The Journal of Regional Analysis & Policy

Special Issue on Rural Development Policy - JRAP 37(1):56-59.

State-level Rural Health Policy

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Introduction

Most discussions of rural health policy overlook the key role that states play in crafting and delivering programs that directly affect the access, cost, or quality of health services to rural residents. However, policies such as regulations embodied in medical practice acts, education programs, and funding for local public health programs are the subject of debate in state capitals. Moreover, the current climate of devolution and block grants serves to increase the state government role in shaping the effectiveness of rural health programs. Despite the lack of discussion of the state role by rural health researchers, state governments play a vital role in rural health. This paper provides state-level policy makers with an overview of the key issues in rural health and principles for developing policies and programs in this area. Furthermore, this paper argues that states should adopt a "rural lens" in health policy formulation. That is, states should explicitly account for the differences in medical geography of their rural areas when crafting and implementing health policy. Additionally, this paper suggests scrutiny of current rural health policies so that significant rural people (the intended beneficiaries) do not lose benefits from the policies through rent-seeking behaviors of powerful interests in the health care arena on the provider side (physicians, hospitals, medical schools).

Rural health policy discussions focus on access, cost, and quality of care issues. Access issues refer to a number of barriers that consumers and communities face in obtaining health care, including the relative lack of specialist physicians in rural areas, as well as individual-level variables (for example, income and health insurance coverage) that ration care or make it more difficult for people to obtain appropriate health care. The average rural county in 1998 had 2.4 times the population per physician as the average urban county, where urban is defined as counties in a metropolitan area (Area Resource File, 2000).

In the case of medical specialists the gap increases: the ratio of population per obstetrics-gynecologist in rural areas is three times that of urban areas; the ratio of population per psychiatrist in rural areas is 3.6 times that of urban areas (Area Resource File, 2000). Cost issues include not only the high costs that consumers face in purchasing health care services, but also the unique costs that arise from delivering health services in areas with a low population density. Those costs include the cost of maintaining emergency room availability spread over a relatively small served population and the cost of travel effort for rural residents to obtain care in urban centers. Quality issues also arise because of the limited number of specialists in rural areas and because for many medical procedures, quality is a function of volume, such as the number of illnesses treated or surgeries performed. On average, rural residents display poorer health status relative to their urban counterparts, and their access to care is generally poorer than that of urban residents (Braden and Beauregard, 1994).

States should implement policies to improve rural health care for several reasons. First, many voters accept the economic concept of a merit good, which in the theory of public finance introduces an ethical dimension into economic thought (Musgrave 1959). The concept of a merit good contradicts the Pareto optimum principle, but does allow the government to take action in the economic domain to provide goods even when their provision is unwarranted because the absence of a market failure. Since many voters support the concepts of adequate health care and education as merit goods, public policies often respond to these concerns. Secondly, rural health warrants specific attention because the medical geography of rural areas differs sharply from that of more urbanized areas. Given that policies are implemented to ensure ade-

quate access to health care for residents in general, if attention is not paid to the interaction of the program or policy design with the regional geography, distinct inequities in access or program performance may result. Third, states have a natural responsibility in the area of rural health because of their subsidiary role in the federal public finance system, which relies on states for delivery and promotes state-specific program implementation of key policies (e.g. Medicaid). In addition, states have an undisputed role in areas such as education (including higher education and workforce development) and professional licensure. Given the importance of education, workforce development, and practice acts for rural health, they also make natural domains for state-level rural health policy.

State Policies and Programs

A broad set of state policies affect rural health care. State policies and regulations that define public health programs, medical professional practice, Medicaid payments, and the education of health care professionals all play a role in rural health. In addition to the state-level Offices of Rural Health, many states have specific rural health policies and programs, including state-funded efforts to attract and retain medical professionals to rural areas, grants for the development of rural health clinics, programs to train medical doctors and other health professionals, health information and monitoring efforts, and programs of research and analysis.

The first types of state policies affecting rural health, with perhaps the greatest impact, are those health and medical policies that lack a specific rural emphasis. Such policies include Medicaid reimbursements and professional licensure and practice acts. They often display a differential impact in rural areas because "one size doesn't fit all" in the context of implementing policy. Consider the example of Medicaid reimbursements for oral health services, where presumably the objective of the program is to provide dental services to Medicaid program participants. In Illinois, the Medicaid program pays dentists a set fee for a given procedure. The reimbursement rate provides dentists with about 50-60 percent of their usual and customary charges, and most dentists do not participate in seeing Medicaid patients. However, there is strong evidence that rural dentists face greater excess demand than do dentists in the metropolitan areas of the state. Byck (2001) reports that the ratio of population per dentist is greatest in rural Illinois (3,162 people per dentist), lower in metropolitan Illinois counties excluding Cook County (1,643 people per dentist), and lowest in Cook County, Illinois (1,548 people per dentist). The fixed reimbursement schedule does not factor in differing market conditions across rural and urban areas, leading to the outcome that relative to urban Medicaid participants, rural Medicaid patients have a more difficult time seeing a participating dentist.

Other state-level health policies similarly tend to ignore the variation in markets across the state. Improving state health policy for rural residents requires addressing the realities of rural health in public health and medical legislation. Some of the other areas for state-level attention include: 1) licensure and practice acts and the extent to which they constrain the ability of mid-level practitioners (i.e., physician's assistants) to extend a physician's practice to a remote site without supervision on-site; 2) state licensure as a competitive barrier to telemedicine advances (for example, in some states only a physician licensed by that state can treat a citizen in that state); 3) examining whether state regulations limit the ability of rural hospitals to form cost-saving agreements with each other; 4) evaluating whether Certificate of Need legislation that requires health care institutions to receive state approval before making significant capital investments is a barrier to competition; 5) consideration of whether state-level public health information systems include sufficient information to make area estimates for rural parts of the state, as well as whether they survey providers in the license renewal process to obtain information that can be used to estimate access to health care; 6) state mandates for providers to see Medicaid or other patients facing access barriers; 7) state regulation of health insurers and whether or not medical underwriting is permitted; and, 8) state policies to reduce the number of people without health insurance.

The second type of state-level rural health policy includes those policies and programs created to address specific rural health needs. Provider recruitment and retention programs top the list as the most common state-level policies and programs designed to support rural health care and improve access (Slifkin, 1999). While physician recruitment and retention programs garner the most attention, there are programs for other health care professionals as well, including dentists, mental health professionals, physician assistants, and nurses. State policies and programs aimed at provider recruitment and retention range from changes in the graduate medical education so that primary care in rural areas receives emphasis to scholarships and loan repayment programs for rural providers. Other state programs include subsidies for rural providers in the form of income tax credits, malpractice premium subsidies, and state programs that

offer professional support (*locum tenens* programs) so that rural providers can obtain continuing education or personal time away from a practice.

Despite their popularity as a policy response to the relatively low population to physician ratios seen in rural areas, researchers disagree about the effectiveness of these recruitment and retention programs. In a review of experiential rural training programs for medical residents, Rosenthal (2000) reports that graduates of these programs practice in rural areas with much greater likelihood than the average family medicine resident, and that the graduates report that they are well trained for rural practice. The educational argument for specialized rural training programs rests upon their ability to nurture the specific "skills, knowledge, and values of rural practice" (Rosenthal, 2000). However, to my knowledge, no cost-benefit analyses exist for these programs and there is some economic evidence that they may simply result in the displacement of providers that would otherwise serve rural areas.

A series of studies of the locational distribution of physicians raises some doubts about the extent of the physician access problem in rural America and whether government intervention will effectively redress the perceived imbalance. Newhouse and his colleagues (Newhouse, et al., 1982a; Newhouse, et al., 1982b; Schwartz, et al., 1980; Newhouse, 1990) present empirical evidence supporting the view that the geographic distribution of physicians follows a process predicted by standard locational choice theory. As the supply of board-certified physicians increased from 1960 to 1977, the location pattern of specialists became more diffuse geographically (Schwartz, et al., 1980). Moreover, as theory predicts, as the supply of specialists increased, smaller communities experienced a greater increase in specialists per person than did larger communities. In the absence of an externality, a program that places a physician in a town that he or she would not have located in otherwise exacts a loss of efficiency. The efficiency loss occurs since the physician is less busy in the placed location than he or she would have been in the market-determined location. The geographic analyses also raise the issue of the potential for physician recruitment programs to displace other physicians and for the need to focus on the characteristics of the residents and their places that make it difficult for residents to obtain care. However, since an equity issue is involved here (equity can be interpreted as a merit good or a type of consumption externality), a second question arises: namely, whether or not these recruitment and retention programs provide equitable access for rural residents efficiently.

How to Do It Right

For states to promote access to health care services in their rural areas, they first need to bring a specific "rural lens" to the development and implementation of health policy initiatives. To understand whether a functioning rural health policy is in place, we can look within the State Department of Public Health and then examine the role and capacity of the Office of Rural Health. Does such an office exist? What is its mission? Does it have staff commensurate with its responsibility? Does it routinely provide input into new program initiatives, ranging from covering the uninsured or to health care workforce development initiatives? If the answer to these questions demonstrates a weakness, then the first policy priority should be to strengthen and enable this office so there is an effective voice for rural health in state government. Beyond the Department of Public Health, a voice for rural health needs to be present at a number of forums including any advisory groups to the governor on rural affairs, workforce development agencies, and in the education policy area (especially higher education).

Many state-level health policies do not take into account the differences between rural and metropolitan areas and how those differences might affect policy implementation. That can lead to differences in policy outcomes between urban and rural areas because "one size does not fit all." Most rural areas would benefit if their state policymakers had a greater appreciation for the unique issues facing rural health as states craft public health and medical programs and policies. Bringing a "rural lens" to the development and implementation phases of these policies and programs would go a long way towards meeting the need for flexibility in designs so that rural people can best improve their access to health care resources.

Secondly, states need to examine their current rural health policies for a provider bias. Most of the current approaches to improving access to health care in rural areas invest heavily in the education and attraction of health professionals, yet the extent to which the programs are involved in health care labor markets is not often acknowledged. The danger with the current approach is that it introduces a possible significant economic inefficiency if limited health resources are channeled into programs and policies that are targeted at powerful health professionals (through grants to medical schools or education grants to physicians) rather than to communities and rural people. A greater understanding and appreciation of the nature of markets in rural health (including hospital markets, health care labor markets, etc.) might generate less distortionary and more efficient policy approaches

that still meet the access objectives. Furthermore, beyond fairly crude designations of geographic areas of need, there is presently little subtlety in the targeting of these programs. States might conduct more stringent evaluation and cost-effectiveness studies to highlight the most efficient means of improving access in rural areas. Also, to avoid the inefficiencies that can arise with poorly targeted programs directed at providers, states should focus more attention on alternatives that deal directly with rural consumers and communities.

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