States of the Union

DOLLARS AND DOCTORS

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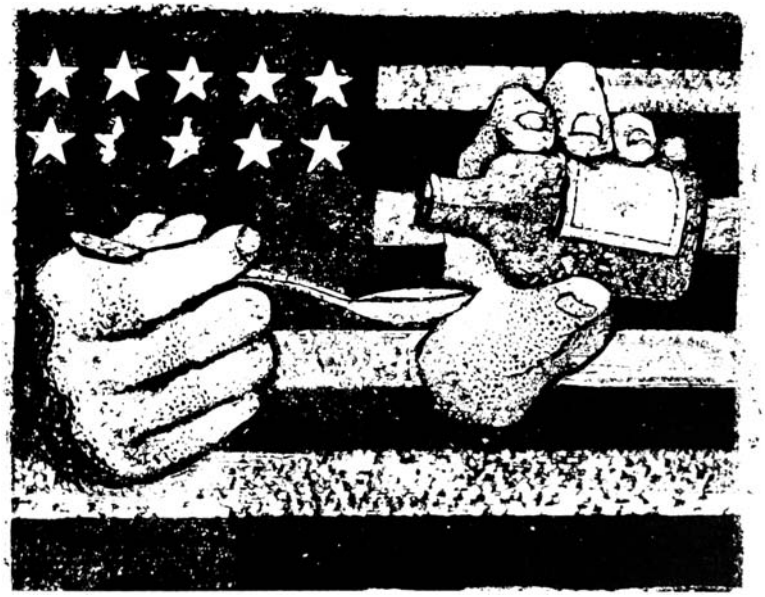

By now nearly everyone must be at least vaguely aware of the health care crisis gripping rural America. It is not only well recognized but almost universally taken for granted, like some mildly unpleasant yet "natural" feature on the social landscape. To many, in fact, the litany of relevant health statistics is as familiar as the Book of Common Prayer, and probably just as soporific:

A mere 12 per cent of our physicians, and 18 per cent of our nurses, practice in outlying areas and small towns; the number of counties without a single doctor has increased from 98 to 138 during the last 14 years; about half of all rural Americans live in places the Department of health, Education and Welfare has designated as "medically underserved," meaning the patient-doctor ratio exceeds 4,000 to one. Truly it can be said of rural people that their cup runneth under.

Less widely understood, perhaps, are some of the concomitants of these health care inequities. While the services have been dwindling, the need for them has been rising. Figures prepared by the U.S. National Center for Health Statistics, for example, show that the infant mortality rate in rural areas is significantly higher than in urban areas; among the rural nonwhite and the rural poor, the rate is double that suffered by white city dwellers. This gap, measured by the number of preventable infant deaths, has been increasing over the last 10 years. Similarly, although women in rural America represent only 20 per cent of the country's women of childbearing age, they account for fully half of all maternal deaths.

The message beamed by such statistics is clear enough: Never has the need for improved rural medical care been greater; never has the response been punier.

I would like to offer two general propositions that I think form the context in which we must look for solutions. The first is that the deterioration of health care throughout rural United States—deterioration proceeding apace for over 50 years—is not a social accident; rather, it is a predictable consequence of a discriminatory social policy that favors urban and suburban Americans at the expense of their rural compatriots.

The second proposition completes the dialectic. It holds that the health care crisis in rural areas differs solely in degree from the crisis nationwide. What rural citizens must endure—spotty services, spiraling prices—we must all endure in some measure; and that the situation will not improve until the medical economic system—the arrangements governing the buying and selling of

health care in this country—is thoroughly overhauled in the interests of consumers.

Much of our history comes down to the people's erratic pursuit of equity in the face of privilege. During the 1930s this was expressed largely in terms of class; in the 1960s, in terms of race. Now the time might be right to speak also of *place,* of those citizens who by virtue of where they live are deprived of full participation in our political and economic system. For by and large our national policy vis-à-vis these rural inhabitants has been one of ferocious neglect. Their voices have been drowned in the urban hubbub; their needs have been continually overlooked.

Indeed, the illusion is becoming widespread that rural America no longer exists, that it is a dead letter and very soon everyone except the minions of agribusiness will live in Megalopolis. The illusion is self-fulfilling: It promotes Federal policies and national trends that ultimately drive people off the land and into the cities. Instances abound:

- Although 60 per cent of the nation's bad housing is out there in nonurban areas, less than 10 per cent of the Department of Housing and Urban Development's housing subsidies are funneled in that direction.
- While rural Americans represent more than half the nation's poor, they receive a disproportionate one-fourth of federal welfare and antipoverty appropriations.
- Rural Americans desperately need public transportation facilities, but just one-tenth of 1 per cent of the Department of Transportation's budget is earmarked for rural transit programs.

The figures trace a correspondingly skewed picture in education, employment, sanitation and most of the other categories that, taken together, go far to define the quality of life in America. Invariably, the small towns and the countryside finish last. Viewed in this light, the health care gap takes its place alongside all the other gaps; it is simply another vital service the system has decreed "off-limits" to rural people —a striking example of "placeism," or discrimination against persons because of where they live.

On the other hand, as my second proposition maintains, the rural health care crisis is the national health care crisis writ large. In both cases the distinguishing features are an obsolete fee-for-service system that makes entrepreneurs out of healers, encouraging them to practice among the affluent; a tendency to embrace specialties or subspecialties and eschew the responsibilities of primary care; and an overreliance on technology that drives up prices and reduces the patient to little more than a broken machine needing repair.

These weaknesses are defended and perpetuated by a profession in total charge of its own destiny. The medical priesthood chooses its novitiates and limits their number; through its faculties and licensing boards it restrains innovation, promotes the expansion of specialties—especially of surgery, a craft that provides us with 2 million needless operations annually—and shields its members from the nuisance of structural reforms. Given the controls and protections, it is not surprising that doctors make more money than any other professional group. Nor need we be astonished that most of them prefer the luxuries of suburbia to the relative rigors of rural life. Anybody would.

IT IS THE whole method of dispensing medical care that is at fault. That is why even the well-intentioned programs promoted by the profession have so little effect. The current vogue of using "physician assistants" instead of doctors, to cite one, may be an interim kindness to rural residents starved for decent health care, but it is also an outrage. It is second-class medicine made available to people unable to pay first-class fees. As Dr. Milton Roemer has pointed out, no other industrialized nation has attempted to solve health care problems by depriving its rural citizens of physician care.

There have been other programs, ranging from the hopeless to the merely inadequate: closed-circuit television, linking country doctors to urban medical centers; the National Health Service Corps, with its dedicated but tiny band of doctor volunteers; costly and largely unsuccessful efforts by local Chambers of Commerce to recruit doctors for their towns. And through it all, a constant sermon from the medical profession urging rural residents to learn the mysteries of hygiene and cleanliness (a way of blaming the victim).

If I seem unduly impatient, it is because the emergency has been fully documented for the better part of a century, and conditions have steadily grown worse. Consider the following four-point dispatch from the *Journal of the American Medical Association:*

"1. There is a universal tendency for physicians to abandon rural districts in favor of the cities.

"2. The number of those remaining belong in a very large proportion of cases to the older generation.

"3. There is little or no tendency for recent graduates to seek practice outside the large centers of population.

"4. In hundreds of rural districts, medical care is inadequate or absolutely lacking."

That report was written in 1925. Under the circumstances, it seems silly to expect the medical profession to reform itself. The ball is clearly in our court. We need to get a better grasp of the politics of health reform to learn how we can convert our discontents into legislation that will reshape the country's medical structure in the interests of rural and urban citizens alike. Health care is too important a matter to be left to doctors.