concerning preventive services and lower income blacks in the rural South--or other special populations in rural America-needs to address both household- and community-level dynamics. Relative to individuals and households, it is important to identify typical patterns of "service-seeking" behavior, as well as the structural and nonstructural barriers individuals encounter as they seek preventive services. The extent to which specific barriers deter individuals from continuing to seek services due to motivation or practicality also should be addressed.

Although service availability and resources are important at the community level, the nature and impact of non-structural barriers are also important. A number of relevant issues were suggested by this study. For example, to what extent is information concerning baseline preventive health standards, entitlement programs, and preventive services being disseminated by local organizations? To what extent do administrators attempt to limit demand for preventive services in the context of limited resources? Issues of provider-patient interaction continue to demand attention. Although perceptions of racism can deter underserved populations from seeking services, it is also important to assess provider attitudes and behaviors directly as a step toward improving interaction patterns.

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