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# THE STATE OF THE RURAL HEALTH CARE SYSTEM

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As one examines the health care system in the United States and in rural America, it is very easy to make seemingly outrageous statements and use expletives that may subsequently need to be deleted. That is because the U.S. health care system is simply outrageous. It is outrageous in the way that those with vested interests promulgate a set of myths about it. It is outrageous in what it costs us as Americans by comparison to health care systems in many other countries. It is also outrageous in the amount of waste, and in the excessive cost of administering the system.

In examining health care available to rural Americans it is a little hard to know just how one should approach the question. There is a problem in deciding just how we should frame the public policy question being examined. For example, is the issue to be discussed a question of the disparity between the health care available to rural people, as compared to the rest of the society? In this context we might examine alternatives for rural people that would seek to bring the services available to them more into line with what is the norm for the rest of the society.

Alternatively, is the issue one in which the care available to rural citizens is simply further evidence of dysfunction within the entire system? Under this framing of the question, the care in rural areas is simply additional variance within the system and the promising alternatives for rural people may be the same as for everyone else in a system needing massive system-wide change.

If I can refine our understanding of the rural health problem in just this limited way, I may have helped.

There are those who feel it important to distinguish between the health insurance system and the health care delivery system. Since I believe they interact considerably, I think we need to deal with the total. Further, since the means by which people gain or lose access to health care is through the means whereby their care is financed, I believe it is important to consider the rights or lack of rights to medical insurance as a part of the social infrastructure with respect to health care. The analogous point could be made with respect to edu-

cation and educational finance. Whether or not, in a particular state, access to some *minimum minimorum* of education is stated or implied as a constitutional right is a part of the social infrastructure with respect to education. Let's proceed and see where we come out.

### The State of the American Health Care System

Without going into all of the gory details, it is useful to get some kind of an idea of where we stand as a nation on our health care system. Consider the following:

- According to the July, 1992, *Consumer Reports*, we will spend about \$817 billion on health care in 1992—about 12 percent of our GNP.
- Of that amount, *Consumer Reports* estimates that \$200 billion are wasted on “overpriced, useless, even harmful treatments, and on a bloated bureaucracy.” Canada’s system, serving 25 million people, employs fewer administrative staff than does Massachusetts’ Blue Cross and Blue Shield, which serves 2.7 million.
- Of the \$817 billion, \$163 billion goes for administrative costs according to *Consumer Reports*.
- *Consumer Reports* states that only a fraction of 1 percent of the total is spent on research.
- Malpractice insurance consumes 3.7 percent of physicians’ practice receipts, though this amount is clearly higher for some high-risk and high paid specialties. Malpractice costs are less than 1 percent of the total in health care costs. Malpractice as the culprit in driving up health care costs is a straw man according to *Consumer Reports*.
- The 1987 rank of the United States among “selected” countries in infant mortality was 24th, with Spain, Hong Kong and Singapore, among others, ahead of us (National Center for Health Statistics). **Note:** Remember that infant mortality is the statistic that basically tells us what kind of prenatal care is widely available to pregnant women in a society.
- Life expectancy at birth, a measure of our overall health system performance, was 23rd for men and 16th for women. One would be better off being born a male in Hong Kong, Spain, Costa Rica or Cuba than in the United States, and better off being born female in Puerto Rico, Spain or Hong Kong (National Center for Health Statistics).

The July, 1992, *Consumer Reports* suggests some widespread myths about the American health care system that are worth sharing with you.

**Myth:** Although some 35 million people are not covered by insurance, the rest of us are getting very high-quality care.

**Fact:** Some of the rest of us are doing well. Many others are victims of a system that traffics in superfluous equipment, unnecessary and potential harmful surgery, over-medication and questionable procedures. Consumers end up paying the ever-escalating bill for all that, either directly or, when employers cut back on coverage, indirectly.

**Myth:** Our country cannot afford to spend much more on health care.

**Fact:** It does not have to. The Consumers Union estimates the combination of waste and excessive administrative costs amounts to \$200 billion—enough to provide quality care to all Americans without additional government spending.

**Myth:** Our system gives us the best medical care in the world.

**Fact:** Our system puts us near the bottom among industrialized countries in infant mortality, the availability of high-quality primary care and public satisfaction (*Consumer Reports*, July, 1992, p. 411).

## Who Are the Least Well Served?

Clearly the least well served by the United States health care system are those citizens who have no medical insurance coverage. There are, according to the Employee Benefits Research Institute, 36.0 million Americans with no health insurance. By all accounts they are the working poor—those not poor enough to qualify for Medicaid—the self-employed, and the employees of small businesses. These clearly are many of the folks of rural America and, indeed, are found in disproportionate numbers there. Of the nonelderly population without insurance, 17.4 percent are in rural areas as against 16.3 percent in urban areas, according to the Employee Benefits Research Institute (EBRI).

The next least well-served group in the national health care system are those citizens covered by Medicaid. This is so because the Medicaid coverage is generally considered to be less than adequate to provide for even primary care services. There are 24.2 million “covered” by Medicaid. Again there are proportionately more of the nonelderly persons covered by Medicaid in rural areas than in urban, 10.3 percent as compared to 9.3 percent (EBRI).

In an effort to better describe the numbers of Americans who are medically underserved, the National Association of Community Health Centers (NACHC) counted the people who have inadequate access to primary health care because of their economic situation, their existing health status or geographic proximity to sources of pri-

mary care. Described as “at risk” for underservice are the low income uninsured, the nonelderly “covered” by Medicaid, and low income persons covered by Medicare. More than 50 million, or 20.5 percent, of our citizens fit the at-risk category.

NACHC describes as “underserved” those of the at-risk group that are already in communities exhibiting poor health status or measures of inadequate well-being, or who are in communities exhibiting physician shortages. They find 17.2 percent, or almost 43 million, of our people to be medically underserved.

Whether we count the 60.2 million Americans without any insurance or on Medicaid, or whether we consider the 43 million identified as medically underserved, we are not doing very well.

### **What Drives the U.S. Health Care System?**

According to Consumers Union, “. . . the system is geared to providing the services that can earn physicians and hospitals the most money—not the ones that will do the public the most good. . . . During the 1980’s, while American hospitals were falling all over themselves to add costly, high-tech neonatal intensive care units, the number of mothers unable to get basic prenatal care climbed, as did the incidence of premature births.” (*Consumer Reports*, July, 1992, p. 447).

Because the basic design of the medical insurance system was aimed at securing a steady cash flow for hospitals rather than in insuring individuals against disaster, the medical finance system has been easily manipulated to increase the incomes of both hospitals and doctors. In economic terms, hospital insurance was designed to solve an option demand problem that hospitals have. “Hospital insurance” would provide services up to some maximum, based on prepayments. When that program is administered for them by Blue Cross and Blue Shield, the hospitals have an interest in pricing their services as high as possible, since they do not worry about the individual’s limits.

Similarly, when the same scheme was applied to doctors’ services, it was in the interests of both hospitals and doctors to employ practices and techniques that captured as much, and as quickly as possible, all of the “insurance” coverage available. Further, unlike auto insurance, medical insurance does not “indemnify” you against a loss, giving you the choice between getting the car repaired or pocketing the money and taking the bus. You only get the benefit if you are in the hospital. Thus hospitals need doctors to prescribe “hospitalization.”

When “flat rating”—that’s what auto dealers do on specific repairs—\$85.50 for labor to replace a water pump regardless of the amount of time—was employed by insurance companies to bring

medical costs into line, doctors and hospitals went for new high-tech medicine as a way to beat the system. Induced demand for new techniques meant a new chance to establish a new, high price structure, and to continue to pump the system.

There is, for example, evidence that hospital occupancy rates are similar in communities with very different numbers of hospital beds per thousand population. Thus, it is not wrong to conclude that the use of hospitals is a function of the numbers of available beds, not of the medical need for hospitalization. Similar evidence of Say's Law—supply creates its own demand—run rampant exists in the use of all manner of medical practice from open heart surgery to the use of CAT Scans and MRI Scans. When that evidence is coupled with knowledge that the use of expensive, high-technology diagnostic testing by physicians is strongly influenced by whether or not they have an ownership interest in the laboratory or facility providing the service, it is very hard not to become very cynical about the whole system.

### **Rural Health Care**

The findings of the study on the medically underserved by National Association of Community Health Centers provides some insight to the character and problem of health care and access to health care in rural America. To determine the number of underserved Americans, an index was created that included poor performance in health status, limited access to primary care physicians, or socioeconomic characteristics. The citizens in the communities in the lowest quartile were then considered to be underserved.

Of the total of 2,147 counties identified as underserved by primary care medical services, 74 percent of the counties were rural, although the urban counties accounted for many more underserved people. The majority of the counties designated as underserved (73 percent), were so designated because of depressed health status rather than access to physicians. In rural counties, access to physicians was much more significant in determining underservice than in urban counties, although more than two-thirds of all rural counties were determined to be underserved by reason of depressed health status alone.

There was, indeed, considerable variation in regions of the country in the determinants of medical underservice. For example, in North Dakota, Nebraska, Tennessee, Missouri, Utah and Vermont, physician shortage was a key role in determining medical underservice. Other areas were designated as underserved because of reduced health status from causes treatable by primary care facilities. This suggests that the approaches to ameliorate problems in rural health care will vary from community to community or state to state. For example, where the problem of underservice is associated

with poor health status resulting from ignorance as much as access, then vigorous educational programs may contribute significantly. Conceivably both the health care problems associated with high infant mortality rates and morbidity from immunizable diseases could be partially addressed in this way. Conversely, where the problem is clearly one of access to primary care facilities or physicians, the approach will be much different.

Interestingly, though not reported, the results of the NACHC study indicate that 18 percent of urban (metro) people are medically underserved as compared to over 15 percent of rural people. I have had no opportunity to seriously evaluate the method of determining medical underservice. However, it would appear that, while there are proportionately more uninsured persons and more persons at risk for underservice in rural America, rural Americans at risk fare somewhat better than do those in urban areas.

## **Conclusions**

When I started to prepare this paper, I was planning to talk about quite different things.

It is true and important that Medicare reimburses rural hospitals at a lower rate than urban hospitals, and that is making life very difficult for many of those rural hospitals.

I was going to address the notion that maybe some of those hospitals should, indeed, go out of business or be consolidated with others on the grounds that a good outpatient clinic with good communications with an urban hospital would be better than a mediocre rural hospital with inpatient services.

I was going to talk about the role of emergency medical services (EMS) provided by volunteers, and the increasing possibilities offered rural communities by telemedicine, including teleradiology and other improvements in communications.

I was going to talk about the potential and the problems of institutionalizing home care for the elderly or others with needs for long-term care.

All of those concepts are relevant to a viable social infrastructure to serve our rural communities health care needs.

However, I think the most telling fact of all is the one indicating that rural Americans, more at risk for underservice, are doing better than their urban brothers and sisters.

It is clear that the remoteness, the isolation for physicians, the poverty and lack of health insurance, and the limited health facilities result in a health care system that is substantially different in rural America than that available in urban America. However, it may very well be that the reduced system available in rural America is

still more effective than all of the fancy high-tech approaches available in the cities.

One can imagine that a community like Brandon, Vermont, with thirty-five trained volunteer members of the EMS program providing a community of about 6,000 people with around the clock ambulance and emergency medical coverage, may indeed have a higher level of medical and health consciousness, than is the case in many urban communities.

Finally, the degree to which rural people are denied access to the larger national health system, may be the degree to which they have been saved from a fate that, indeed, includes death for many of those who seek help, but are malserved by that system.

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