Rural Health Care—Is Prepayment a Solution?

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RURAL AMERICA is becoming increasingly interested in the possibility of an alternative health care system, as a result of 1973 Federal legislation to provide belated underpinning for health maintenance organizations. Concerning the kinds of HMOs being proposed, I am not impartial—I think that nonprofit, prepaid group health plans present the best alternative to the fragmented, fee-for-service nonsystem.

The significant national shift toward a largely urban society places new emphasis on rural America. The portion of the country that is not included within standard metropolitan areas includes 54 million persons who are served by 37,000 physicians in areas that range from the farm village, to the mining camp, to the wide place in the road, to the county seat, to the college town, to the small trading center.

Generally, agricultural and blue-collar occupations are the norm—fewer people are in professions or management, income levels are lower, and generally higher morbidity rates prevail in rural areas than in the rest of the nation. In rural areas there are proportionately almost twice as many chronically disabled persons as there are in urban centers, and infant mortality rates lead the nation. Public health issues are sometimes basic—a lack of sewage systems, good water supply, and various public services.

Rural lifestyle continues to have elements of helpful neighborliness, a sense of community, often without the polarization and fragmentation common to urban life. But today's news reaches those in isolated hollows and lonely flatlands as quickly as it reaches those in the cities—news of debates about national health insurance and TV documentaries on the health care crises help to shape expectations in the countryside.

The HMO legislation with constructive amendments, thoughtful new ventures with capital support, and, most important, organized community efforts can help to illustrate alternatives to end the isolation of the rural solo physician, his frustration and helplessness, lack of backup and relief, and alter the dire lack of resources and the unevenness of financing and payment—factors which have driven family practitioners from the countryside or discouraged their potential replacements.

It is possible to establish health teams by using paraprofessionals and controlling costs through monthly premiums to cover prepaid comprehensive health care. But the HMO concept is not without serious problems. How effectively a rural HMO can be developed and serve its subscribers is related to local resources, organization, financing, and personnel. Its success will depend on whether potential pitfalls in the legislation and regulations can be overcome or removed.

A.T. & T.'s personnel manager has indicated that the HMO law actually "designed a Cadillac." Many

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This paper is drawn from Ross' experiences and his remarks at the National Conference on Rural Health Maintenance Organizations in Louisville, Ky., July 8, 1974. Tearsheet requests to M.H. Ross, Administrator, Fairmont Clinic, P.O. Box 1112, Fairmont, W. Va. 26554.

Public health issues in rural areas are sometimes basic environmental concerns, such as lack of sewage systems or a safe water supply

Appalachia - Jan Faul

rural areas will have trouble keeping a second-hand HMO pickup truck on the road. Waivers of all kinds will be necessary to start and maintain rural HMOs.

Some may view the HMO law as embracing a set of entirely new ideas to cope with health care problems. Before a missionary spirit grips the HMO proponents as they prepare to market the startling new concept of prepayment, some neglected aspects of rural history may be useful.

Rural History

More than four decades ago, Dr. Michael Shadid and the Farmers Union in Beckham County, Okla., formed the Community Health Association and agreed on group practice, consumer input, medical and hospital financing, and prepayment. The cooperative hospital was dedicated in 1932, and Oscar Ameringer, the great rural folk artist-humorist-public speaker of the early "social gospel" tent-meeting era, spoke while seven barbecued beeves were being served to 3,000 hungry well-wishers. From Two Harbors, Minn., to the Mississippi Delta, those who dreamed along cooperative lines organized prepaid structures. These plans had long- and short-term lives, as well as mixed results.

Isolated industries, such as logging, often turned to prepayment for medical services as a way to supply physicians in areas where none would locate otherwise. The Western Clinic of Tacoma, Wash., for some 40 years was typical of similar groups that maintained prepaid arrangements for lumberjacks. One-physician outreach offices were linked to the multispecialty group base.

Rural America includes many thousands of hard-rock, anthracite, and bituminous coal miners. Coal industry traditions with respect to payroll deduction prepayment go back at least to 1842 at George's Creek Coal and Iron Company in western Maryland, where 50 cents a month supported a physician in the community. To this day, copper firms in the Rocky Mountains operate the rural group practices and hospitals that were established through early prepayment plans.

On the Mesabi Iron Range of northern Minnesota, in a 100-mile-long crescent, there is a fairly unbroken history of 75 years of physician-owned, group practice clinics, including mergers, separations, and rural satellites; long experience with fixed monthly prepayment in a panorama of control ranges from steel company domination to a collective bargaining worker voice to today's voluntary enrollment in a prepaid group health plan.

More than 70 years ago the Colorado Fuel and Iron Company ran a comprehensive health care delivery system for steelworkers and coal and iron miners from Wyoming to New Mexico. The system, underwritten by payroll prepayment, comprised a modern hospital in Pueblo, Colo., with specialists and residency programs which included lecturers from Vienna, health education, sanitation, and social welfare programs, interlocked with dozens of transferable family physicians in isolated mountain communities who used railroads and horse-drawn ambulances for transportation.

In southern West Virginia during the first quarter of this century, an Episcopal church-sponsored hospital, having salaried physicians and a school of nursing, coordinated inpatient care on a multicounty basis. Coal miners from numerous companies participated, first at 15 cents and later at 25 cents a month for hospitalization. Hospital referrals were from solo practitioners scattered over an extensive rural area. Each of these physicians had separate prepayment arrangements with local miners and their families.

Many industry programs partly represented welfare efforts by management to offset early labor strikes or to thwart potential union efforts. Marketing the plan was easy—dual choice was unknown, and voluntary enrollment was not part of the model. Some industrial prepayment plans did exploit patients; others grossly reduced employer costs of workmen's compensation, and several deserved and received well-founded and serious criticism regarding quality of care rendered. Low-cost budgets, physicians isolated from their well-to-do and prestigious colleagues, and primitive environmental and social conditions were the key factors in an era when medicine functioned with rudimentary knowledge and equipment.

Union demands by workers for an equal voice in health care matters often took the form of requesting "free choice of physician," long before organized medicine adopted such a slogan for legislative lobbying purposes. It is ironic that some medical society spokesmen today reject prepayment as a labor union, socialist, or bureaucratic invention although its foundations universally were laid by entrepreneurial businessmen on the American frontier.

From the viewpoint of consumer participation, many of these compulsory rural-industrial programs could be seriously faulted. Nevertheless, they represent early experience in a variety of methods for prepaid delivery of rural health care; they were successful on a large geographic scale, even as they maintained a local and small-community orientation. Purchase of health care through prepayment in the mining settings was propounded by the establishment and generally supported by the medical profession, despite the increasingly sacrosanct status of the fee-for-service system.

Rural Dollars for Urban Health

Rural America includes millions of black persons, considerable numbers of Chicanos, and almost all American Indians. It is where thousands labor as migrant farmworkers, and it comprises the areas most affected by minimum wage laws. Rural America includes the vast Appalachian population (only three cities qualify as nonrural in the State of West Virginia); people from Blue Ridge and blue grass to prairie grass, range lands, and arid deserts; the people of the Ozarks,

the Delta, and the Corn Belt; and the millions on the southern landscape who toil in textile plants or other industry and work a small farm, garden, or livestock acreage at home.

Throughout the country, larger numbers of elderly and low income people live in rural areas than in the rest of the nation. The sparsely populated southeastern, south central, and middlewestern regions have the greatest concentration of rural localities that are medically underserved. The unequal distribution of health care services in our nation is well known. Rural States and rural counties of urbanized States are well below national averages and minimum levels of manpower and services for decent standards of health care.

Less known, however, is a hidden and unique subsidy system by which excellent distribution of quality health care is available in metropolitan areas of California, New York, Florida, and similar urban States, at the expense of rural people. All insurance programs, for a number of reasons, provide a funneling mechanism by which premium dollars of rural people are delivered as a subsidy to large cities and urban areas. What happens to Medicare premium dollars paid out of the pockets of aged men and women in rural areas?

Part B, the supplementary medical insurance program of Medicare, provides some physician and other health services to the aged. It is financed by monthly premiums deducted from social security checks and by an equal contribution from the general treasury. When the Medicare program began, the premium was $3, but with increasing costs—primarily in highly urbanized areas—the premium rose to $6.70. The contribution from the general treasury has risen accordingly. Thus, a combined total of $13.40 per person per month is now contributed. Currently, each enrollee pays a yearly deductible of $60 and 20 percent co-insurance on all bills.

Since the inception of the Medicare program, the amounts reimbursed to people in rural areas are the lowest in the nation. In calendar 1971, the overall average part B Medicare reimbursement was 37 percent higher than that in rural counties; in central-city metropolitan counties, it was 59 percent higher than in rural areas.

In 1971, Medicare reimbursements to enrollees in the 50 States averaged $100.16. California reimbursement was $150.69, New York $135.12, and Florida $130.65. Consistently at the bottom of the national listing, West Virginia reimbursement in 1971 was $49.47; California was 200 percent higher, central-city metropolitan counties averaged 134 percent more, and the U.S. average reimbursement was 102 percent higher. In order, the other States closest to the bottom were North Carolina, Kentucky, South Dakota, South Carolina, Virginia, Iowa, Ohio, Wyoming, Arkansas, and Tennessee. Few of these predominantly rural States shared well in the national prosperity since the end of World War II. Parts of 8 of the 11 States with low reimbursement lie within Appalachia.

In 1971, a Medicare beneficiary paid out-of-pocket premiums of $65.40, an amount matched by the general treasury for a total payment under part B of $130.80, or $10.90 per month. In 12 rural counties, the average annual reimbursement per enrolled person was well under $36 or $2.75 per month, which amounts to 25 percent of the premiums paid. In 185 rural counties in 25 States, Medicare beneficiaries received average annual part B reimbursements of less than $4 per month.

The amounts reimbursed in rural areas are unreasonably low, compared with the average U.S. reimbursement under Medicare, particularly because the counties receiving the lowest reimbursements have an overall age-sex weighted distribution that would be expected to result in higher than standard reimbursement. Rural reimbursements are shockingly out of line in relation to total premiums paid by the beneficiary and in his behalf from the general treasury. We can only conclude that aged Medicare beneficiaries in rural areas are clearly subsidizing the health care of persons living in more prosperous areas.

Many factors contribute to low Medicare reimbursement in rural areas: poverty and other effects of the social order; low ratios of physicians and other providers to population; more aged, poorly trained, and nonspecialty physicians; provision of nonreimbursable services; lower prevailing physician fees than national averages; insensitive or unimaginative fiscal intermediaries and carriers; lack of rounded medical and ancillary services; inaccessible or poorly organized health care facilities; a lower percentage of physicians accepting assignments (West Virginia 37 percent compared with 55 percent nationwide in 1973); racial and other discriminations; serious transportation handicaps, including practicalities of travel time (versus distance), expenses, and "lost pay"; less knowledge about preventive medicine among patients and physicians; patients' fear of physicians and hospitals; greater outmigration of young persons who would be more likely than the elderly to use services and to submit claims; rural pride or passive attitudes, including avoidance of seeking assistance or filling out forms; absence of health education programs and public health services; little industrial employment or low-wage workers without broad fringe benefits which create sophisticated local health insurance mechanisms; lack of community social and public services, liberal political outlook, patient advocates or ombudsmen to counter apathy, geographic isolation, fear of the establishment; and limited formal education and a higher percentage of illiteracy. All of these factors contribute to patients' non-use of services, not understanding their rights, or not submitting claims for reimbursement.

It is unfortunate that neither the Social Security Administration nor Congressional committees concerned about health care have undertaken or financed studies to shed light on the gross inequity for rural Americans—nor have they proposed solutions.

Medicare is not alone in siphoning dollars from rural communities into prosperous metropolitan areas. I believe that investigation of Blue Cross-Blue Shield and commercial insurance reimbursement would reveal equally shocking patterns of rural premium payments that subsidize high-priced health care resources in well-to-do urban areas.

While resenting the Dogpatch stigma attached to rural areas, we must recognize that entire regions of rural America are in poor economic shape. Like underdeveloped areas on other continents, these rural regions are characterized by low income populations or minority groups, or both, and long-denied opportunities in this richest nation in the world; thus, neither rural HMOs nor anything else can help unless there is open acknowledgement of the need for massive national assistance.

Rural HMOs

HMO appropriations will accomplish little without improvements in the HMO law. Bold, open support of nonprofit prepaid group practice is one possible route to avoid bankruptcy if national health insurance—possibly allowing uncontrolled fee-for-service inflation, unpoliced ripoffs and frauds as in nursing homes, and continuing unnecessary surgery and hospitalization—is enacted.

Physicians who join in pioneering, forward-looking, progressive advances in humanitarian and scientific areas often forego large incomes and at times have to withstand a subtle exclusion or snobbish contempt from academically oriented colleagues or, indeed, even the ugly manifestations of hostility from certain sections of organized medicine. Without the pioneering physicians' understanding support, leadership, and professional cooperation, progress in health care delivery would be impossible.

Rural consumers face a health care industry and a system that may govern their lives but often ignore their needs and sometimes exclude them entirely. Let us hope that rural HMOs can design useful, realistic, and functional consumer participation roles rather than formal ones designed to "fool the Feds" or, worse, fool ourselves.

Among existing group practices, interest in rural HMOs ranges from small two-physician settings to large groups such as the Marshfield, Geisinger, and Trover clinics. There are certainly dramatic differences between a large west coast Kaiser group and the small clinic setting which I represent. As much difference, someone might say, as between lightning and a lightning bug. I prefer to think of the difference in capabilities as between that of an elephant whose gestation period is 2 years and the rabbit which may breed 12 times a year. It is possible to be small but creative.

Again, the purpose of the HMO legislation is to promote, not frustrate, fledgling HMO plans, especially in rural areas. Within statutory limits, wise administrative leadership can grant waivers and avoid a rule book mentality in order to create the opportunity for viable, rural HMOs.

New HMOs must link up with other forces on the rural scene. The National Health Service Corps places two-person physician teams in counties of acute shortage. The Johnson Foundation's new major funding of both hospital-based and rural community group practice is a private initiative of historic proportions.

Lack of transportation remains a principal impediment in accessibility to good rural health care. We must get off the drawing boards and into action ways to use thousands of rural school buses which lie idle for hours each day. The University of California's Health Policy Program studying Veterans Administration hospitals has carefully focused on the 84 "worst-off" State economic areas. These are "generally rural." It is significant that many VA hospitals are in rural areas having acute physician shortages and could provide an enormous potential for rural HMO development if administrative vision were sufficiently farsighted.

In 1938 it was said that one-third of the nation was ill-fed, ill-housed, and ill-clothed. Although the nation also suffered from human ills in general, physical and mental, the priorities that people placed ahead of health and medical care deferred the adoption of universal national health coverage for four decades. What we do now to build rural HMOs which serve the community can strengthen the nation and enforce the right of all Americans to good health care. It can prevent the perpetuation, for example, of stunted children with rotten teeth who are denied an opportunity for decent health care, strong bodies, and good minds.

Private group practice of medicine started 87 years ago in tiny Rochester, Minn., but the Mayo brothers' concept has never swept the entire nation. Groups became the dominant form of practice only in the upper Midwest and did not penetrate the urban East. Recent years have seen the rapid growth of single specialty groups which hold little promise for comprehensive care or consumer hopes. Indeed, the prepaid group health model has not spread generally in the nation and least of all to rural America.

Those of us who have criticized various aspects of the existing health care delivery system have a special obligation to try to make rural HMOs a success and to point directions. We need to exert constructive efforts to improve health care delivery and provide varied rural alternatives. The task of building rural HMOs will be most difficult. The courage and the organizational genius required to meet the enormous obstacles and lack of resources may not be matched in necessary fiscal underpinning, generous and wise interpretation of the HMO statute, and community understanding.

Failure to create nonprofit, prepaid group health outposts may deny our rural people some small place in the sun. More importantly, the lack of prepaid models will leave the nation without yardsticks of health care quality, cost control, and rural alternatives as national health insurance looms on the political horizon.