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INTRODUCTION

Rural Healthcare: The Challenges of a Changing Environment

by J. Paul Newell

I am delighted to be a part of these proceedings. Just to establish my biases, perhaps more than my credentials, you need to understand that I come to this task from three historical and shaping perspectives. The first is that of Family Medicine. I spent twenty-three years of my career in academic Family Medicine and continue to view that particular primary care discipline as the one best suited for providing patient care.
access into the medical system, because of the broad base of training and education it provides for its graduates in the knowledge, skills, and attitudes needed to take care of people on the front line. The second is that of Public Health, my second and current career. I have come into the Public Health ranks only recently, but my understanding of the dimensions of what we mean—or should mean—by health care has been powerfully confirmed and bolstered. The third bias is a particularly personal one; I was raised in a small four corners town of barely one thousand persons, living there until going off to university in the late 1950s; it has been only in the last decade that I have recognized the many ways in which that life experience has shaped my understanding of the issues that this symposium will be addressing today.

All of us are blinkered by our disciplinary training. Coming from a medical discipline as I do, I know how large those blinkers can be. In the mid-1980s, when I was the Chairman of the Department of Family Practice at Southern Illinois University School of Medicine, my horizons on the constituents of health and health care were immensely broadened by a sociologist who worked for the same Department. She would begin with an overhead outlining the complexities of the medical care system, with its intricate layers of primary, secondary and tertiary care, its specialties and sub-specialties, its hospitals and ancillary services and others. She would then put that system—in which I grew up academically—into a context of health care, including Public Health, environmental services, and nonmedical approaches. She would then answer the question “what does it take to develop and maintain a healthy population?” by tucking the health care system into a corner of the third overhead and surrounding it by things such as an effective educational system, political and governmental systems that work, transportation systems that facilitate access, business and economic systems that provide the money that keeps all of our systems greased and moving, formal and informal social support systems including churches and voluntary organizations, effective systems for ensuring public safety, and others.

The point that she so eloquently made is the one that I will make today. Health and health care are incredibly complex concepts. Rural health care is no less a complex concept. Your efforts to deal with some critical legal and ethical aspects of rural health care will, hopefully, become a part of that larger understanding.

The environment for providing health services to rural Americans is rapidly changing because of significant social and economic changes that are taking place in rural America and dramatic transformations occurring in the larger health care system. In many rural communities, local hospitals and health delivery systems have been unable to respond
to the pressures created by these changes, in part because of limited resources and in part because of limited vision and foresight.

Rural society and the rural infrastructure have undergone major transformations in the twentieth century. Rural America is now characterized by its diversity rather than its dependence on agriculture and farm life. Today, service industries, manufacturing, and construction have replaced farming as major economic activities in rural areas. Despite its diversity, the rural economy is very fragile and extremely vulnerable to global economic forces. Many of the sectors (e.g., farming, mining, oil and petroleum, and manufacturing) associated with the rural economy have had economic downturns during the 1980s and continuing.

The above trends have also been accompanied by shifting demographic trends. The 1970s were labeled a "rural renaissance," with the rate of rural population growth outpacing urban growth for the first time in the twentieth century. However, this trend was reversed during the 1980s, primarily because of the depressed rural economy. More recently, rural population growth has again been faster than urban growth, but much of the recent growth has occurred in developing suburbs and fringe areas of metropolitan areas, a number of which were reclassified as urban in the 1990 census.

The rate of poverty in rural America now exceeds that in the major cities of our country. Eighteen percent of rural Americans are impoverished, with one-fourth of all rural children living in poverty. In the rural regions of Georgia, these rates are sometimes strikingly higher, and the racial composition is heavily weighted to African-American. By comparison, the rural poor receive a disproportionately smaller share of public aid than the urban poor, perhaps a reflection of limitations in the infrastructure of distribution.

The social and economic transformation of rural America will have a major effect on how health services are provided there. At the same time, the larger health care environment is changing. Some of the important health system trends that are creating pressures for rural health care delivery are:

1. Restricted reimbursement by public and private payers, resulting in conflict between cost-containment and access goals;
2. Increased financial risk for hospitals, particularly smaller, rural facilities;
3. Structural changes in the health care delivery system, including continued consolidation;
4. Shift of the locus of care from inpatient to outpatient settings;
5. Changes in physician practice patterns because of increased competition and the expansion of managed care programs;
6. Health care institutions' increased need for capital;
7. An inadequate supply of health personnel (physicians, nurses, and allied health professionals) in rural areas;
8. Rapid advances in medical technology with increased consumer and provider expectations; and
9. Fragmentation of and lack of resources for emergency medical systems in many rural areas.

All of the above factors, as well as the changes taking place in rural society, help to explain why many rural hospitals and rural health care systems are experiencing such economic distress. Let me now expand on some of those thoughts, and let my biases show. Let's begin with a subject near and dear to my heart.

I. EDUCATION AND TRAINING

How does the health professions' education and training system impact the availability and quality of health care in rural areas? A summative statement might be that it is not really helping. It has been true for decades, and it is true today, that most of the students in health care disciplines, education, and training programs are being recruited from urban areas, are being trained and educated in urban areas, and are entering practice in urban areas. In some areas, Georgia being one, the disparities have steadily worsened, in spite of the efforts of some. Chronic shortages exist in virtually every category of health care provider, with the most notable of those being in the primary care disciplines. Although 23% of Americans live in nonmetropolitan areas, only 13.2% of all physicians and 6.7% of hospital-based physicians practice in these areas. Although 23% of Americans live in nonmetropolitan areas, only 17% of nurses live there and one out of seven of those nurses actually practices in an urban area. Although 23% of Americans live in nonmetropolitan areas, only 17% of the allied health personnel reside in those communities. The ratio of primary care physicians per 100,000 population is approximately 95 in metropolitan areas, compared to 56 in nonmetropolitan areas, and approximately 28% of the nonmetropolitan population lives in areas designated to have a shortage of primary care physicians, compared to 10% of the metropolitan population. This recitation of the numbers can go on and on, but the critical result is that rural residents frequently experience grave difficulties in obtaining access to care. How this links with other access problems will, I hope, become clearer as I go on.

Next, I will address some bright spots, along with some caveats and some fears for the future. The Area Health Education Centers (AHECs) in Georgia and other states have made significant, highly cost-effective,
and measurable differences in encouraging health professionals to settle in rural areas, through their support of undergraduate and postgraduate training in rural and small town practices. Unfortunately, the AHEC network in this state is in great jeopardy because the will seems not to be present to find the small amount of state funding needed for their continuance, either in new dollars or in reallocated ones. The loss of the AHECs would be a great blow to our efforts to meet rural health care needs through an adequate supply of well-trained providers.

Family Practice postgraduate training has made a substantive contribution to the supply of physicians in rural areas and smaller communities, not enough to keep up with the retirement of an aging population of general practitioners, but meaningful nonetheless. Each year since the recognition of Family Practice as a specialty, a large portion of residency graduates have chosen to practice in small towns and rural communities, with 10 to 14% in communities with fewer than 2,500 people, and 45% in communities with populations smaller than 25,000. Much of the political incentive behind the establishment of Departments of Family Medicine in medical schools came from small town and rural legislators. To the extent that graduates have continued to choose small communities, the academic discipline of Family Medicine is successfully accomplishing its mission. The challenges, however, continue. Students raised in rural communities are underrepresented in training programs, and economic pressures, such as a large debt load from medical school, result in limited interest in less lucrative primary care practice. Family Medicine education almost everywhere in the United States has tended to ignore the power of affiliation with the AHECs, and to my sorrow, this has been true in Georgia, where there has even been hostility and resistance on the part of organized Family Medicine. Family Medicine needs to look hard at the issues that affect the choices made by young physicians. It needs to work hard to prepare them for present and future realities. It needs to pay attention to the support of rural physicians. It needs to do all of this in the interests not only of rural people, but in the interests of its own survival.

I am proud to be a member of the faculty of Mercer University School of Medicine because this school provides one of the outstanding national examples of what can be done in medical education to support and encourage students in their progress toward the primary care disciplines of Family Medicine, Internal Medicine, Pediatrics, Obstetrics and Gynecology, and General Surgery. Over the past several years, Mercer University School of Medicine has had a higher percentage of its graduates entering Family Medicine postgraduate training programs than any other medical school in the United States. That is a proud record, one which resonates greatly to the credit of the school and to the
benefit of the residents of rural Georgia because most of the graduates stay in the state and many enter rural and small town practices. Unfortunately, Mercer University School of Medicine is by far the exception to the general rule in medical schools in this nation. Most medical schools are focused on science, technology, research, and specialization. From a technological perspective, they have given us the most advanced medical system in the world, but from a distributive and social justice perspective, they have helped to create almost third world conditions for many of the residents of this country.

One of the encouraging developments in recent years has been the proliferation of training programs for mid-level providers. These are the physician assistants, the family nurse practitioners, the nurse midwives, and others who are being trained in increasing numbers to provide health care services which supplement those of the physicians in the system. It is to their credit that almost half of these graduates choose primary care and rural or small town practice. The Area Health Education Centers in Georgia have played a substantial role in the development of new training resources for mid-levels, especially in southwest Georgia. Unfortunately, we continue to have many hurdles to cross before mid-level providers are appropriately integrated into clinical rural practice, here and elsewhere. Nurse practitioners, in their zeal for prescribing privileges, and physicians, in their zeal to protect their precious turf, all need to realize that while we do not need a new layer of primary care providers in the system, we do need well-trained mid-level providers who can provide much of the primary care services, at a lower cost, in integrated and team-oriented systems of care. In the best interests of building rural health care systems, all of us have much to bring to the table, and we are wasting valuable time and resources in idle ideologic debate.

It seems increasingly clear that both distance learning and telemedicine technologies are going to bring many benefits to rural citizens. Distance learning will provide benefits to rural citizens because of the role it can play in moving health disciplines education and training out of urban academic settings and into rural ones, and because of the potential it has for bringing rural health care providers into contact with sources of information and learning which otherwise would be difficult and expensive to access. Telemedicine will benefit rural citizens because of the possibilities it holds for bringing effective consultations to rural practices, with concomitant savings in both money and time for the patients served. While the technology now exists for both, it is going to take much more time and effort to effect wholesale transfer of these resources to those who most need them; much learning, both by providers and consumers, is yet needed; and working out issues of costs,
reimbursement, and other complications will provide much entertain-
ment.

Now, I would like to dwell some on another general topic.

II. ADVANCES IN MEDICINE

Technology and other forms of progress in medicine have made the 
American health care system the envy of many, and in many respects, 
that envy is well-justified. Unfortunately, when we turn to examine 
some of its consequences, we have at least to pause in our admiration. 
A quick, but highly critical example: the infectious diseases mortality 
rates, long on the decline in this country, actually increased last year, 
only in part because of the continuing HIV/AIDS epidemic. Much, if not 
most, of that increase was in infectious disease categories previously 
amenable to our vast array of antibiotics. What we have done in our 
technological zeal to stamp out infectious diseases is overuse powerful 
-drugs and encourage the emergence of bacteria that are resistant to 
virtually everything currently on the market. The proliferation of 
technology has had equally devastating effects on rural health care 
systems. The price of much modern technology and of the personnel 
-needed to drive it is far beyond the reach of most rural hospitals. Many 
of them were established decades ago in the early days of Hill-Burton 
and in much quieter medical times. Consequently, much of the high tech care is now centralized, pulling the biggest dollars away from rural 
hospitals. Many of these hospitals have already collapsed, and many 
others are now in transition.

Some more specific, but equally disturbing consequences include the 
following: the almost insurmountable transportation woes of rural 
residents who are forced to drive long distances even for basic care or to 
visit hospitalized family members; rapidly increasing costs that stretch 
the already thin economic resources of rural areas; increasing rates of 
medical indigency, which further reduce the funding base; the shift from 
inpatient to outpatient care. Although the shift from inpatient to 
outpatient care has brought interesting opportunities for rural hospitals, 
it has brought expectations as well. A rural provider is held to the same 
medical and legal standards as any comparable urban provider, with or 
without the technology. I look forward to the presentation by Phyllis E. 
Bernard for more ideas on this subject.

Now, I would like to discuss my next area of concern.

III. FISCAL EXIGENCY VS. LONG-RANGE PLANNING WHICH IS NEEDS-
AND PRINCIPLES-BASED

Managed care exemplifies probably the greatest health care system 
change of this, the last decade of the twentieth century. Managed care
is the provision of health services through an organized delivery system, with a single point of entry and formal patient enrollment. This presents quite a contrast to the traditional system of health care, which could scarcely be characterized as organized. In 1984, 89% of the insured population in the United States was covered by fee-for-service or indemnity plans and 8% by some form of managed care. Projections for 1997 put the comparable percentages at 20% and 70%, an enormous change in a very short time. While managed care has not yet hit the rural areas of Georgia, it certainly has reached others and not always to the benefit of the citizens. Some of the downside of managed care might include items such as these:

1. Total pay, bonus, and option packages for health insurance CEOs are 80% higher than the average for other companies of the same size and financial performance;
2. For-profit hospitals and health systems had a 10.5% profit margin in 1994, compared with 4.3% for the not-for-profits;
3. Medical industry PACs have doubled their campaign contributions to prominent Republicans;
4. The New York Department of Health cited 13 of the 18 largest Medicaid managed care programs in the state for providing “substandard” care;
5. The Florida Supreme Court will conduct a grand jury investigation of Medicaid fraud, including the state’s scandal-ridden managed care program;
6. The year 1995 set a record for hospital deals, with 735 hospitals involved in a total of 230 mergers or acquisitions and roughly 1 in 5 community hospitals changing hands in the last 2 years;
7. Five companies hold 80% of the market for pharmacy benefits management and 3 of the 5 are owned by drug manufacturers.

It is hard to imagine that rural residents will benefit from such shenanigans as those. It does not take a rocket scientist to determine the impact on already fiscally shaky rural health systems if for-profit managed care corporations figure out ways to take money out of the communities that so desperately need those resources. In some respects, when it comes to managed care, being poor may be an advantage because many of the managed care organizations will stay away. Perhaps the best question to ask with respect to the bottom line practices that have become such a way of life in the health care industry is, “What did we come here to do in the first place anyway?” If we are able to contain costs in some fashion, how is that going to affect rural communities already experiencing sometimes severe gaps in service
access and quality? Is cost containment only to be obtained at the expense of those served? Is managed care just an oxymoron, where the management applies only to costs and the caring is thrown out the window? This is certainly not always the case, but equally certainly, it sometimes is. Must we continue to place the decision-making about the future of our fragile rural health care system in the hands of the technocrats, the business persons, and the "bottom line boys," or do we need to bring that future-making process back where it belongs, with the people who will reap the fruits of those decisions. Michael S. Jacobs is going to speak about antitrust reform and its effect on rural health care markets; I am hoping that he will at least raise the question as to whether our vaunted traditional models of good old American competition are actually compatible with service to, and responsibility toward, other human beings. Do we need some new paradigms of competition which will actually meet the needs of the people needing service?

Finally, I want to talk just a little about one last subject.

IV. POLITICS, VALUES SYSTEMS, SOLE PROVIDERS, AND OTHER NEEDS/RESOURCES DILEMMAS

These are some not so random thoughts.

It is customary, following the Clinton administration's debacle over global health care reform, to say that this issue is dead. It is not! The private sector is creating immense reform of the system, based on certain principles, some of which may not be in the best interests of rural residents or others for that matter. Federal and state level politicians continue to nibble at the edges of the system, trying to fix with little bandages what is, to many of us, a badly broken system. For the time, it is clear to me that the political will for large solutions to such a large problem simply is not there. The lobbies, the vested interests, the political fears, and the high levels of intolerance and ignorance are too much to overcome, given the low levels of courage and short attention spans.

Answering that lack of response, business is weighing in, here and elsewhere. Business, in the form of payers, is driving the cost-containment process and business, in the form of insurers, is making a lot of money for providers. However, the consumers of health care are being left out of the equation. If that is all right with you, it is not all right with me. An encouraging note is that the Georgia Business Forum on Health presented its report, Health Care That Works, to the Georgia Health Policy Center, in February of this year. The values articulated were as follows:

1. A system driven by voluntary choices rather than mandates;
2. Access to affordable coverage for all;
3. No free rides, for providers, patients, employees or businesses;
4. Accountability for all players;
5. Good value for the customer, whomever that might be.

Another encouraging note, at least in Georgia, is that Georgia Health Decisions has developed a consensus statement concerning the constituents of a standard benefits package for health care insurance offerings in this state; this sits currently in the legislature awaiting action. It will be interesting to see if the will and courage are there.

There are so many other issues. Just a few include the following:

1. The Privatization Boondoggle. The private sector has already demonstrated its understanding of Willy Sutton’s law—going where the money is. Why should governments be giving responsibilities away without the assurance that services will be continued and expanded? The privatization of Medicaid is a particular instance; it could have devastating effects on rural Georgia.

2. Welfare Reform. In our haste to reduce payments to deadbeats, let us not forget that many of them live in rural areas and they are not deadbeats either by choice or by behavior. Efforts to cut funding without concomitant efforts to address the underlying issues that continue to exist and to grow are bound to create more problems than they eliminate.

3. Religious Issues. They are not a small consideration in “The Bible Belt.” While it is important to be truly tolerant of others’ beliefs, on making decisions about health care we must be clear in the distinction between principles and ideology. Lisa C. Ikemoto will be addressing a particular instance of this concern, which is not a small one in the light of all that we know about mergers and acquisitions in the current dynamics of health care system change in rural regions.

4. Ethnic Issues. One of our national presidential candidates has fairly put the fat in the fire around the immigration issue. I am here to tell you that in rural south Georgia, migrants and seasonal farm workers, legal and illegal, are coming and going, and staying, in inaccurately counted droves. Their presence is a great economic boon to the area; from a health care provider perspective, it can be a great economic drain because virtually none of them have any visible means of paying for even the limited emergency services they
receive. The humanity that we build into our efforts to grapple with this issue may well define the outcomes for all of us.

V. CONCLUSIONS

My sociologist friend, who taught me what I really needed to know about the complexities of the health care system, also made an accurate prediction of the course of rural health care more than a decade ago. Not only did she predict continued decline, she pointed to the fact that if the then high level of interest in “fixing” the rural health care system did not bear considerable fruit within less than ten years, the interest would shift elsewhere and rural America would be forgotten. In spite of my somewhat apocalyptic vision of the present and the future for rural health care, I actually operate out of a position of considerable trust, faith, and optimism in virtually everything I do. I trust that this symposium is evidence of renewed concern. I have the faith that it will lead to new and health giving conclusions. I am optimistic for the future when we will work unselfishly together to solve problems and meet needs, in rural Georgia and elsewhere. Without that commitment to cooperation, I fear that persistent decline may well be inevitable, and the sociologist's prediction would become reality. Let us not tolerate that outcome.