

Review & Commentary on Health Policy Issues for a Rural Perspective – November 1st, 2003

## Editorial: Defining Access To Care

Recently, in the middle of a day already too blessed with interesting issues, I got a phone call from a reporter for a prominent national newspaper—my simultaneous reactions—fear, opportunity. The reporter's question, as I heard it, was both reasonable and unanswerable: show me rural providers are doing a poor job and need the money to provide rural Medicare beneficiaries better access to care or admit that Congress need not address historic Medicare rural payment inequities.

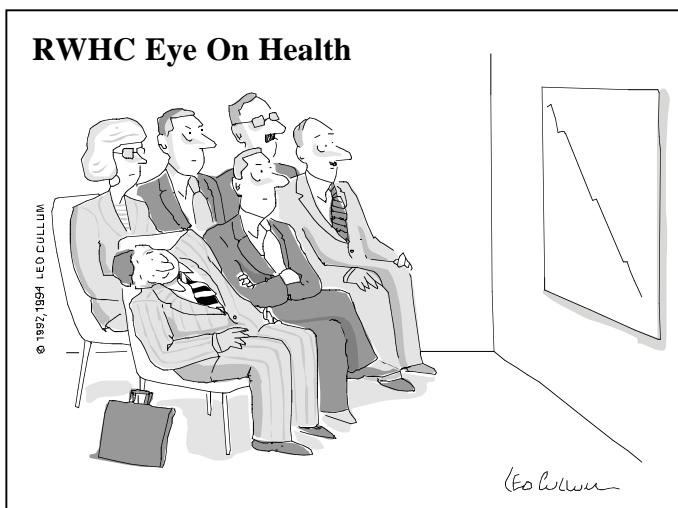
As I struggled trying to respond, it became clearer to me why I could not answer the reporter's question as asked, even though I am used to talking to the press, wanted to be helpful and understood the importance of the issue. There isn't a lot of data specific about rural Medicare beneficiaries and what there is tends to understate the differences due to what, I believe, are lower expectations by rural seniors.

For better or worse, and I think for the better, many of us define access to health care by Medicare beneficiaries as inseparable from the issue of community wide access to care. If one looks carefully at the data that is available (a series of charts from the federal Centers for Disease Control is included on the following page) it is hard to imagine that rural young and seniors alike don't have significant challenges as they try to access health care in their communities.

The problem of addressing the narrow question of access for the rural Medicare beneficiary apart from the community is that such access can't reasonably be accomplished. If those under 65 years of age don't have reasonable access to health care, even with insurance, you can be sure that there isn't an exclusive senior's club around the corner serving the Medicare crowd. Apart from insurance issues, access "boats" tend to rise and fall together in a rural community.

The irony regarding Medicare payment reform is that rural communities have not been asking Congress to subsidize care for non-Medicare patients in order to support the rural infrastructure (which by the way, large urban hospitals have done with great success for nearly 20 years). What they are asking is that Congress recognize rural communities can no longer afford to subsidize the federal government's obligation to the Medicare beneficiary.

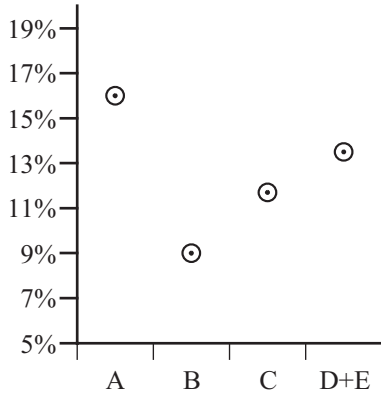
The growing momentum in the private sector for employers to shift from defined benefit plans to defined (employer) contribution plans is expected to make the health care "market place" significantly more price competitive. Whether this is true and whether or not we will collectively address the potential perverse incentive in some such plans to defer needed services is unclear.



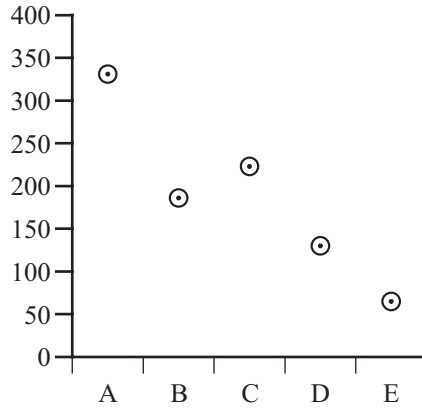
"Americans value rurality for what it is, what it is not, and what they believe it is or is not." Tom Rowley, 1994.

## Rural In The Midwest Means Less Access To Health Care & Worse Health

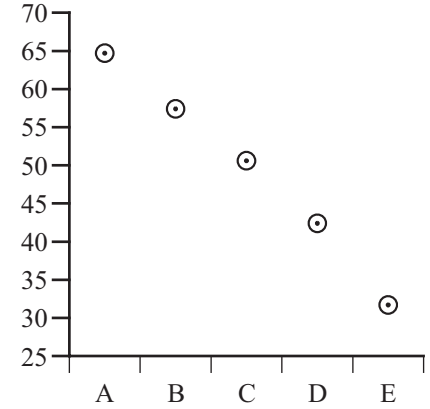
**Uninsured Rates Among Persons Under 65 Years Of Age, '97-98**



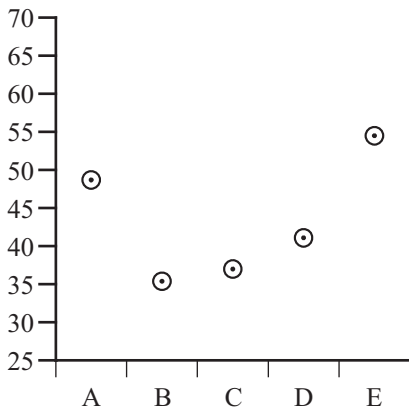
**Patient Care Physicians Per 100,000 Population, '98**



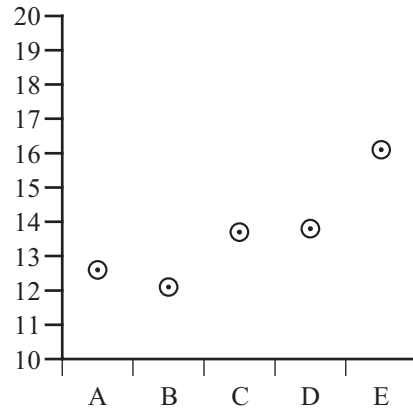
**Dentists Per 100,000 Population, '98**



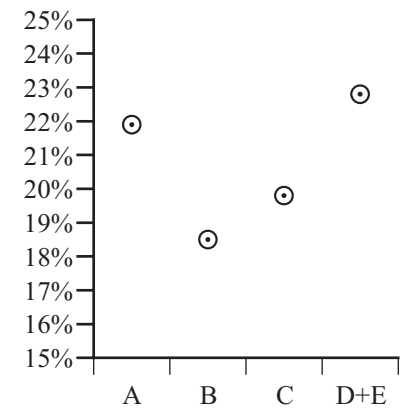
**Death Rates For All Cause Among Persons 1-24 Years Of Age, '96-'98**



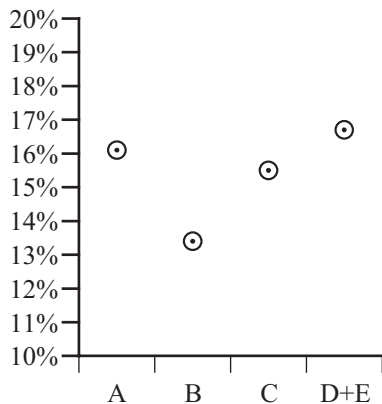
**Suicide Rates Among Persons 15 Years Of Age And Over, '96-'98**



**Obesity Among Persons 18 Years Of Age And Over, '97-98**



**Limitation Of Activity Caused By Chronic Health Conditions Among Persons 18 Years Of Age And Over, '97-98**



### Key

#### Metropolitan Counties

A = Large central

B = Large fringe

C = Small

#### Non-Metropolitan Counties

D = City  $\geq$  10,000

E = No City  $\geq$  10,000

Note: Population Based Data Is Age Adjusted

Data: *Health, United States, 2001*  
 With *Urban and Rural Health Chartbook*,  
 Centers for Disease Control and Prevention  
 Graph: RWHC, 10/03

What is clear is that rural providers are entering any competitive scenario with a major disadvantage—the hidden tax or cost shift imposed by the current Medicare program through its pattern of paying less in rural areas (in both absolute terms and as a percent of “allowable” costs.) While the issue of fair competition is less relevant for the more isolated rural or frontier communities, it is very relevant for the majority of rural residents—those who live in “markets” adjacent to metropolitan areas.

If at the end of the day we cannot convince urban America that the data shows an actual or potential differential access problem for the rural elderly, isn't it as equally fair to ask why Medicare pays more in urban areas (both in terms of relative to rural costs and relative to the percentage of urban costs) without demonstrated impact on urban beneficiary access?

Access isn't just about being able to pay or have some one pay for you but about there being an intact system for people to use—and for rural beneficiaries that happens when there is a local system available for the community, young and old together.

It is critically important to emphasize that rural access to health care is not just dependent on decisions made in Washington D C. Since July, the Rural Wisconsin Health Cooperative has been in conversation with the State's Office of the Commissioner of Insurance about a serious access problem caused by insurance companies.

We are seeing a growing number of situations where insurance companies are refusing to contract with local rural providers, even though those providers are willing to accept the same contractual language as the insurers' urban based provider partners. The threat to the rural infrastructure is just as serious as the one from Medicare underpayment; there simply is not enough potential volume in any rural community to afford losing patients who want to access care locally.

The risk of this problem is particularly evident where rural residents have to commute into an urban area for work and the employer's health plan tends to be “urban-centric.” We are seeing situations where people unnecessarily are being forced to drive past local care thirty, sixty or more minutes to see a family practitioner, to deliver a baby or for a specialty consultation. As the insurance market gets more cut throat, we are at risk of seeing this phenomena morph to affect many more employers and employees.

Section 609.22 of the Wisconsin Statutes has provided “Access Standards” that health insurers must meet if they restrict who can provide the insured individual health care. The good news is that the law requires reasonable access “consistent with normal practices and standards in the geographic area.” The bad news is that the State has not said what is “reasonable.” This is the task at hand here in Wisconsin.

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## Wisconsin Can Improve Its Outcomes

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From the *Wisconsin Community Health Report Cards 2003: Working Paper* by the Wisconsin Public Health and Health Policy Institute; the complete report is available at:

[www.pophealth.wisc.edu/wphi/index.html](http://www.pophealth.wisc.edu/wphi/index.html)

### Report Background

“The conceptual framework underpinning this effort is based on a model of population health improvement illustrated below. This indicates that health outcomes and their distribution across the population are produced by a set of health determinants, which in

The **Rural Wisconsin Health Cooperative**, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care, which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

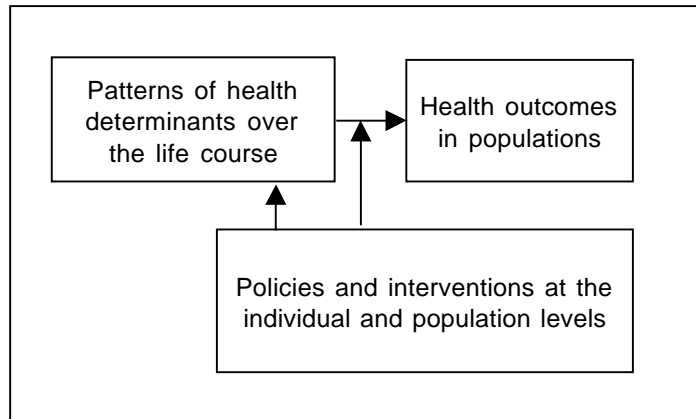
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turn are influenced by policies and interventions which enhance or limit the determinants.”

“Health outcomes are often reported in terms of mortality, since years of life are very important and mortality data are available and reliable. However, most of us believe our health is measured not only in years of life but also in the quality of those years. We have therefore created a health outcome measure that also incorporates how people in Wisconsin communities rate the state of their health while alive. We report on how this measure changed over a five year period.”

“We acknowledge that the rating of communities can be controversial. We present this report in the spirit of encouraging improvement and discussion, not judgment. Every community has strengths and weaknesses; we hope that the higher rated communities provide insights for improvement and that the lower ones might draw additional resources for improvement.”



“We consider this a first version of what we intend to be an ongoing reporting process. There is much to be done to improve the methodology we have used here, as well as to investigate the relationships about how health outcomes are produced and can be improved. The Institute plans to make

this reporting, as well as research based on it, a major component of our activity over the decade. We welcome and encourage feedback and advice regarding how we might improve this effort so that it is truly useful in making Wisconsin communities as healthy as they can be.”

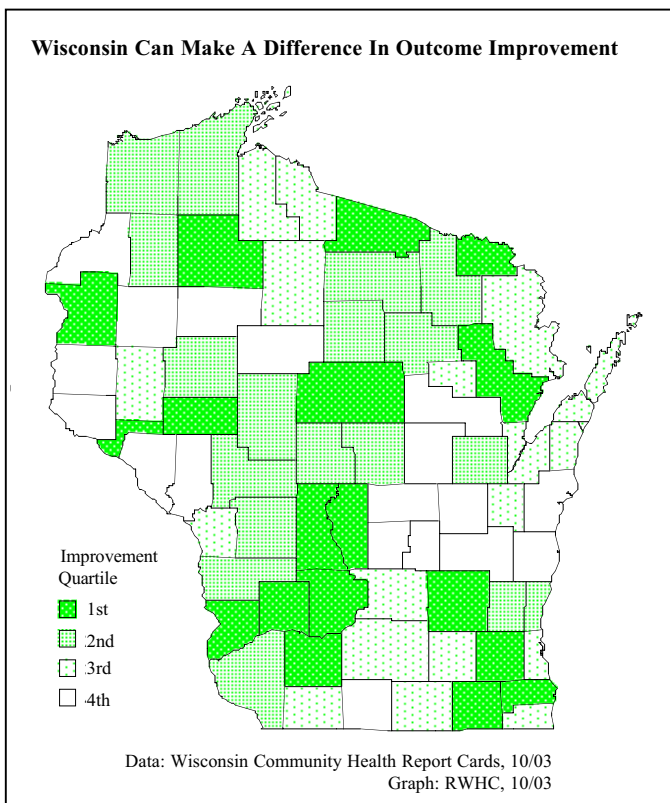
### General Format of the Report Cards

“Throughout this report, Wisconsin counties are rated according to where their population health lies in comparison to other Wisconsin counties. For each health measure detailed in this report, the 72 counties are ranked and separated into 4 groups (quartiles), each containing one-fourth of the counties.”

“The report presents the overall summary population health ratings for current and five-year change in health Outcomes and current and five-year change in health Determinants. Each of these ratings is a summary of a number of individual health measures.”

“The current and change ratings for health Outcomes are based on a combined index of mortality and general health status. Both mortality and health status are weighted equally in the summary ratings.”

“There are many health determinants with varying degrees of importance in influencing health outcomes. Data on many of them are not available at the county level. We have based our choice of health determinants data used in this report on the Health Priorities of the Wisconsin State Health Plan, and produced a determinants rating for each county based on what we know from the literature on how they should be combined. The ratings for health Determinants are based on a combined index of 18 population health measures.”



“Depending on the measure, the counties are given a rating to indicate the quartile into which each county fell, ranging from “most improved to least improved” (map on prior page) or ‘healthiest’ to least healthy.’ ”

“One can see that ‘current’ levels of health are not necessarily indicative of the direction, relative to other counties, that health measures are changing. For example, while Adams County has poorer current levels of health Determinants than most counties, the county has been improving faster in health Determinants than most other counties. We would expect that if such relative improvement continues, Adams County will rate higher in future report cards on the ‘current’ ratings.”

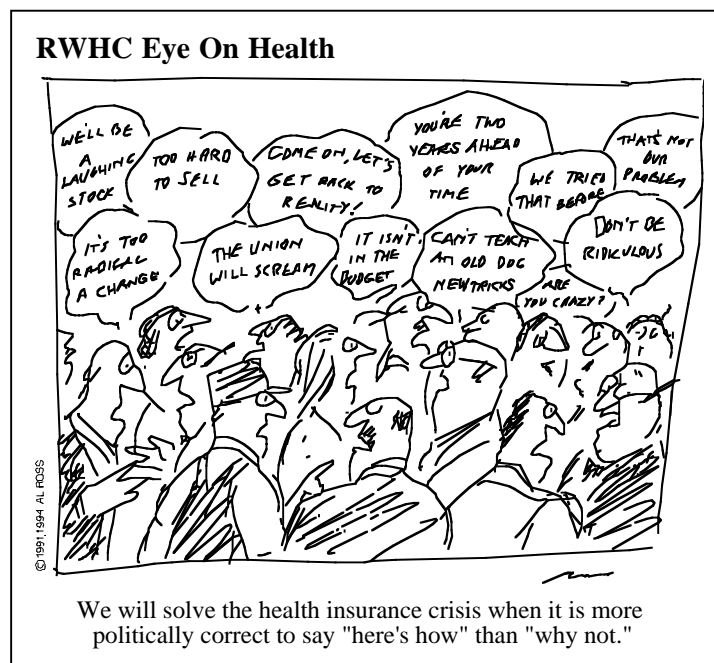
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## Rural Is Not Rural Is Not Urban

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From the *Health Insurance Coverage In Rural America* by the Institute for Health Policy, Muskie School of Public Service at the University of Southern Maine with The Kaiser Commission on Medicaid and the Uninsured, 9/03; the whole report is available at [www.kff.org/content/2003/4093/4093.pdf](http://www.kff.org/content/2003/4093/4093.pdf):

“Among the 41 million uninsured in the United States, nearly twenty percent live in rural areas, but not all rural residents face the same risk of being uninsured. This chart book presents an analysis of the



most recent national data on health insurance coverage based on a county’s proximity to a large urban area—an important factor discriminating rural residents’ access to economic opportunities and health care services.”

“A strategy that may be effective in reducing the uninsured rate among residents of rural communities in close proximity to urban areas may not meet the needs of those in more remote areas, where more workers earn low wages and work for small employers, and more families are poor.”

“No single portrait can accurately capture today’s rural America. Rural counties are widely diverse not only in their geography, but in their populations, industries, and their economies. Despite these variations, rural counties as a whole are substantially different from all of urban America in ways that pertain directly to the adequacy of health insurance coverage and access to health care. Significant urban-rural differences include:

- Fact #1: Rural Americans have lower incomes than their urban counterparts.
- Fact #2: While racial and ethnic minorities comprise only seventeen percent of the rural population they are more economically disadvantaged than minorities in urban areas.
- Fact #3: Rural Americans tend to be somewhat older than urban residents.
- Fact #4: On average, rural residents tend to be in poorer health and are less likely to access preventive services than urban residents.
- Fact #5: The economic health of rural America is fragile with a declining population and employment losses in key industries.
- Fact #6: Small businesses are the bedrock of the rural economy where health benefits are much less likely to be offered.
- Fact #7: The nature of employment is changing in ways that further disadvantage rural America’s income base and health insurance coverage.

- Fact #8: Rural America is likely to face a disproportionate number of challenges in the current economic environment.
- Fact #9: The rural health care system is vulnerable because of its health professional shortages, small volume hospitals, and disproportionate reliance on public reimbursement levels, key factors affecting the availability and quality of rural health care services.”

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## Rural In The Eye Of The Beholder

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From “The Value of Rural America” by Thomas D. Rowley in *Rural Development Perspectives*, Vol. 10, No. 1, Oct. 1994:

“For many people, rurality connotes intrinsic value. That value can be positive, as expressed by such rural descriptors as pastoral, bucolic, and untamed. It can be negative, as in desolate, backward, and isolated. These values have developed throughout the Nation’s history and are expressed in its literature, art, music, popular culture, political opinion, and residential preferences. Furthermore, **Americans value rurality for what it is, what it is not, and what they believe it is or is not.**”

“Like many other values, the value of rurality varies across time and culture. And like many values, it is often defined by its antithesis. William Howarth, professor of English at Princeton University, traces the rural versus urban dynamic through most of this Nation’s recorded history, providing examples from the exploration of the New World, the settling of the frontier, and the modern era. He draws upon literature to look at the prevailing views of rural America and observes that nostalgia for rural roots increases

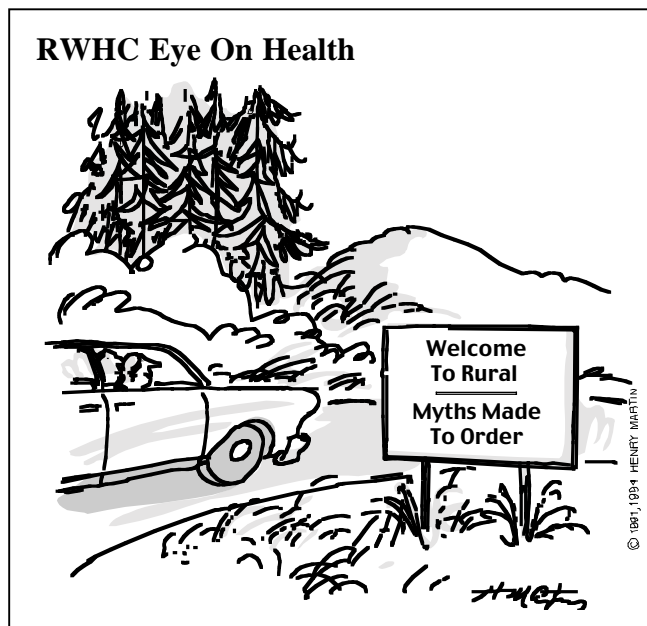
during periods of rapid social and economic change. He contends that expressing rural values is a mechanism used to stem fears of cultural loss.”

“This theme is mirrored in landscape architect Herbert Gottfried’s observation that rural values are tied to the land as symbols of social and natural stability. He believes that rural landscapes contain coherent images that stabilize everyday life. The rural landscape is, he argues, a ‘layered phenomenon,’ comprising the marks of human activity interwoven with natural endowments. He suggests that enhancing the legibility—the sensory experience—of the landscape, improves the value of rurality.”

“Historian David Danbom points out that America’s reverence for rural life developed slowly and changed substantially over time. The early colonists viewed rurality as dangerous, unsophisticated, and even wicked, instead revering the city like their European cousins. That view changed with the American Revolution. The new Nation’s rural areas, populated largely by independent, land-owning farmers, stood in contrast to Britain’s stratified society and provided a strong foundation for the development of America’s democratic institutions.”

“As the Nation became increasingly urban, rural America’s cultural stock continued to climb precisely because it was not urban. In essence, Danbom contends

that celebrating rural is a way of criticizing urban-industrial life. John Logan, an urban sociologist, further explores the anti-urban sentiment that gives rise to rural value. That anti-urban bias, he points out, is perplexing in several ways. First, racial prejudice toward urban concentrations of Blacks and Hispanics ignores rural America’s large minority population. Second, the things feared lost in urban areas—family, community, hard work—are, in fact, still there. Finally, the ills of urban society—crime, poverty, familial breakdown—are also found in rural areas.”



“Hence, Logan shares Howarth’s belief that prorural values are a protective mechanism against cultural loss regardless of the fact that a large share of what is valued is the ‘mythology and symbolism of rural places rather than their reality.’ Thus, the value of rurality is not only based on what it is not, but also in part on a misconception of what it is (Willits and Luloff). This should come as no surprise since, according to Logan, ‘rural America has the special advantage of being the place where most of us don’t live any more, which frees us to reconstruct it in our imagination.’ ”

### Implications for Rural Policy

“The results of this exploration into the value for rurality suggest that there is merit in considering that value in rural policymaking. Stemming from various roots, however, the value placed on rural America, with its complexities and contradictions, defies facile manipulation. Rather, the value placed on rural America presents policy makers with difficult questions.”

“First, whose values should prevail in decisions about rural America? Rural Americans who live and work there? Urban Americans who don’t, yet comprise the Nation’s vast majority? While the two groups surely hold some values in common, there are just as surely many differences. Can rural and urban interests find enough common ground to forge solutions that satisfy both?”

“Second, if much of what people value in rural America stems from misconceptions and myths, what does that say about policy based on those values? Does providing more accurate information on the structure of rural economies, the prevalence of social problems, and the degree of environmental degradation dampen the value Americans have for rural people and places? Does a more accurate representation of rural circumstances undermine the basis for rural policy?”

“These questions are as important as they are difficult. They represent a fresh, and potentially fruitful, line of inquiry for rural development research in the United States. Current scrutiny of Federal programs calls for better understanding of the reasons for and results of governmental action. Is the public getting what it wants? Is its value for rural America being considered?”

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## Fancy Footwork

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From *A Country Doctor’s Casebook: Tales From The North Woods* by Roger A. Macdonald, M.D., published by The Minnesota Historical Society Press:

“Barbara looked up from her book. ‘Are you home for good?’ ... ‘On call! When everyone else in the world is more important than family.’ ”

“ ‘I’m trying to find a partner! I’ve written letters, telephoned people who hung up on me, offered more than we have to give, but no takers.’ ”

“ ‘You said this new dean of the medical school, this Dr. Arnold Smith, was a friend.’ ”

“ ‘Well, friend. He attended on one service while I was a student.’ ”

“ ‘Don’t friends try to help each other? See him, tell him how badly you need an associate. Isn’t the medical school there to provide doctors for our state?’ ”

“I arrived at the office of Dr. Arnold Smith on the tick of the hour. First I encountered his secretary, a female dragon we medical students had dubbed Dean Fran (in polite society), on the theory that her iron will was the real power behind this particular throne. She agreed that I had an appointment—she’d made it herself—but it seemed I’d been pre-empted.”

“ ‘The Dean is *far* too busy with Important Issues to honor your appointment. I’m sure you understand, *Doctor*.’ She gave ‘Doctor’ that same scornful emphasis I remembered so well, in a tone of voice capable of shriveling a medical student at fifty paces.”

“ ‘I came nearly three hundred miles for this meeting,’ I said. ‘I consider providing physicians for the citizens of our state to be a reasonable activity for this medical school to be involved in. I intend to keep our appointment, thank you.’ ”

“Dean Fran suggested that I blow it out my ear, not quite that politely. I stormed out of the office and slammed the door hard enough to threaten its opaque glass window, something I’d wanted to do all those

years ago. Then I headed for the john. While I stood there communing with that long, white receptacle, coloring the air purple, who should saunter in but Dean Smith himself.”

“I looked at him sidewise, the way you do in situations like that, and said, ‘Just the person I had an appointment to meet with.’ ”

“He blinked and raised his head. ‘Ah—yes?’ ”

“ ‘Ah yes, indeed, sir.’ ”

“ ‘What about, uh—’ ”

“It was clear that my face was dependably forgettable. ‘Roger MacDonald, graduating class of ‘46.’ ”

“Conditions did not invite the custom of shaking hands, but I gained the impression that he would not be unwilling under more propitious circumstances.”

“I said, ‘Our appointment was to discuss the acute, even dangerous, shortage of rural physicians.’ We moved to the washbasins and splashed soap and wa-

ter merrily. ‘And the fact that I’m going crazy from overwork in Northpine.’ ”

“ ‘Where?’ ”

“ ‘Up north. Minnesota? I wrote you three times during the past year but received no answer.’ ”

“ ‘The mail is unreliable these days.’ ”

“Dean Smith edged toward the door, his scholarly hands now quite dry. I followed him into the hallway, walking right along-side him as though we were colleagues, buddies even.”

“ ‘I need help and I want to know what our university, my school, can do. *Will* do. We out there need partners—Excuse me, sir, before you return to your office—Sir?’ ”

“His door snicked shut on the fanciest footwork I’ve seen outside a chorus line. I jerked it open, endured Dean Fran’s grade-A scowl for as long as past conditioning would allow, then slammed it with a glorious rattle.”

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