AgEcon SEARCH
RESEARCH IN AGRICULTURAL & APPLIED ECONOMICS

The World's Largest Open Access Agricultural & Applied Economics Digital Library

This document is discoverable and free to researchers across the globe due to the work of AgEcon Search.

Help ensure our sustainability.

Give to AgEcon Search

AgEcon Search
http://ageconsearch.umn.edu
aesearch@umn.edu

*Papers downloaded from **AgEcon Search** may be used for non-commercial purposes and personal study only. No other use, including posting to another Internet site, is permitted without permission from the copyright owner (not AgEcon Search), or as allowed under the provisions of Fair Use, U.S. Copyright Act, Title 17 U.S.C.*

RURAL HEALTH CARE CRISIS

Sam M. Cordes
University of Nebraska-Lincoln

Rural health concerns are not exactly a new phenomenon. For example, in 1862, President Lincoln's Commissioner of Agriculture described the high incidence of insanity and respiratory disease among farm people, noting that the longevity of farmers "is not as great as we might suppose." On the scholarly side, significant attention has been directed toward the issue since the 1948 publication of a book titled *Rural Health and Health Care* by Frederick Mott and Milton Roemer.

While rural health concerns are not a new phenomenon, the amount of attention they are receiving appears to be at an all-time high. These concerns and the fundamental values and issues underlying them are complex; and they represent an extremely challenging and equally rewarding opportunity for public policy educators.

An overview of these concerns and issues can be provided in the answers to four rhetorical questions:

1. What is the rural health crisis?
2. Why are rural health services valued?
3. What is the sensible framework within which to consider rural health policy options?
4. What are the opportunities and challenges for public policy educators in this area of concern?

What Is the Rural Health Crisis?

What do people mean, and not mean, when they make reference to the rural health crisis? One might hypothesize that the underlying concern would be human capital and rural labor productivity, which is the theme of this workshop. Indeed, research has shown health problems are often a significant barrier to labor force participation in rural areas (Scott et al.).

Notwithstanding the conceptual soundness of linking the "rural health crisis" to the human capital concept, I do not believe that is

the issue at stake. Instead, I believe the term "rural health crisis" conjures up concern over the health services infrastructure in rural America.

Of course the immediate question that comes to mind is this: Isn't the provision and utilization of health services an input into the production function for health and human capital? In general, the answer is "yes," but the linkage is probably not as strong as one would think, or like.

For example, a recent Florida study concluded that the number of prenatal visits and hospital beds per 1,000 population had a statistically significant relationship in the expected direction to infant mortality (Clarke and Coward). However, the number of obstetricians and gynecologists per 1,000 population did *not*; and the complete model explained a mere 18 percent of the total variation in infant mortality.

Stated differently, other variables such as genetics, lifestyle, and nutrition—to name just a few—are probably much more significant than health services in influencing health status, and human capital.

Why Are Rural Health Services Valued?

Apart from any contribution health services may or may not make to the stock of human capital, they serve many other functions. Among those functions are, (a) caring, (b) reducing uncertainty and (c) meeting broad legal and societal requirements.

Caring. Victor Fuchs notes

> . . . People who are in trouble, who are in pain, who are disabled, want to see someone, to talk to someone, to share their troubles with someone. As much as a "cure," they want sympathy, reassurance, encouragement. . . . Above all they want someone who *cares* . . . Indeed, with the decline of religious belief, the breakup of families, the increase in mobility and anonymity in our urban culture, it may well be that the demand for "caring" is greater than ever before.
>
> "Caring" is particularly important at the close of life, when a "cure" is impossible. . . . (Fuchs, p. 65).

Reducing Uncertainty. Two significant ways in which health services reduce uncertainty are by their sheer presence and by providing information. Simply knowing that health services are present or readily available in a community may have as much value in terms of reducing uncertainty and anxiety as will the value derived from actually using the services. This is one reason why so much concern exists over the distance to health services in the sparsely populated areas of the Great Plains and Intermountain West.

Additionally, an individual may place a high value on reducing un-

certainty via accurate health care information, even if the information provided represents "bad news." Typical questions an anxious individual may want answered are: Is there anything wrong with me? If there is something wrong with me, how did it happen, can anything be done about it, how long will it last and should I go to work?

Meeting Broad Legal and Societal Requirements. Crawford argues that this role of health services includes . . .

> (securing) required physical (examinations) for employment, school related activities, operation of a motor vehicle, and procurement of life insurance. Also included here are legal requirements for physician coverage at various school sports events. In at least one state, Pennsylvania, the state association regulating school sports events (PIAA) requires a physician to be present at all PIAA-sanctioned football games. Some smaller rural communities with high school football teams have found themselves nearly forfeiting a game for lack of physician coverage.

Additionally, it is important to view rural health services within the broader context of rural economic development. It is possible to identify at least three roles for health services vis-a-vis broader rural economic development goals: 1) the amenities role; 2) the employment role; and 3) the investment funds role.

The Amenities Role. While not necessarily a major factor in influencing the location of business and industry, it is not unreasonable to believe that a community with adequate health services will be more attractive to potential employers than will a similar community with inadequate health services.

Apart from their role in attracting businesses and industries, health services may be even more important in attracting and retaining community residents. The concept of people as an economic base has become increasingly important with the growth in "passive income" (dividends, interest, rent and transfer payments.) Today, passive income accounts for approximately one of every three dollars in U.S. personal income, with much of this income tied to the retirement-age population.

While it is true that jobs attract people; it is equally true that people attract jobs; and communities need to be much more cognizant of the contribution Social Security, Medicare and other transfer payments make to the local economy. I contend that the economic stress in rural areas associated with the farm crisis in the 1980s would be considered a minor economic ripple in comparison with what would happen if the 6 to 8 million elderly residents in rural America left and took their spending power, including Medicare, with them.

The Employment Role. An Oklahoma study indicates that a full-time physician in a rural community typically employs about four

persons (Doeksen and Miller). The study also suggests that local spending generated by a physician's practice and the practice's personnel may generate an additional thirteen nonmedical jobs in the local economy.

Similarly, it has been estimated that a typical hospital in a rural Pennsylvania community of 7,700 population could account—directly and indirectly—for one-fourth of all the community's jobs (Erickson et al.). Additional work by Doeksen and Altobelli suggests the impact of hospital closure may be greatest in smaller rural communities—at least in a relative sense.

Another way in which health services can conceivably contribute to economic development lies in their ability to export services to a much wider geographic area. Spectacular examples of this approach include the world-renowned Geisinger Clinic in tiny Danville, Pennsylvania, and the Marshfield Clinic in Marshfield, Wisconsin. Smaller-scale examples include drug and alcohol rehabilitation centers serving the urban elite but located in rural areas, such as the Hazelden Foundation in Center City, Minnesota.

The Investment Funds Role. Part of the Pennsylvania study cited earlier involved an analysis of an eight-county nonmetropolitan area, and it was determined that the cash and short-term investments associated with the area's sixteen hospitals totaled more than $6 million. Moreover, 90 percent of these funds were held in local financial institutions. These holdings provide a substantial source of funds that can be used for investment purposes by local businesses and individuals.

A Sensible Policy Options Framework

What framework makes sense when considering rural health policy options? As an economist, the answer is simple: supply and demand! Let us begin with the realization that many Americans—in both rural and urban areas—face difficult situations in having their health care needs met. However, the primary reason for the problems faced by urban citizens is on the demand side. Specifically, many urban residents face financial constraints, including inadequate health insurance coverage, that prevent them from translating their physiological and psychological *needs* into *effective demand.* At the same time, it is not apparent that an inadequate supply of services is generally a bottleneck in urban areas.

In contrast, in rural areas, both the supply and demand side of the equation require considerable attention, although the emphasis changes from one part of rural America to another. For example, I would argue that the supply of services—at least in a spatial context—is not as much of a problem in the rural Midwest as it is in the Great Plains and Intermountain West.

Although issues on both the supply and demand side require attention, most of the attention historically has been on the supply side. The initial supply-side push began with The National Hospital Survey and Construction (Hill-Burton) Act of 1946. While not specifically designed for rural areas, this Act had the effect of channeling billions of dollars into the construction or modernization of rural hospitals. As a consequence, the ratio of hospital beds to population was brought into parity between rural and urban areas and remains so today. Today, the hospital industry, much like agriculture, faces significant excess capacity—in both rural and urban areas. During the 1986–1989 period, an average of forty rural hospitals closed annually (Doeksen and Altobelli), and it has been estimated that nearly one-fourth of all rural hospitals are at serious risk of closure (U.S. Senate Special Committee on Aging).

In contrast to hospitals, the supply of most types of health personnel, including physicians, is substantially less in relation to population in rural areas in comparison to urban areas. This problem has occurred despite a variety of supply-oriented programs and policies intended to attract and retain health personnel in rural areas. Examples include the National Health Services Corps and a variety of other incentive and loan forgiveness programs. In my judgment, these types of programs have had a positive impact on the supply of health personnel available in rural areas, and such programs need to be continued and expanded.

At the same time, I believe it is important to recognize the limitations of supply-side programs targeted specifically to rural areas. The major limitation of such programs is they do not typically address the larger macro-environment that generates the aggregate or national supply of health service inputs. For example, if medical schools do not take measures to systematically increase the type of physician that makes the most sense in rural areas—namely, family practitioners—rural programs developed to attract physicians into rural areas will be thwarted by the small size of the relevant pool of physicians available.

Turning to the demand side, more than 17 percent of Americans living in nonmetropolitan counties were uninsured in 1987 in comparison to less than 15 percent of Americans living in metro counties (Patton et al). These figures are significant in that a 1988 survey revealed that 24 percent of the nation's uninsured said they had been denied care for financial reasons (Reinhardt).

Today, the demand-side, unlike the supply-side, is not a focal point for targeted rural programs. However, this was not always the case. Indeed, perhaps the most remarkable health service program directed specifically at low-income farm families was initiated by the U.S. Farm Security Administration, forerunner of today's Farmers Home Administration. In the 1930s and 1940s, this program provided

loans and grants to families to enroll in prepaid medical care plans that provided physician, hospital, and sometimes dental and drug, services. In 1942, the peak year, these subsidized local health insurance plans served more than 600,000 persons in nearly 1,100 rural counties (Mott and Roemer).

While targeted rural programs on the demand-side are virtually nonexistent today, rural residents are, of course, covered by two national programs: Medicare for the elderly and Medicaid for the poor. While Medicare is not discriminatory on the demand-side in that its coverage is the same for both rural and urban residents, it is discriminatory in reimbursing rural health care providers. For example, rural hospitals have been waging a long struggle with Medicare over the fact its reimbursement schedule favors urban hospitals.

Additionally, Medicaid discriminates in a *de facto* fashion against the rural poor. The reason being that one of Medicaid's major recipient classifications is persons eligible for Aid to Dependent Children (ADC); and in many states, ADC eligibility is limited to single-parent families. Because low-income, single-parent households are relatively more common in urban areas than in rural areas, a greater proportion of the rural poor are likely to be outside the scope of Medicaid.

One answer to the demand-side of the problem—in both rural and urban areas—is universal health insurance coverage. A number of such plans have been proposed during the last several months, but a consensus does not appear to be emerging. In short, there is a consensus on the need, but no consensus on the mechanism. This is a scenario that has been replayed on several other occasions during the past fifty years.

Public Policy Opportunities and Challenges

The area of health care policy, including rural health policy, has many challenging dimensions that intrigue the public and, hopefully, the public policy educator. Some of the many questions and information tidbits I have used over the years to stimulate discussions, debate and dialogue follow:

1. In 1970, the U.S. spent 7.4 percent of its Gross National Product (GNP) on health care services, or $346.00 on a per capita basis. In 1989, the share of the GNP spent on health care services had increased to 11.8 percent, or $2,354.00 on a per capita basis (Levit et al.). Why is this often viewed as an alarming statistic? Are we equally alarmed that the proportion of our GNP spent in many other areas has also increased, e.g., the amount spent on computers and communications technology?

2. No other country spends nearly as much of its GNP, or as much on a per capita basis, for health services as the United States

(Schieber and Poullier). Despite the amount spent, the United States has at least 37 million citizens without health insurance (Davis); the United States ranks nineteenth in life expectancy behind Spain, Cuba, Costa Rica, Japan, Greece, Italy, Norway and many other countries; and the United States ranks twenty-fourth in infant mortality, with an infant mortality rate significantly higher than that found in Taiwan, Iceland, Singapore, Hong Kong, Ireland, Sweden, Brunei and many other countries (Population Reference Bureau). Given these data, would you prefer the health care system of some other country? Do you think your preference would change if you were more wealthy? Less wealthy? Employed? Unemployed?

3. Only two industrialized countries in the world do not have a national health insurance plan: South Africa and the United States. None of the countries with a national health insurance plan spend nearly as much as the United States on health services, and most of the health status indicators in these countries are far superior to ours. Additionally, scientifically designed cross-national polls show clearly that Americans are much more dissatisfied with their health care system than are citizens of other industrialized countries (Blendon et al.). Why, then, do we not have a national health insurance plan?

4. National health insurance and socialized medicine are two very different concepts. National health insurance is typically some type of tax-based financing scheme. For example, Medicare is a national health insurance scheme for those over 65 years of age. Socialized medicine is a system whereby the health care delivery system is owned and operated by the government. In the United States, the Veteran's Administration health care system and the Indian Health Service are examples of socialized medicine. What are the advantages and disadvantages of each—national health insurance and socialized medicine—for the consumer? The taxpayer? The provider of the service?

   In the United States, socialized medicine is often viewed with disdain, especially by the nation's political leaders. At the same time, these same leaders often receive their own health services at facilities that are owned and operated by the federal government, e.g., Walter Reed Hospital and Bethesda Naval Hospital. Is it possible to explain this apparent paradox? How?

5. Sam Walton, Randolph Hearst, Ernest and Julio Gallo, Gene Autry and James Cargill have net worth in excess of $200 million (*USA Today*), and all qualify for Medicare benefits because they are at least 65 years of age. At the same time, a significant number of low-income women are unable to afford prenatal care. Are the nation's tax dollars that are earmarked for health services being allocated equitably?

6. In the United States, health services are rationed largely on the basis of ability to pay. Examples of other rationing mechanisms follow:

   The Queuing Mechanism. In British Columbia, 720 patients are on a waiting list for by-pass surgery (Schmitz).

   The Lottery Mechanism. Clozapine, a promising but costly drug for the treatment of schizophrenia, is allocated to patients in Pennsylvania's state hospitals on a lottery basis (*Omaha World Herald*).

   The Age Mechanism. In some countries, expensive treatment procedures such as kidney dialysis is provided only to younger patients (Etzioni).

   The Mechanism of Selected Coverage of Services. In 1987, Oregon's Medicaid program stopped funding most organ transplants in order to reach more women in need of prenatal services. The winners are the large number of mothers who need prenatal services and the losers are the small number of people needing organ transplants. The first loser in Oregon was seven-year-old Adam Howard who died just $10,000.00 short of the $90,000.00 he needed for a liver transplant (*Newsweek*).

   Distance. A number of Americans, especially in the sparsely populated areas of the Great Plains and Intermountain West, do not always receive services when needed simply because the nearest provider may be seventy-five or more miles away.

   Of these various rationing schemes—ability to pay, queuing, the lottery, age, excluding certain services from insurance coverage, and distance—which do you prefer? Why?

7. Consider the following quote:

   > Congress took the founding fathers at their word, establishing post offices in even the remotest locations. Mail reaches Supai, Arizona, at the bottom of the Grand Canyon on the Havasupai Indian Reservation via a three-and-one-half-hour-long, eight-mile trek by mule train . . . mail is trucked seventy-five miles from Peach Springs to the Canyon, then packed on ten mules. The mule train is welcomed by many of the Supai Post Office's 112 daily customers. (*USA Today*, p. 4F).

   Access to the postal system is universal, effectively guaranteed by Article 1, Section 8 of the U.S. Constitution, and rural residents are effectively subsidized by urban residents. Are postal services more important than health services? If not, then why do we not also have universal access to health services in rural areas? Should sparsely populated rural areas that cannot financially sup-

port a minimal set of health services be subsidized by the more populated areas of the country?

8. Corporate America seems to have become more concerned about rising health care costs in the era of increased global competitiveness. For example, a top executive at Chrysler Corporation notes that his company " . . . is quite concerned about the competitive advantage inherent in the dramatic differences between United States and foreign health care costs. We must compete with foreign automakers having a $300.00- to $500.00-per-car advantage over us due to health costs alone" (Maher, p. 169). How valid do you believe this argument is, and how much does it concern you? Why?

These eight questions, and others like them, are exciting issues for the public, and public policy educators.

Additionally, public policy educators and educators with a community development orientation, have a special role in helping community leaders and policy makers think through the various options in two areas—economic development and health services delivery—and the relationship between the two. Earlier, I noted several connections between rural economic development and health services. Let me add to that list by calling your attention to an interesting case study done in Uinta County, Wyoming (Wyoming Department of Health and Social Services).

Uinta County is in the far southwestern portion of Wyoming bordering Utah. At the time of the study, about one-half of the pregnant women in Uinta County were traveling out of state to deliver. The main reason was Uinta County had only one obstetrician and it desperately needed a second. Study results indicated that $682,000.00 in patient care expenditures annually were flowing out of state from Wyoming, primarily to Utah. When these direct expenditures were combined with the indirect economic impacts and were translated into employment, it appeared that as many as twenty-two jobs could be at stake.

Now, most local development advocates I know in small communities would sell their soul for a new manufacturing plant that would generate twenty-two jobs. Ironically, these same individuals are often blind to the job-creating potential of the health services sector and never consider it as part of their local economic development options.

Another interesting example was called to my attention when I served on Secretary Sullivan's National Advisory Committee on Rural Health. We were meeting in Jackson, Mississippi and Mississippi's Governor, Ray Mabus, provided testimony to the committee. In his remarks he noted how Mississippi had dramatically expanded Medicaid coverage. That struck me as strange. Here I am in

the poorest state in the nation and I am being informed about this incredibly progressive program that is underway.

Later in the day, my curiosity got the best of me and I found out about a report titled *Economic Impact of the Mississippi Medicaid Program on the Economy of Mississippi* (Mississippi State Department of Health). Medicaid is a federal-state partnership and, in the case of Mississippi, every $1.00 in state funds is matched by $3.69 in federal funds. The report I was provided used an input-output model to focus on the economic impact of the infusion of federal Medicaid funds. Results indicated that by the time the $3.69 in federal funds had circulated through Mississippi's economy, state tax revenues had increased by 81 cents. Hence, the $1.00 in tax revenues spent initially by Mississippi would, because of the federal match, eventually return 81 cents back to the state coffers—in addition to meeting a very important human need.

Another factor that links health services to broader economics and community development goals has to do with local leadership. Richard Couto has studied the process by which rural communities improved their health services and notes:

> Under the right conditions a process may occur where the leaders of health fairs and clinics become (or often already are) recognized as 'doers'; the community begins to think better about itself, providing a boost in mental health; specific skills, such as fund raising, are revived; and new skills that are acquired in clinic development, such as proposal writing and organizing to obtain money through revenue sharing, can be applied to additional problems like the need for improved water systems, roads and housing (Couto, p. 75).

Indeed, the role played by the leadership factor in the larger rural development equation deserves much more attention—for two reasons. First, it appears to be a crucial factor and research is beginning to document its true importance (DeWitt et al.). Second, it is one of the factors that can be changed. Other factors such as distance to an interstate highway or a major metropolitan market may be very important factors affecting development, but are beyond anyone's control. In conclusion, health professionals, including physicians, often have leadership skills that are in short supply in rural areas; and residents who rally around needs and issues develop insights and skills that can be transferred to other community needs and issues.

Are rural health services the singular key to community development and local leadership development? Of course not, but they are a legitimate and often overlooked part of the framework public policy educators and community development professionals should use when working with local communities.

One specific area I have not addressed is the nontraditional ways

of delivering health services in rural areas. This theme is beyond the scope of this paper, but I do believe in the notion that "necessity is the mother of invention." More specifically, as I look at the pressures being placed on the rural health services infrastructure, I see some creative and innovative ideas at work.

Some of these ideas are not all that new, e.g., the use of physician assistants, nurse practitioners, mobile clinics, first-rate transportation services and airborne ambulances.

Some of the other nontraditional approaches are quite new. For example, in 1989, Congress required the U.S. Department of Health and Human Services to establish a program to provide grants to selected states to develop Rural Primary Care Hospitals. These hospitals *cannot* offer traditional inpatient care, except through using a maximum of six holding beds to stabilize patients for up to seventy-two hours. These small-scale facilities will not have to meet existing hospital requirements for twenty-four-hour operation (except emergency care); and the services of dieticians, pharmacists and certain laboratory and radiology technicians need only be available on a part-time, off-site basis (Office of Technology Assessment).

Such nontraditional approaches need to be conveyed to local communities to inform them of their full range of options, and to break the historical enamorment with the notion that every single town needs a doctor and a hospital.

Let me close by indicating that public policy educators and community development professionals have much to offer in addressing the rural health crisis. However, let me also say that I am disappointed that the U.S. Department of Agriculture (USDA)-College of Agriculture complex has fallen so far behind others in being on the cutting-edge in this important area of work.

In 1975, I made my first major presentation on rural health at a Farm Foundation-sponsored conference in Roanoke, Virginia (Cordes). My topic was "Assessment of Current and Recent Research on Rural Health Care Delivery by Colleges of Agriculture and the USDA." At that time, I identified seventy-four research projects in the USDA-College of Agriculture complex that had a significant component directed toward rural health issues. Today, I doubt that I would find more than a dozen. At the same 1975 conference, Dr. Robert Kane, who is now at the University of Minnesota, was asked to summarize the work underway outside the USDA-College of Agriculture complex. In my judgment, what he found was dwarfed in comparison to what my USDA-College of Agriculture colleagues had underway.

Since then, however, colleges of medicine and schools of public health and many others outside the USDA-College of Agriculture establishment have forged to the forefront; and it is their leadership and involvement that dominates the following developments:

- The extensive research efforts now underway, including seven federally-funded rural health research centers across the country; and *The Journal of Rural Health*, a refereed scholarly journal in its seventh year of publication.
- The activities of the National Rural Health Association. This Kansas City-based association is a powerful advocate for rural health interests, including research and teaching.
- The establishment and growth of the Office of Rural Health Policy within the U.S. Department of Health and Human Services; and the National Advisory Committee on Rural Health chaired by the Honorable Robert Ray of Iowa.
- A recently completed study by Congress' Office of Technology Assessment titled *Health Care in Rural America.*

These activities, and many others like them, have little input and involvement from the USDA-College of Agriculture establishment.

I do not lament this lack of involvement by rural social scientists within the USDA and colleges of agriculture because we are no longer in the limelight or in the leadership role. Instead, my concern is simply that we are no longer making a significant contribution to an ever-increasing need. Our lack of involvement also concerns me because I believe many of the health professionals who are now in the leadership role are not nearly as knowledgeable as we are about the larger rural environment, including the intricacies and complexities of rural community dynamics. At the same time, the health professionals have a much stronger comparative advantage than we do in understanding the larger health care environment.

In short, a stronger marriage needs to exist between academic-based health professionals and rural social scientists. Such a marriage would generate tremendous benefits to both policy makers and rural Americans.

REFERENCES

Blendon, R. J., R. Leitman, I. Morrison, and K. Donelan. "Satisfaction with Health Systems in Ten Nations." *Health Affairs*. 9(1990):185–192.

Clarke, L. L., and R. J. Coward. "The Effects of Residence on Infant Mortality." *The Journal of Rural Health*. 7(1991):246–265.

Cordes, S. M. "Assessment of Current and Recent Research on Rural Health Care Delivery by Colleges of Agriculture and the USDA." Paper presented at Rural Health Care Research Forum, Roanoke, Virginia, 19 Mar. 1975.

Couto, R. A. *Streams of Idealism and Health Care Innovations: An Assessment of Service-Learning and Community Mobilization*. New York NY: Teachers College Press, 1982.

Crawford, C. O. "Some Manifest, Latent and Misconceived Functions About Medical and Health Care of Rural Communities." Rural Health Staff Paper 11, Department of Agricultural Economics and Rural Sociology, Pennsylvania State University, 1976.

Davis, K. "Expanding Medicare and Employer Plans to Achieve Universal Health Insurance." *Journal of the American Medical Association* 265(1991):2525–2528.

DeWitt, J., S. S. Batie, and K. Norris. *A Brighter Future for Rural America? Strategies for Communities and States*. Washington DC: National Governors' Association, Center for Policy Research, 1988.

Doeksen, G. A., and D. A. Miller. "Rural Physicians Make Good Economic Sense." *Journal of the Oklahoma State Medical Association* 81(1988):568–573.

Doeksen, G. A., and J. Altobelli. *The Economic Impact of Rural Hospital Closure: A Community Simulation.* Grand Forks ND: The Center for Rural Health, University of North Dakota School of Medicine, 1990.

Erickson, R. A., N. I. Gavin, and S. M. Cordes. *The Economic Impacts of Pennsylvania's Hospitals.* University Park PA: College of Business Administration, The Pennsylvania State University, 1984.

Etzioni, A. Health Care Rationing: A Critical Evaluation. *Health Affairs* 10(1991):88–95.

Fuchs, V. C. *Who Shall Live? Health, Economics and Social Choice.* New York NY: Basic Books, Inc., 1974.

Levit, K. R., H. C. Lazenby, S. W. Letsch, and C. A. Cowan. "National Health Care Spending." *Health Affairs* 10(1991):117–130.

Maher, W. B. "Back to Marketplace Basics." *Health Affairs* 9(1990):169–170.

Mississippi State Department of Health. *Economic Impact of Medicaid on the Mississippi Economy.* Jackson, Mississippi: Mississippi State Department of Health, 1988.

Mott, F. D., and M. I. Roemer. *Rural Health and Medical Care.* New York NY: McGraw-Hill, 1948.

Newsweek. "Not Enough For All." May 14, 1990, p. 53.

Office of Technology Assessment. *Health Care in Rural America,* p. 204. U.S. Government Printing Office, 1990.

Omaha World Herald. "Lotteries Will Determine Which Patients Get Drug." July 30, 1990, p. 6.

Patton, L. T., G. R. Nycz, and J. R. Schmelzer. *Health Insurance Coverage in Early 1987: A Metro-Nonmetro County Chartbook.* Marshfield WI: Marshfield Medical Research Foundation, 1990.

Population Reference Bureau, Inc. *1991 World Population Data Sheet of the Population Reference Bureau, Inc.* Washington DC: 1991.

Reinhardt, U. "Dwindling Access, Soaring Costs Plague Health System." *Rural Health Care* 13(1991):7.

Schieber, G. J., and J. Poullier. "International Health Spending: Issues and Trends." *Health Affairs* 10(1991):106–116.

Schmitz, A. "Health Assurance." *In Health.* January–February 1991, p. 40.

Scott, L. C., L. H. Smith, and B. Rungeling. "Labor Force Participation in Southern Labor Markets." *American Journal of Agricultural Economics* 59(1977):266–274.

U.S. Senate Special Committee on Aging. *The Rural Health Challenge.* Serial No. 100-N. U.S. Government Printing Office, 1988.

USA Today. "Constitutions Impact." May 22, 1987, p. 4F.

———. "Forbes 400 of USA's Richest People." Oct. 11, 1988, p. 4B.

Wyoming Department of Health and Social Services. *Economic Effects of the Out-Migration of Obstetric Services in Uinta County.* Cheyenne WY: Division of Health and Medical Services, 1989.

Political Economy of the Dysfunctional Family