Op-Ed

Health care in rural communities

The imbalance of health care resource distribution needs correction

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Competing interests:
None declared

West J Med
2000;173:294-295

The rapid pace of change in health care delivery in the United States has touched all parts of the nation, including small and rural communities. Rural people have been affected by the revolutions in financing, from fee-for-service to managed care; in the use of technology, where treatment is now data-intensive; and in the relationships between patients and professionals, where there are more options and greater expectations of quality and accountability. However, these changes have not affected rural communities in the same way they have affected more central and populous places. Rural people may not be getting their share of the benefits of medical progress and the new structure of health care.

The health care systems of urban America have expanded at a pace reflected in the percentage of the economy dedicated to medical care: from 8% of gross domestic product in 1980 to 13.5% in 1998.[1] This growth has not been matched in rural communities because the most important components of that growth—the highest and newest technology, the expansion of systems to monitor and track care-giving and costs of care, and the entry of new types of professionals and institutions into the field—have all occurred largely in urban areas. Rural America remains relatively under-resourced in health care. Many rural communities continue to experience shortages of physicians; as of midyear 2000, 1,182 non-metropolitan areas or populations were designated as Health Professional Shortage Areas (HPSAs) (US Dept of Health and Human Services, unpublished data, 2000), and 36.8% of all rural hospitals lost money compared to 32% of urban hospitals under financial strain.[2]

A series of articles that are launched in this issue of *wjm* and are based on the book *Rural Health Care in the United States*[3] describe the comparative characteristics of the rural health care delivery system. The series and the book make the case that rural America has indeed been left behind. If managed care was to bring discipline to the health care market and encourage innovation through competition, then rural places lost that positive effect because managed care companies largely ignored rural markets. Rural health care changed more as a result of the increased integration and assimilation of professionals and institutions into systems and networks than in the way in which health care is financed. Indeed, comprehensive relief legislation focusing on rural health care has been introduced in Congress in 2000. Special programs and policies, such as the Rural Hospital Flexibility Program, which was part of the Balanced Budget Act of 1997, and the Rural Outreach and Rural Networds grant programs have been implemented to cope with the imbalance of major payment programs such as Medicare.

Primary care physicians are an important resource for rural health care. But the distribution of physicians remains skewed toward urban areas: rural America has 20% of the nation's population, but less than 11% of its physicians.[3] This imbalance has become worse over time. In 1980, the percentage of physicians practicing in non-metropolitan counties was 13.6%, but it had fallen to 12% by 1990. The total supply of patient care physicians grew by 24.3% between 1990 and 1997, but by only 11.1% in non-metropolitan areas.

The programs that attempt to address the distribution of professional resources and support direct care have been successful up to a point, but they run against a tide of stronger forces that draw capital, people, and services into central places—the cities—and away from rural areas. In a sense, the imbalance of health care resources between rural America and the remainder of the nation is a "condition." That is, it is a persistent characteristic of the system. We describe it, however, as a "problem," which should, as

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John Kingdon explains in his classic work on policy, attack solutions, even from what he calls the policy "garbage can."[4]

The trouble is that these solutions address the symptoms rather than the fundamental causes of rural disparities. More than one commentator has noted that the United States does not even have a "rural policy," much less a rural health care policy.[5] But only a comprehensive policy, one that links health care resource distribution with underlying economic forces and overall economic planning, can deflect or reverse the factors that cause the imbalance. But the United States has no such policy, a fact that individual states are learning as they attempt to bring the rural regions into the twenty-first century.

References

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