

The Heartland's Heartstrings: The Power, Challenges, and Opportunities of Rural Health Advocacy in Washington

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The political power of rural health is legendary in Washington, DC. In September 2003, it caused a breakdown in deliberations over the highly-anticipated Medicare drug benefit. Senator Grassley (R-IA) walked out of negotiations with Representative Bill Thomas (R-CA) because rural Medicare provisions were not high enough on the agenda of items to address. The \$25 billion, ten-year rural health package almost derailed the ultimate passage of the \$400 billion drug benefit.¹ More recently, rural health funding cut-backs contributed to the surprising defeat of the conference agreement on the Department of Health and Human Services appropriations bill. At least seven Republicans voted against the final bill—more than the margin of loss—that, unlike either the House or Senate versions, zeroed out several rural health programs.² The \$90 million in funding was ultimately restored to the \$601.7 billion bill, but not without a major political embarrassment to Republicans who generally have such disagreements behind closed doors.

These stories are dramatic pages in a long history of significant successes in rural health policy. In the post-Depression period, the Farm Security Administration created systems in 41 states to provide accessible care—serving as a model for subsequent national reform plans. In the 1950s and 1960s, health planning took hold, offering a rational model and funding for rural facility development. The federal focus on rural health outreach, training, and delivery system demonstrations accelerated in the 1980s. In the 1990s, culminating in a major investment in 2003, Medicare adopted policies that created special payment categories and rates for an array of rural providers.

In 2006, the power of rural health in Washington is still strong, but changing. Shifts in demographics, economics, and politics pose new challenges to rural health advocacy. In addition,

health trends, such as consolidation of insurers and erosion of coverage will likely exacerbate problems facing rural health systems. This commentary reviews why rural health has a strong hold on federal policy, upcoming challenges, and the opportunities that rural advocates have to fundamentally change the United States healthcare system.

Rural Health's Hold on Federal Policy

There is a factual explanation for the power of rural health in federal policy. About 54 million Americans live in rural areas—a number that exceeds the number of seniors nationwide. Generally, rural people face larger and more difficult-to-solve health problems. They tend to be older, poorer, and sicker. They face barriers in accessing needed healthcare. Travel times to

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providers are generally longer in rural than in suburban or urban areas, and attracting and retaining providers is a perennial challenge. Sustaining hospitals, nursing homes, and other services for people with high needs poses a financial as well as a logistical problem.

The ability of these problems to merit increased federal

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attention is enhanced by examples of success. Members of Congress are proud of the innovation and adaptation of their local rural health systems. Many of the payment policies in Medicare for rural hospitals originated to expand on models in states like Montana, North Dakota, and Iowa, homes to powerful Senators like Baucus (D-MT), Conrad (D-ND), and Grassley (R-IA). North Carolina has also inspired federal policy. Its creation of the first Office of Rural Health and innovative rural workforce policies has had a major effect on national health policy.

In addition to the facts and success that propel rural health policy, there is an element of mythology. Many Americans still view rural America as emblematic of bucolic life. We envision family-owned businesses, farms, and the values of small-town life: honesty, decency, and simplicity. This is somewhat disconnected from reality; for example, most rural work is in manufacturing or the service industry, and many farmers are immigrants. Nonetheless, these images are evoked with surprising frequency in the halls of Congress as justification of subsidies for rural health.

And, clearly, our democracy is structured to give rural residents a political edge. The Senate, with two representatives from each state irrespective of their size, gives rural populations a clear advantage. For example, California's population is nearly 73 times higher than that of Wyoming, giving each person in Wyoming a much greater ability to influence Senate policy. And, about half of all Americans live in 10 states, making coalition building relatively easy among the 40 other states that have higher proportions of rural residents.

Because of these facts, myths, and structural advantages, rural health advocates may rank among the most cost-effective lobbies in Washington. There is neither a large rural health political action committee nor a largess in rural communities that gives it an edge in the cut-throat world of Washington. Instead, there is a currency to the facts and stories about rural Americans and the health providers who care for them that has created a strong and relatively unique power base.

Challenges Ahead

The advantages of rural health in federal policy may be needed more—and strained more—in the future. The globalization of our economy has taken a heavier toll on rural America. Job growth has been depressed in rural areas more than in others. The lack of job opportunities has contributed to out-migration of young people and the more rapid “graying” of rural America. This overlays persistent poverty in many rural areas, especially in the south.

These economic and demographic trends have affected rural health systems. Demand is up, given the older and sicker population. The nature of the demand is also shifting as rural areas increasingly become recreation areas; accidents and trauma are rising. This combination has meant that healthcare has grown as an important element of rural economies.

There are also two major trends in the health system that could particularly affect rural areas: consolidation and contraction. *Consolidation* refers to the increasing dominance of large segments of the supply of healthcare in the United States. A handful of

major private insurers now dominate coverage in the United States. Hospitals and nursing homes are increasingly part of large chains. Even doctors have tended to join larger groups. While this could offer support for some rural providers, it could mean less focus on local needs as regional needs prevail.

Contraction refers to the continued erosion of private coverage. There was a 13% reduction in the proportion of small business workers covered by their employers between 2000 and 2005. At the same time, large establishments that have often crowded out local, small businesses are less likely to offer insurance than they were in the past. This has led to a surge in the number of Americans who lack health insurance—or whose insurance is still leaving them vulnerable to catastrophic costs. Most economists suspect that these trends will continue.

Both supply-side consolidation and contraction of coverage are being accelerated by federal policy. Medicare's new focus on large regions has meant that more rural beneficiaries have access to private plans. Yet, it remains to be seen how rural providers and the people they serve will fare in plans that cover large areas, often multiple states. And, in Medicaid, the budget reconciliation legislation will, according to the Congressional Budget Office, reduce Medicaid coverage through a set of policies that tighten eligibility rules, raise premiums, and make applying more difficult. Rural people rely more on Medicaid than those in urban areas, and thus could be disproportionately affected.

This contraction extends to federal appropriations as well. While the initial conservative approach to policy was to encourage privatization of government functions at all costs, a backlash from fiscal conservatives has emerged that has led to intense pressure to reduce the size (i.e., spending) of government. This generally has been focused on small programs. These programs historically escaped the budget knife by having local champions. But, as Washington roils in investigations of special interest influence, protecting local funding is called “earmarking” and is subject to intense review and criticism. This is exacerbated by a break-down in bipartisanship. The exclusion of Democrats from the conferences on major legislation has meant a loss of numerous rural voices in the crafting of legislation. Moreover, the concentration of power in party leadership could subvert local and regional differences to a larger set of politics.

Opportunities

Despite these challenges, the elements that have empowered rural health policy in the past are intact. There is still a fact-based claim for different treatment. Arguably, the case is stronger given increased need and the economic importance of rural health systems. Evidence also will accumulate on the limitations of blanket solutions at the top of the policy agenda. The challenges of rural healthcare delivery will not be solved by information technology alone. Pay-for-performance may not work to improve value in small rural hospitals as it could in large urban facilities. And, the idea that empowering consumers with information and accounts to shop for healthcare simply cannot work in most rural health delivery systems. Awareness of this “square peg in a round hole” problem will strengthen the case for separate consideration

of rural health needs in public policy.

There is also a new and potentially stronger mythology emerging about rural America. Globalization can allow for new types of economic growth in rural areas. Some areas have focused on regional planning, recasting higher education to train for emerging industries, and taking advantage of the information revolution to remove geographic barriers. If technology has enabled outsourcing to India, why not to rural Indiana, some argue. In addition, as the focus increases on our natural resources, rural Americans may be seen as stewards of our unique national and natural assets. This new set of images fosters an advocacy based on strength rather than weakness and emphasizes what has always been true in rural health: local delivery innovation works.

But, it will also require a more sophisticated advocacy. In an overall system that suffers from poor outcomes, high costs, and access problems unknown in other wealthy nations, advocacy based on equality is a challenge. When our urban health systems face serious problems themselves, does equality make sense? Instead, it may be time to move away from politics of comparisons and toward ideals. Rural health policy advocacy could be based on simple principles to which the whole system should aspire, such as affordable access for all, fair financing of efficient care, and focus on health promotion and prevention. This could justify the continuation of successful Medicare payment policies, increases in funding for training, and new programs to improve access. Embracing the idea that we could do more for less—but

this may require an upfront investment—could appeal to the fiscal conservatives. By moving away from arguments based on victimhood or unfair treatment, it rejects the implicit assumption that this is an allocation problem, and rural funding must come at the expense of others.

Finally, many challenges in rural health delivery stem from larger, systemic problems of high costs, coverage gaps, inadequate and unfair financing, and sporadic quality. The next debate on fundamentally changing the United States health system may come soon, as business leaders engage in it as a matter of survival. It could be that the best use of the incredible capital of rural health advocacy may not be in supporting small policies that effectively put a finger in the dyke. Rather, rural health leaders should consider that the best hope for achieving their goals is to advocate for real reform of the system. This may not only precipitate change, but ensure that the unique needs of rural delivery systems are met within the context of a larger redesign of the system.

In closing, the idea of adhering to a large vision even when making local change was something I learned from Jim Bernstein, among others. In my graduate studies at University of North Carolina at Chapel Hill, I had the privilege of working in the Rural Health Research Program and with him. Federal health policy was improved by his actions and example. I hope his legacy will live on through progress in improving the health of rural, and all, Americans. **NCMedJ**

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