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AUTHOR Margolis, Richard J.
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ABSTRACT

The quickest way to learn what is wrong with our U.S. health system is to observe its malfunction in rural America where the lack of services, shortage of physicians, high cost of illness, inadequate insurance coverage, and lack of citizen voice in health proceedings are most profound. The major health problem in rural areas is one of personnel. Although 30 percent of the U.S. population live in rural areas, there is only 1 doctor for every 1,400 persons. Rural communities have trouble attracting doctors for the following reasons: medical students are traditionally members of middle class families and have little interest in or connection with the rural poor; medical schools tend to promote specialization, pointing their students toward urban specialization centers and away from rural general practices; local medical societies impede any non-fee-for-service health practices; the American Medical Association and the American Association of Medical Colleges oppose recent propositions for a compulsory program of equitable physician distribution; and increasingly Health, Education, and Welfare personnel are speaking in terms of the coming "regionalization" of rural health facilities, an indication of the demise of the small rural hospital and, perhaps, the small rural community as well. (JC)

NOTES on the HEALTH of RURAL AMERICA

By Richard J. Margolis

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Being optimists, Americans tend to resent bad news; which may be why news about conditions in rural America has never been in great demand. As a case in point, rural medical services have been deteriorating steadily for the better part of a century, yet a myth has arisen that they are constantly improving. If we are not careful, the triumph of that illusion may signal the defeat of some badly needed reforms.

Part of the illusion is unwittingly promoted by officials of both the American Medical Association (AMA) and the federal government; their "progress" reports tend to be naively cheerful, conveying the impression that solutions to America's rural health problems are within easy reach. "Rural health and preventive medicine are leadership areas we are currently emphasizing," a Department of Agriculture official intoned last January before the Senate Rural Development Subcommittee. "...we are sponsoring research that will identify primary needs in rural health and result in positive recommendations based on documented findings."

As we shall see, the "primary needs in rural health" have long been self-evident; the last thing rural Americans need is another set of documented findings. Still, if that official's testimony was not sufficiently reassuring, consider the testimony delivered last year by Dr. Robert E. Reiheld, chairman of the AMA's Council on Rural Health, before the House Subcommittee on Rural Development: "Through a continuous and comprehensive program, the Council on Rural Health has worked toward the development of optimum health for rural America.... Experience indicates that no one approach will solve the health needs of every community, but solutions can be tailored as required."

Who would ever dream from Dr. Reiheld's ten pages of hearty affirmations that more than 5,000 towns in America were without the services of a single physician?

We are in the presence of an old American custom vis-a-vis rural America--one of Panglossian neglect. The habit dates back at least as far as 1910, the year President Theodore Roosevelt's Commission on Country Life issued its much heralded report on the quality of life in rural America. That report included a few paragraphs on health. "Theoretically," noted the Commissioners, "the farm should be the most healthful place in which to live"--but alas, "it is a fact that...health conditions in many parts of the open country....are in urgent need of betterment." Congress's instant response to this and to the Commission's other reasonable reproofs was to refuse to contribute a single dime toward their dissemination.

More than half a century later President Lyndon B. Johnson, facing a similar set of disclosures, essayed a similar suppression. This time the sour tidings were the work of the President's own National Advisory Commission on Rural Poverty, a group of twenty-five professors, editors, and executives who, with the aid of a large staff, had spent more than a year probing the miseries of country life. Among other things, the Commissioners in their report, The People Left Behind (1967), confessed to being "profoundly disturbed by the health problems of low-income people in rural America. Nowhere in the United States is the need for health services so acute, and nowhere is it so inadequate." This perceptive study, replete with such melancholy intelligence, displeased the President. Consequently, its distribution was cruelly limited.

(It is not surprising that both these seminal works, TR's and LBJ's, are now out of print. The supply of bad news about rural America continues to exceed the demand.)

Meanwhile, the health requirements of 60 million Americans who inhabit rural America (that is, who live outside SMSAs--Standard Metropolitan Statistical Areas) continue to be largely neglected. One need not insist that the health system works well in our cities and suburbs--everyone knows it does not--in order to argue that it hardly works at all in our rural areas and small towns. In fact, the quickest way to learn what is wrong with our health system in general is to observe its particular malfunction in rural America. Here is where one finds all the system's unavailability of medical services; the cruel shortage of physicians and other health specialists; the high cost of illness along with the pitifully inadequate insurance coverage; and the average citizen's utter lack of a voice in the entire proceedings.

2.

At the heart of the rural health crisis lies the gross maldistribution of personnel. Overall, the United States averages one doctor for every 781 persons; in rural areas the ratio is nearly double--one doctor for every 1400 persons. To look at it another way, although 30 per cent of our population still lives in rural areas, these places are being served by only 12 per cent of the nation's doctors and by just 18 per cent of the nation's nurses. Moreover, and contrary to various quasi-official pronouncements, matters keep worsening. Since 1963, for example, the list of counties without doctors has lengthened from 98 to 135, a 37 per cent increase during a period in which both the public and the medical profession were alleged to have awakened to rural America's health crisis.

Such statistics, of course, tend to mask the humiliation and miseries endured by rural people as they seek health care in a "sellers' market." Many small town residents must travel fifty or even 100 miles for ordinary medical service. Families without automobiles are out of luck, since public transportation in rural America has all but disappeared. In many Appalachian communities a person wanting to see his doctor in town often pays a neighbor as much as $30 for taxi service. And if the situation requires an ambulance, the family must be prepared to pay in advance. A few years ago at a Senate Health Subcommittee hearing chaired by Edward Kennedy, a woman named Mrs. Hill stood up and shouted from the audience, trying to explain to the senators how ambulance service worked in her rural section of West Virginia:

> Mrs. Hill: Before they come out to do anything, you have to have cash for them. If it is a welfare patient, they still have to have cash.
>
> Senator Kennedy: Before they will take you?
>
> Mrs. Hill: It costs about thirty-six dollars to come from Morgantown, for a one-hour trip.... They ask you before they go if you have the money to pay them. You have to have cash. When they brought my grandmother home, we had to have the cash ready or they wouldn't have gone after her and picked her up.

Ambulance service is not the only cash-and-carry aspect of rural medicine. Recently a woman who lives in the hills of eastern Kentucky told me what happened when her four-year-old boy, Danny, developed appendicitis: "I didn't have much money, but Danny was in awful pain, so I paid somebody to ride me into Prestonsburg. The doctor looked at Danny. He said the boy had to be operated before his appendix ruptured, but first I had to work things out with the Hospital Director.

"Me and Danny went to the Director. He told me it would cost $350 and I would have to give a $100 down payment. I said I didn't have no one-hundred dollars. He said, 'Well, when you get it, come back and we'll fix your boy up.' My Danny was vomiting right there in the Director's office. He was real sick.

"I went and borrowed the money from a cousin in town and came back with the money. The Director, he says, 'You have to show you got an income so as you can pay back the debt.' I said all I ever get is a check every month from the VA (Veterans Administration) for $57. He said that would be just fine. Then he made me sign a paper

promising to turn over that check to him each month until the bill was all paid. I couldn't fight him. Danny had to have the operation."

The incident, one might argue, could as easily have occurred in a city as in a small town. Yet it seems to me that the special ingredients which make up the mother's story--her emergency trip to Prestonsburg, her lack of options in choosing a doctor or a hospital, her utter poverty, and, finally, her helplessness in the face of medical mercenaries--are, in combination, peculiarly rural. The primitive health system in rural America is still capable of saying to the patients, "Your money or your life."

3.

Thanks to the doctor shortage, small town physicians can earn a lot of money--frequently more than that earned by their urban colleagues. The patients never stop coming--or paying. In Prestonsburg there are general practitioners who see more than 200 patients each day. The line on the sidewalk in front of the doctors' office is sometimes a block long before breakfast. (This may be good business but it is probably bad medicine. As another doctor explained to me, "Nobody, not even Albert Schweitzer, can competently handle more than 75 patients a day; there just isn't time.")

Some rural doctors seem less interested in promoting the health of their communitites than in preserving the fee-for-service profits of their businesses. Recently a former VISTA physician, Dr. Daniel S. Blumenthal, told a Senate subcommittee how he and fellow VISTA workers challenged the fee-for-service system in Lee County, Arkansas.

Lee County is among the poorest in the nation, with nearly three-quarters of the population living below the official federal poverty line. When Blumenthal and VISTA arrived in 1969, no one could doubt that health care was a pressing need for most residents. There were just four doctors in the county trying to serve 20,000 persons, and two of those doctors were over 65.

With the help of a grant from the Office of Economic Opportunity, Blumenthal established a clinic, "However," as he told the Senate subcommittee, "my efforts at delivering medical care were greatly hampered by the county medical society, which was composed of the four local doctors."

The doctors simply refused to admit Blumenthal to membership in the society. And since medical society membership was a sine qua non

for obtaining staff privileges in the county's only hospital, the result was that Blumenthal and his patients were effectively denied access to the hospital.

"The medical society," Blumenthal testified, "made it clear that its objections were not to me personally, nor to my capabilities as a physician. Rather, I was denied medical society membership and hospital staff privileges because I represented an alternative mode of health care delivery: I was providing free care to poor people; I was part of a federal government program; I was not in private practice."

In an interview with the local newspaper the president of the county medical society declared, "The private physicians in Marianna (the county seat) have no argument with Dr. Blumenthal as an individual doctor....We have, on several occasions, told Dr. Blumenthal that we would welcome him into the community and the local medical society if he would leave the VISTA program and function as a private physician.

Eventually the VISTA clinic sued the county hospital to gain staff privileges for its physicians, winning a favorable settlement out of court in 1971, a year after Blumenthal had left the county.

Again, in Canaan, South Dakota (a fictitious name) the issue was not fee-for-service medicine but medical monopoly. The residents of Canaan already had one physician, but since he was turning away prospective patients and netting about $90,000 a year, they decided to seek an additional doctor. (Canaan's population is 2500; another 2,000 live in the immediate area.)

Accordingly, residents applied for help to the National Health Service Corps (NHSC), a federal program that places volunteer physicians in medically underserved areas. But the NHSC law contains a catch-22: before a community can be sent a physician the local medical society must certify that one is needed. In effect, the rule allows local doctors to veto the program, and that is precisely what the Canaan doctor did.

Officials at the National Health Service Corps say they do not know how often this occurs. "We're usually able to work something out," says NHSC's Dr. Robert Shannon. "We try to educate the local doctors."

Most experts appear to view the maldistribution of doctors with an air of benign fatalism. As Dr. Reiheld has observed, "It is certain that many small communities that once had their 'own' physician will never again have one of their own." For such towns, Dr. Reiheld

blandly prescribes anodynes like improved transportation, new emergency facilities, "better understanding of individual health practices," and "self-help methods to insure rural health coverage"--whatever that means.

Yet the doctorless towns I have visited have no intention of giving up. They still want physicians of their own. Consider South Dakota, where 266 towns are without doctors. During the 1950s and early 60s some of these towns went deep into debt in order to build small hospitals, often with the encouragement of federal and state officials. Later, as local doctors retired or died and new ones failed to materialize, many hospitals were forced to close. Towns like Murdo, Wall, and Edgemont were stuck with empty, unused medical facilities. Now they are searching frantically for doctors.

Along Highway 18 one can read this forlorn sign:

DOCTORS NEEDED
IN
EDGEMONT, SOUTH DAKOTA
IDEAL OUTDOOR RECREATION
PLEASE CALL
605-662-7500

I called the number and learned it was the local Conoco station, owned by Jack Nelson, who was both mayor of Edgemont and chairman of of the doctor recruitment committee. Edgemont's 16-bed hospital, I was told, had been shut down in 1969, when the town's one doctor died of old age. The recruitment committee has been busy ever since, but without luck. Each year its members visit medical schools in other states (South Dakota still lacks a four-year medical college) in hopes of luring graduating seniors and interns to Edgemont. A recruitment brochure points out that the local school system "maintains a library," and wistfully locates Edgemont "in the Heart of the Hard Grass Country!"

Recruiting can be expensive. For one thing, any young doctor who shows the slightest interest in working in a small community is instantly invited down for a few days' "look-see," all expenses paid. As often as not the candidate brings his wife. "We wine and dine them," says Jim Stender, president of the hospital board of trustees in Custer, S.D., "and we introduce them around to everybody. Then they thank us and go away, and usually that's that. We never hear from them again."

Once in a while a town strikes it rich. Oneida (pop: 900) was lucky enough a few years ago to find John M. Knutson, a South Dakotan then attending the Rush Memorial Medical College in Chicago. In exchange for his promise to set up practice in Oneida (on a trial basis), the town's citizens offered him a $16,000 scholarship and the use of a rent-free clinic. Knutson, a kind man, considers the $16,000 to be

a loan; he has started to pay it back out of his earnings in Oneida.

The clinic, gleaming with $30,000-worth of new equipment, was waiting for Knutson last January when he began his practice. It had once been Oneida's hospital, forced to close in 1966 because the single, overworked doctor, as one resident explained, "left town out of self-preservation."

When word came last autumn of Knutson's firm intentions to practice in Oneida, people got busy remodeling the old structure. It was a community effort, just as construction of the original hospital had been back in 1950. (In those days the entire Oneida high school football team would help out every afternoon following practice.) I asked John Zebrowski, owner of the local hardware store, why the town had gone to so much trouble and expense to bring in a doctor, when there were several available 50 miles away in Pierre.

"Well, of course we need a doctor here for emergencies," he said. "But that's not all. Frankly, I don't enjoy going to Pierre--too many strange faces. A person wanting a doctor shouldn't have to wander all over the state. He should have one right here on the spot."

5.

So the unequal struggle continues, with each village doing what it can to assure adequate health care for its residents. Yet most of the institutions that shape our health care system--including the federal government and the big, university-based medical treatment and research centers--seem beyond the village's reach and indifferent to its aspirations.

Part of the blame can be attributed to the nation's 115 medical schools, which continue to train too many city-bound specialists--especially surgeons--and not enough rural-bound general practitioners. Four decades ago, when the "country doctor" was still a fixture of many rural landscapes, eight out of every nine doctors in America were in general, or family, practice; today the ratio is one in four.

In recent years, through a system of grants and contracts, Congress has encouraged medical colleges to teach "family medicine," and that at least slowed down the rush into specialties. Still, the big teaching hospitals have been slow to establish residencies and fellowships in family medicine.

"All the pressure in medical school is to learn a specialty and practice in a big city," says Oneida's Dr. Knutson. "When I told my

professors I wanted to go back to South Dakota they thought I was crazy. All my teachers, all the people I revered, were big-city specialists. It takes a lot of stamina to choose another direction. You keep wondering if you're doing the right thing."

Medical school admissions policies tend to perpetuate the urban and suburban bias. Most medical students come from non-rural upper-middle class backgrounds; one out of every three is the son of a physician. According to a study made by the U. S. Public Health Service, only 18 per cent of medical students come from towns of less than 5,000 persons, although such towns account for 38 per cent of the total population.

All of which suggests that, despite the latest plethora of federal incentive programs, most young doctors still prefer urban glamour to rustic charm. If rural America is to enjoy its fair share of physicians, some kind of compulsory program--a "doctor draft"-- will probably have to be enacted. That is what Senator Kennedy had in mind last year when he submitted his health manpower bill calling for a percentage of medical school graduates to serve for two years in rural areas or urban ghettos, the doctors to be chosen by lottery. The bill failed, but the Senator has resubmitted it to the current Congress.

Both the AMA and the American Association of Medical Colleges (AAMC) oppose this bill on the traditional grounds that voluntary schemes are always preferable to compulsory ones. But voluntary schemes thus far have solved nothing. Besides, why shouldn't the distribution of our new doctors be considered a question of public policy? It is the taxpayer, after all, who educates doctors by footing at least half the medical schools' bill. Over the past decade federal spending for health manpower programs has increased from $65 million a year to $536 million a year. As Rosemary Stevens, an associate professor of public health at Yale, has observed, "The federal government has become the medical schools' new proprietor."

Actually, what with Medicare, Medicaid, and other outcroppings of "HEW sprawl," the feds are fast becoming proprietors of our entire health care system. As HEW goes so goes the nation--and that may mean bad news for rural Americans.

Increasingly now HEW planners speak of the coming "regionalization" of rural facilities; that is, of a network of large medical centers, each one serving dozens of surrounding small towns. Some officials, in fact, have been spreading word of their intent to "phase out" the many 16- and 20-bed hospitals that still function in small-town America. These small hospitals constitute the heart of whatever remains

of rural health care machinery.

"Sooner or later," an HEW functionary has assured me, "we will arrange matters so that only the bigger hospitals will be able to meet our Medicare and Medicaid standards of eligibility. When that happens, the small hospitals will disappear." It is already beginning to happen. The new Health Maintenance Organization Act, for instance, which offers subsidies to communities wishing to start prepayment health care organizations, has for all practical purposes written off rural America. The standards of eligibility are beyond the capabilities of most small towns.

To many rural Americans the idea of regionalization has an all too familiar look; it bears a striking resemblance to notions that for half a century have spelled the decline of small towns: not only the regionalization of hospitals, but also the consolidation of schools, the abandonment of railroads, the mapping of highways so as to bypass small towns, and the denial of subsidies to communities unable to establish their credentials as "growth centers." These are among the historic policies that will soon have to be reversed if small town citizens are to win an equitable footing in the nation's mainstream; if rural America, that is, is ever to regain its health.