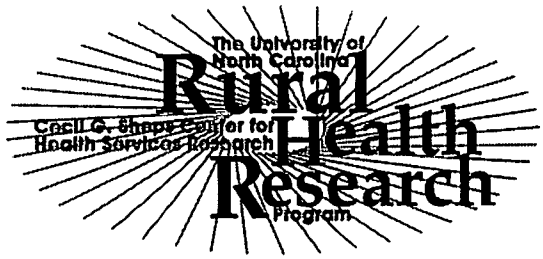
RURAL HEALTH CARE

IN HISTORICAL PERSPECTIVE

November 1989

Conrad Seipp, PhD



WORKING PAPER NO. 5

The North Carolina Rural Health Research Program is designated and supported by the Federal Office of Rural Health Policy, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services. Grant No. CSR000002-03-0.

RURAL HEALTH CARE IN HISTORICAL PERSPECTIVE

Conrad Seipp, PhD

For more than half a century attention has been directed to the problems which residents of rural America face in securing adequate health services. As early as 1921, Frank Billings, a prominent Chicago internist and a former president of the American Medical Association, expressed concern about what he saw as "a dearth of medical men to supply the needs of the rural population." He was alarmed not only by a shortage of practitioners in rural areas compared to an excess in the cities, but also by their inability to make effective use of the rapidly expanding body of medical knowledge. This maldistribution, he felt, followed from the fact that "the country physician lacks modern facilities for diagnosis and for the needed hospital treatment of his patients."[1]

Herman Biggs, another influential leader of American medicine at that time, shared these judgements. As Commissioner of Health in the State of New York, Biggs had been shaken by the failure of the rural practitioners to deal more effectively with the influenza epidemic which swept the country in the aftermath of World War I. Like Billings, he saw the physicians in rural America condemned to the practice of inferior and obsolete medicine without organized support. He therefore proposed that state aid should be made available to those specially designated rural districts which requested assistance for the construction and maintenance of health center facilities. Such centers would be designed to provide "scientific, medical and surgical, hospital and dispensary facilities, and nursing care" as well as "facilities for annual medical examinations to detect physical defects and disease and to indicate methods of correcting the same." Such centers would also assume responsibility for carrying out all public health activities and for the control of epidemics. The proposed health centers were to promote "the combination and integration of preventive and therapeutic services" and to make available to the private practitioners working in rural settings facilities, laboratory services and diagnostic aids, and professional consultation.[2] Biggs saw such health centers as enabling rural physicians to incorporate advances in the science of medicine into their practice and to reduce their professional isolation. This, he argued, would result in better patient care at the same time that it would encourage new medical graduates to

---

[1] Billings, F. "The Future of Private Medical Practice." *Journal of the American Medical Association*, 126:349-254, 1921, p. 349.

[2] All quotations are from the proposal introduced before the New York State legislature. The full bill together with commentary about it is available in the following source: Terris, M. "Herman Biggs' Contribution to the Modern Concept of the Health Center." *Bulletin of the History of Medicine*, 20:387-412, 1946.

locate in rural areas. The health center was visualized as the vehicle for ameliorating both the quantitative and qualitative problems that seemed to be associated with the provision of health care to the rural population.

In 1920 and again in 1921 authorization for the creation of health centers in rural districts was considered by the New York State legislature. Although the bill drafted for this purpose commanded widespread support among various consumer groups and others, it failed to win enactment. It remains, noteworthy, however, as the first concerted attempt by a government in this country to provide assistance to improve the quality and extend the scope of health-related services available specifically to the residents of rural areas. But far more important, the defeat of this legislative proposal signalized the formalization of the existing delineation of responsibilities. This was to be enforced by a virtually unparalleled political mobilization of professional interest that has decisively shaped all of the subsequent history of the provisions of health services to rural America as well as to the country as a whole. Not only was the prospect of organized collaboration between the public sector and the private practitioner effectively precluded by the rejection of this legislative initiative, but its defeat served to insure the continued separation of preventive and curative care. That the medical profession in New York State was able to confirm the inviolability of the prevailing arrangements for the practice of medicine not only succeeded in eliminating the possibility of change at that time, but it served to make certain that comparable alternatives would be dismissed as unrealistic in future years.

Yet it is relevant to note that the proposal which Biggs made was in many respects both modest and weak. It was intended to support and reinforce the work of the rural private practitioner. It was not mandatory but rather permissive, enabling those in a rural area to form a district through which they could acquire the facilities and secure the assistance to upgrade their services. Although the provision of free care to the indigent within those rural districts which would be established was visualized, the private practitioner was to be protected in this regard through the administration of a means test. The relevance with which spokesmen for organized medicine attacked this legislative proposal related not so much to its specific provision as to what they saw as the intrusion of government into the realm of their sovereignty. They succeeded in branding it as a subversive and "bolshevistic" measure.

In order to understand the extent of the opposition of the medical profession to this health center proposal, it is necessary to appreciate how insecure it was at this time and the extent to which it was swept by emotionalism. This was the result of the recent challenge physicians in New York had experienced in 1919 when they had successfully prevented the state legislature from providing for comprehensive health insurance. More generally, the years after World War I also manifested a widespread suspicion of foreign ideas and an uneasiness if not alarm about the prospect of any kind of change. Although the defeat of this proposal constitutes but one episode in

an extended chain of actions undertaken by the medical profession to prevent any possible restrictions upon its autonomy, it served as a potent warning that was heeded across the nation. Among its immediate consequences were the limitations that were placed on the scope of activities undertaken by the public health and voluntary agencies engaged in health-related work.

There were, however, few organized public health programs which served the residents of rural areas 50 years ago. In 1920 there were hardly more than 100 counties in the entire nation which provided sufficient public health services to warrant a full-time director, and a decade later this was the case in only about 500 counties.[3] In most regions of the country, these counties were among the most urbanized. Even where rural counties organized public health programs, the scope of services they offered was extremely restricted. A combination of timid leadership, a shortage of persons trained for public health work, and inadequate financial support most often served to insure the restriction of rural health department activities to what later came to be characterized as Haven Emerson's basic six: communicable disease control, environmental sanitation, maternal and child health preventive services, and health education, together with two instrumentalities of these, vital statistics and laboratory services. Any care rendered by a public health agency which could not be justified as preventive or educational was typically proscribed in deference to the assumed perogatives of the private practitioner in the treatment of a person's health-related problems.

At the same time that the health center proposal formulated by Herman Biggs was rejected by the New York legislature, the United States Congress gave its approval to a measure to make maternal and child health services more readily available throughout the country. This legislation, the Sheppard-Towner Act, authorized the federal government to provide financial assistance to the states for the operation of clinics for pregnant women and well babies. Even though this enactment had a direct impact upon an essentially rural population in only a few states, it warrants attention here because it clarifies the obstacles that surrounded subsequent attempts to develop organized health programs for the residents of rural areas of the country.

The Sheppard-Towner program, which was enacted in 1921, remains noteworthy on a number of grounds. It was the first grant-in-aid program making federal financial assistance available to the states for the provision of a *human* service. Its passage by the Congress is attributable to the fact that women, who were among the most active proponents of this legislation, had just been enfranchised. With the successful culmination of the suffrage movement, many members of the Congress then mistakenly believed that women would be able to constitute themselves as a new voting bloc. Organized medicine, however, opposed this legislation as an unjustified infringement on the private practice of medicine. Although it recorded its opposition to

---

[3]Mott, FD and Roemer, MI. Rural Health and Medical Care. New York: McGraw and Hill, 1948, p. 276.

the legislation as originally introduced and succeeded in modifying its provisions, its leaders were unable to prevent its enactment. This failure is in sharp contrast to the extraordinary political authority which the American Medical Association subsequently came to command, enabling it for more than three decades to exercise a virtual veto power over all federal legislative initiatives relating to health and medical care. Prior to the passage of the Sheppard-Towner Act, the leadership of the medical profession had experienced little need to to bring its opinion to bear upon the members of the US Congress, exercising its influence at the level of the state governments where both the initiative for and the administration of health-related measures for the most part resided. Organized medicine was, in short, completely inexperienced in lobbying in favor of its interests within the federal legislature. However, this was a deficiency which it immediately set out to correct. When the initial five-year authorization of the Sheppard-Towner program expired, for example, the American Medical Association was able to insure that the program would be terminated after another two and a half years. The program lapsed in 1929 when, with the outset of the Great Depression, the need of the states for the assistance forthcoming from this source was without question greatly heightened. The states remained without such aid until the passage of the Social Security Act in 1935 when the program was reactivated and its funding increased.

The Sheppard-Towner program retains significance not only because it served to increase the rigidity of the divorce between the public and the private sector in the health field but because it also heightened the separation between preventive and curative services. The Children's Bureau which supervised the services undertaken in those states which elected to participate in the program attempted to insure that the measures undertaken would not be visualized as an intrusion upon the established domain of the practicing physician. In most states great care was exercised in securing the acceptance of physicians in private practice, both collectively and individually, before services were made available to prospective recipients. And the services rendered were typically restricted to those which could be characterized as educational and preventive. Through the constraints which the Children's Bureau imposed upon the scope of the services offered through this program, it was able to secure the acceptance and support of many pediatricians and obstetricians who became directly or indirectly involved in its work. Furthermore, the program unquestionably served a useful role in demonstrating to many physicians how they could undertake preventive measures on behalf of their private patients. But these accomplishments did little to allay the objections that the program provoked among the leaders of organized medicine as an unwarranted intrusion of the government into professional affairs.

The problem which Billings and Biggs had addressed immediately after World War I became increasingly apparent and acute during the next two decades. The steady rise in the proportion of new medical graduates pursuing specialization served not only to reduce the pool of general practitioners from which replacements for rural physicians might be drawn.

Specialization, together with the increasing importance of its counterpart, the hospital, magnified both the sense of professional isolation of rural practitioners and the disparity in the kind of care they could render as compared with their urban counterparts. By whatever definition that might be used to characterize a population as rural, in most localities residents of such areas were becoming increasingly disadvantaged in regard to the access they possessed to health services as well as in terms of the adequacy of the care they might receive.

Feasible alternatives to the existing arrangements for making high quality health services more readily available to rural America, however, were becoming increasingly difficult to visualize. The medical schools as the promoters of the science of medicine and the specialization which this impelled became progressively less able to deal with or even appreciate the problems faced by the rural general practitioner. The vehemence with which organized medicine rejected any departure from private fee-for-service practice further restricted options. While it is true that the American Medical Association mounted an unrelenting war during these decades to extirpate what was characterized as contract medicine, it should be noted that only infrequently did local medical societies undertake punitive action against company doctors employed in isolated coal and lumber camps or in railroad hospitals which operated in small towns along the the western trunk lines. Many such physicians, hired by an employer and obtaining at least much of their income from a check off or mandatory withholding from a worker's pay, served an essentially rural population. A small part of those in rural areas who would not otherwise have had access to physician services were thereby able to secure care, but the available evidence suggests that such arrangements rarely entailed the provision of quality service.

A far more serious challenge to the prevailing optimism of organized medicine was the acute poverty of many segments of the rural population. While the Great Depression is identified as a phenomenon of the thirties, it should be recognized that the the collapse of this country's agrarian economy began in the previous decade. Hundreds of thousands of immigrants, sharecroppers and tenants could not obtain whatever services might be available in the areas where they resided due to their acutely limited income. During the thirties farm foreclosures, natural calamities such as the Dust Bowl, and the increasing mechanization of agricultural production served to create a displaced agrarian population. In the face of massive rural poverty and distress, the decisive barriers which prevented many of the residents of such areas from securing medical services were financial.

The administrators of the agricultural programs of the New Deal were not insensitive to this fact. In addition to attempting to increase farm income generally, late in the thirties they undertook to indemnify those families they assisted by providing them through the Farmers Security Administration with medical insurance. This entailed securing the assurances of local medical societies in rural areas that their members would provide services to those the government

insured. Local practitioners generally acceded to those arrangements, recognizing that a paying patient was preferable to a non-paying patient or no patient at all. Enrollment in such insurance arrangements peaked at more than 600,000 farm families in 1,100 rural centers prior to this country's involvement in World War II, but the program was abandoned shortly thereafter.[4] While this constituted a realistic response to what was recognized as a major problem, it should be emphasized that the medical expense coverage it provided was a payment mechanism only, preserving the enrollee's free choice of physicians in private practice. As such it provoked a minimum of professional objections.

This country's wartime mobilization precipitated another even more significant involvement on the part of the federal government in the provision of medical services to one segment of the rural population, those employed in migratory farm work. The government, anticipating that the war would create a severe shortage of domestic labor, recognized that the country's agricultural crops could be successfully harvested only by deploying the migratory work force with maximum efficiency; one way that was seen to insure the productivity of the country's migratory workers was to provide them with readily available medical services. Thus, the Public Health Service was charged with responsibility for organizing free clinical services to migrants in more than 250 camps throughout the country. While many physicians were employed in this program, the majority of encounters, it is of interest to note, were handled by nurses who assumed an expanded duty role under medical supervision. The scope of this activity is suggested by the fact that it served several hundred thousand persons.[5] When this program was terminated at the end of the war, the migrant population reverted to its pre-war dependence upon whatever services state and local health departments or church groups were able and willing to make available to it. Not until 1962 did the federal government actively reenter the field of health care for migrants. This came with a federal enactment which provided financial assistance to those state and local agencies already rendering services to this segment of the rural population.[6] This program has operated with continuing problems. However, the administration experience that was acquired in organizing and managing such a large and geographically extended program of personalized medical services as that which was undertaken as a wartime emergency measure was not completely lost, for many of those who were involved in its direction subsequently went on to assist in the development of other systems of rural-based clinical services.

During the years prior to World War II, recognition that many residents of rural areas faced serious and often insurmountable difficulties in securing adequate medical care increased.

---

[4]Mott, FD and Roemer, MI. Op. cit., p. 405.

[5]Ibid, pp. 422-431.

[6]On this and subsequent developments in regard to health care for migrant workers, consult the following: Shenkin, BN. Health Care for Migrant Workers. Cambridge: Ballinger, 1974.

Many different kinds of measures were initiated under voluntary auspices to meet the needs that were visualized. In the mountains of southern Appalachia, for example, the Frontier Nursing Service began its extraordinary activity as a midwifery agency; ultimately it was involved in assisting in many hundreds of home deliveries each year.[7] In Maine a unique program sponsored by the Bingham Associates was created through private philanthropy. It served to make the expertise and specialist consultation forthcoming from a major Boston medical center available to small rural hospitals in Maine and to expedite the referral of patients to that center.[8] The two-way flow of information and resources that was developed between the peripheral institutions and the Boston center was for many years pointed to as a model worthy of emulation elsewhere. As the product of a particular set of circumstances at a specific stage of development it proved impossible, even where additional foundation support was secured, to extend its operations and create similar relationships with rural hospitals in western Massachusetts and elsewhere in New England.

Yet another approach to the provision of medical care to a rural population was pioneered in western Oklahoma where in 1929 a cooperative was organized to make comprehensive medical care available to its enrollees through a prepaid group practice. The Elk City Medical Cooperative with the support of the state Farmers Union was able to withstand a decade of endeavor by the local and state medical societies to force it out of existence. Not only did it achieve financial stability and widespread public acceptance, but it provided what seemed an appropriate model that could be duplicated in comparable rural communities.[9] Shortly after World War II there were in fact at least 100 localities in which a medical service cooperative was in operation or in the process of being established.[10] The majority of these were in small rural towns, especially in the high plains of the Southwest. Only a few, however, have survived to this day. They were terminated less because of the harassment they received from organized medicine than due to their inability to adjust to the post-war escalation in the cost of medical care and to the increased income potential of those physicians who remained in practice in rural areas.

Most often, however, the solution to the problems of insuring that a rural community had access to medical services was seen in the recruitment of physicians willing to locate in such areas. In the mid-thirties the Commonwealth Fund started a fellowship program, those receiving an award agreeing to practice in a rural setting. Several state medical schools in the south initiated a loan forgiveness program for those students who promised to establish themselves in a rural

---

[7]Dye, NS. "Mary Breckinridge, the Frontier Nursing Service and the Introduction of Nurse-Midwifery in the United States." *Bulletin of the History of Medicine*, 57:485-507, 1983.

[8]Garland, J. The Bingham Associates Program.

[9]Shadid, MA. A Doctor for the People. New York: Vanguard, 1939.

[10]Johnston, HL. Cooperation for Rural Health, Miscellaneous Report 123. Farm Credit Administration, United States Department of Agriculture, 1948.

practice. Some medical schools also sought to enroll students from rural backgrounds who expressed an interest in working in such areas upon completion of their studies. And an increasing number of schools offered their students clinical preceptorships in rural areas in the hope that by participating in a rural practice they would be encouraged to locate themselves in a comparable setting. Over the years such programs have multiplied even though few have been able to demonstrate unequivocal success.

During the post-war years more and more rural communities began to offer inducements to attract a physician. Many were assisted in this by the Sears Foundation which underwrote the cost of constructing a physician's office with the hope that this would encourage a physician to locate there.[11] The results of the effort to recruit physicians by offering them such inducements were, however, mixed. Many communities were unable to attract physicians and some which did found that the resulting arrangement proved temporary or less than satisfactory on other grounds. Communities which merely sought to replace the doctors they had lost due to death or retirement most often failed to take into account the changes that were occurring both in medicine itself and in the conditions necessary to make the work of a physician in a rural setting professionally satisfying to the new medical graduate.

With this country's involvement in World War II, the role of the federal government in the health care field greatly expanded. A substantial proportion of the nation's physicians and nurses served in the armed forces, reducing the numbers available to care for the civilian population. As part of the war effort not only did the government initiate the previously mentioned medical service program for immigrants, but it created an extensive program to make care available to the dependents of members of the armed forces and it greatly expanded its activities in such established areas as the control of venereal disease. It also undertook a far-reaching consideration of prospective developments in the field of health care during the post-war period.[12] Few of the proposals which were generated then were subsequently acted upon. Most hinged upon the enactment of some system of national health insurance. In retrospect, it seems likely that the widespread belief that Congressional approval of insurance was imminent deflected attention away from the consideration of alternative measures.

One important measure which owed its origin to the appraisal undertaken during the war years, however, was the Hospital Construction and Survey Act which authorized what came to be

---

[11]Kane, R. "Mail-order Medicine: An Analysis of the Sears Roebuck Foundation's Community Medical Assistance Program." *Journal of the American Medical Association*, 232:1023-1025, 1975.

[12]Representative of such deliberations is the following document: U.S. Senate Subcommittee on Wartime Health and Education, 78th Congress, 2nd Session, Subcommittee Report No. 3, Wartime Health and Education, Washington: US GPO, 1944. A major figure in formulating plans for the post-war years was Joseph Mountin, then Deputy Surgeon-General of the Public Health Service. An appreciation of the proposals he advocated at this time can be obtained from the following source: Mountin, JW. Selected Papers of Joseph W. Mountin. Joseph W. Mountin Committee, 1956.

known as the Hill-Burton program. This program, first enacted in 1946, proved to be extremely durable and commanded widespread Congressional support. In recent years it has also come to be the object of extensive criticism.[13] What is today often overlooked were the ambitious objectives which those who formulated this program's original legislative mandate hoped it would achieve. The legislation, by providing federal matching assistance to the states for construction of hospitals and related health care facilities, relied upon the familiar grant-in-aid mechanism. However, it imposed a demanding set of requirements upon the states. Each was obliged to designate an agency responsible for surveying all existing health facilities within its boundaries and formulating a plan to be renewed annually for the development of a regionally coordinated system of inpatient care.

The Hill-Burton legislation, it is true, did not specifically address the problems of rural America. In the early years of its operation, however, the needs of rural areas were given special consideration. Potentially far more important in insuring the access of rural residents to medical services was the demand the program made upon the states to delineate self-sufficient service regions within their boundaries and to identify base, regional and peripheral facilities within them. This was the essential framework which it was hoped would provide for the orderly development of locally coordinated systems of care dictated by need and capable of avoiding the duplication of costly technology. Biggs' visualization of the health center as reinforcing the work of the local private practitioner with the resources and the supportive services it could make available to them was resurrected. However, little was achieved along these lines. In fact, those health centers which were constructed with financial assistance from the Hill-Burton program generally served only to rescue the health department from the basement of the county courthouse and relocate it without functional change in a more modern structure.

The hope that the Hill-Burton program would foster a planned and regionally coordinated development of health services in this country proved to be illusionary. There are many reasons why this was the case. During the Great Depression as well as during the war years, few civilian hospitals had been constructed. After the war as a result, the supply of hospital beds in modern facilities was so acutely limited in most parts of the country that the leverage which the state Hill-Burton agencies could exercise over new construction was at best limited. Furthermore, the country then lacked persons with the experience and technical knowledge to staff the program adequately. No less important, few state governors seemed willing to invest themselves in a cause which not only was without a popular constituency but in which they were likely to incur the opposition of powerful vested interests. However, there is also reason to question the capacity of the country's hospitals to have accepted the expansion of their functional role as a coordinated

---

[13]Lave, JR and Lave, LB. The Hospital Construction Act. Washington: American Enterprise Institute, 1974.

element of a regional service system and the increase in the scope of community responsibility which this would have entailed. Since World War II hospitals have been institutionally destabilized by the successive waves of technological developments which have engulfed them; they have rarely been able to project themselves beyond their immediate intramural concerns. During the years after World War II, it is true, it was reportedly suggested that the hospital would evolve and establish itself as "the health center of the future," but in most cases this has clearly been no more than an expression of a lofty aspiration.

Those few rural hospitals which after World War II attempted to expand the scope of their responsibilities beyond the acutely ill invariably encountered major difficulties. A notable example is the Hunterdon Medical Center, created after the war in what was then still an essentially rural area of New Jersey.[14] While this center initially attracted great attention as a potential prototype for the future, many of the original objectives visualized for it such as its integration with the county health department were never consummated. Furthermore, its basic premise of a full-time hospital-based specialist staff was ultimately abandoned. During the post-war years when the concept of "progressive patient care" was eagerly seized by the country's hospitals, it is also relevant to note that these institutions most often proved unable to develop the formalized working relationship with nursing homes and home health agencies that was first proposed as an essential feature of this innovation.[15,16] The rationalization of services represented by the creation of intensive care units was readily adopted, but measures that could not be accomplished intramurally were most often not undertaken.

However disappointing the Hill-Burton program may have been to some, it did enable the residents of many rural areas to gain more ready access to modern hospital facilities. The construction of hospitals in such areas, however, did not succeed in checking the general decline in the number of physicians working in such settings. Rather, the program at best served to prevent what undoubtedly would have been a greater worsening of the availability of physicians to the residents of rural America.[17] To most it seemed obvious that residents of rural areas could not secure medical services in the absence of physicians, and after World War II increasing attention was given to physician-population ratios which suggested extensive underservicing. The Surgeon General of the Public Health Service, for example, highlighted the problem by reporting in 1947

---

[14]Trussell, RE. Hunterdon Medical Center. Cambridge: Harvard University Press, 1956.

[15]Curry, HB. et al. Twenty Years of Community Medicine: A Hunterdon Medical Center Symposium. Frenchtown, NJ: Columbia Publishing Company, 1974.

[16]Weeks, LE , (ed.). Progressive Patient Care. Ann Arbor: University of Michigan, 1964.

[17]This is the conclusion arrived at in the following study: Rushing, WA. Community Physicians and Inequality. Lexington, MA: D.C. Health, 1975.

that there were 81 counties in the nation without a physician and 141 counties with more than 5,000 persons per active physician.[18]

At that time, it is relevant to note, one body of influential opinion sought to deny that rural areas were disadvantaged by the prevailing distribution of physicians. The Bureau of Medical Economics of the American Medical Association issued a series of reports over the period from 1947 through 1954 which dismissed as unjustified the conclusion that more physicians were needed in rural areas.[19] In these publications, physician-population ratios were rejected as a meaningful measure of the need for "an economic service subject to the operation of the law of supply and demand." It was also contended that state and county boundaries should not be used to delineate the geographic areas whose residents a physician served. Instead, the nation was divided up into discrete medical service areas reflective of the actual practice of physicians. When the existing distribution of physicians was analyzed in this way, the conclusion was forthcoming that very few rural residents did not have reasonable access to the services of a physician.

The growing dominance of the hospital-oriented specialist during the post-war decades was viewed as problematical not only by the general practitioners, however. Many medical educators responded with alarm at what they saw as the increasing fragmentation of medical care. They accepted specialization as necessary if effective use was to be made of the rapid advances occurring in the science of medicine, but they also recognized the need for physicians qualified to exercise an integrative role, able to deal with the less complex problems of their patients and to assist them in securing any more specialized help they might require. A number of medical schools undertook, with financial support from the Commonwealth Fund and other foundations, either major revisions of the medical curriculum or the provision of more comprehensive ambulatory clinical training experiences for their students. Such innovations, variously identified as comprehensive care or family medicine, had little immediate impact on medical practice in rural areas or elsewhere. Nonetheless, the attention that was directed to the promotion of comprehensive care, emphasizing continuity and broadening the scope of a non-specialized service to include the application of the knowledge accruing from the field of psychiatry, subsequently proved to be of considerable significance.

During the years after World War II various organizational developments were also undertaken to attempt to insure a more effective working relationship between general practitioners and specialists in several different rural areas. For example the United Mine

---

[18]Parran, T. "Hospitals and the Health of the People." *Journal of the American Medical Association*, 133:1047, 1947.

[19]Dickinson, FG. "Medical Service Areas in the United States." *Journal of the American Medical Association*, 133:1014-1015, 1947. Idem, Distribution of Physicians by Medical Service Areas. Chicago: American Medical Association, 1954.

Workers Welfare and Retirement Fund, which provided a comprehensive prepaid medical program covering union coal miners and their dependents, also attempted to rationalize the working relationships between specialists and generalists in many rural areas. Specialists were recruited to work in remote parts of Appalachia, especially when the chain of Miner Memorial Hospitals was constructed, and through the use of retainers, assistance was provided for the creation of many outlying general medical clinics. Although innovative programs such as these attracted a considerable amount of national attention, like earlier developments they proved to be unique responses to a particular set of circumstances and the opportunities they afforded.

Despite the development of such programs, there seems little question, in retrospect, that for most of America's rural residents access to medical services became increasingly problematic during the two decades after World War II. Not only were more and more rural communities unable to replace the general practitioners they lost through death and retirement, but the consequences of the professional isolation of those who continued to practice in such areas became of increasing concern. However, the mounting dominance of the large urban medical center and the specialization of physicians which was central to this development came to be seen by many as creating a problem not only for the residents of rural areas but for the urban population as well.

During the second half of the decade of the sixties, a pervasive and compelling new emphasis began to assert itself focusing upon the need for American medicine to make more adequate provision for what came to be characterized as primary care. The attention that centered upon the issue of primary care came as a comparatively sudden development; it occurred as a response to the conjuncture of forces external to medicine as well as mounting pressures within the profession. Although differences of opinion about the scope and the intent of primary care persist, there is agreement that it constitutes "first contact" care and that the overwhelming majority of problems leading people to seek medical assistance can be adequately handled by a physician appropriately trained for such work. Primary care came to be visualized by its proponents as encompassing the following distinctive attributes: 1) an emphasis upon the continuity of care, its practitioners remaining involved in the management of the health problems of their patients even when they secure more specialized services, 2) the willingness and ability of its practitioners to deal with the anxieties and psychological problems of their patients, 3) an appreciation and understanding of patients as members of a family and as participants in particular communities with its practitioners availing themselves of opportunities to make use of whatever insights may be forthcoming from the social sciences in attempting to assist their patients, and 4) the inclusion of measures to prevent illness and promote health within their practice to the maximum extent possible.

With the articulation of these aspirations, the primary care provider came to be recognized as a new kind of medical practitioner who hopefully might serve to stem the mounting

fragmentation and depersonalization of the medical enterprise and successfully resist the excessive use of increasingly costly and complex medical technology. Three commission reports all rendered during the year 1966 helped to focus attention on the importance of the first contact or primary medical care provider. Each of these reports was prepared under different auspices with different mandates, but each argued persuasively that a priority need of the American medical system was to develop such a practitioner. The terms used to describe this provider varied: the Willard report called for a family physician, the Millis report spoke of a primary care physician, and the Folsom report emphasized the need for a personal physician, but beyond this semantic difference was a consensus which struck a responsive chord in many quarters.

Major steps to promote the development of primary care followed in rapid succession. In 1969 the American Academy of Family Practice was established, encouraging the promotion of a new medical specialty of family medicine. Many departments of pediatrics and internal medicine in the country's medical schools embarked upon programs to qualify physicians as primary care providers, and programs were started to train medical assistants and nurse practitioners to function in this capacity. The federal government greatly increased the financial incentives for the medical schools to undertake the training of primary care practitioners, especially as it replaced the institutional grants it awarded such institutions with capitation grants. No less important were many of the programs which the government initiated at this time. As part of the war on poverty, the Office of Economic Opportunity provided support for 40 neighborhood health centers offering a comprehensive complex of services to disadvantaged populations; while most of these centers were developed in the country's inner cities, 12 served rural populations. These centers were distinctive in that they entailed a multidisciplinary team approach to health care delivery and community involvement in both policymaking and program operations. More rural communities were able to develop such centers when administrative responsibility for these activities was transferred to the Department of Health, Education and Welfare which was already promoting such centers on the basis of a different legislative mandate. During the following years the U.S. Congress enacted a number of additional important laws to assist underserved rural areas in securing medical providers and in developing service programs consistent with their needs and capabilities. In 1970 the Emergency Health Act provided for the creation of the National Health Service Corps to make health care personnel available to underserved areas. Another enactment provided the support for the initial development of 12 Area Health Education Centers in different parts of the country. Although these centers were started with an ambitious agenda of intent focusing upon the training of personnel to serve at the periphery of the health delivery system, after several years it came to be evaluated by its federal administrators solely in terms of its ability to reduce the

maldistribution of health providers within the rural areas in which it operated.[20] This was soon followed by two other major endeavors undertaken by the federal government to promote the development of health service programs in rural areas. The Health Underserved Rural Areas and the Rural Health Initiatives programs were started within a year of each other and then in 1976 they were combined under a single administrative authority. Together they were intended to foster a more effective and coordinated use of the resources forthcoming from the federal government in the development of service systems rendering primary care in medically underserved rural areas. However, other governmental agencies were also actively involved in this mission. The health office of the Appalachian Regional Commission, for example, actively supported a variety of health initiatives within the geographic area it served.

During the decade of the seventies the multiplicity of the federal initiatives designed to increase the access of underserved rural areas to health services appears often to have been confused and confusing, especially when perceived from the community level. In many of the measures which served to make federal assistance available to rural areas, a considerable disparity can be noted between the body of intentions leading to the introduction of legislative proposals, what ultimately was included in those enactments which secured congressional endorsement, and the federal administrative regulations subsequently formulated in terms of them. The latter, furthermore, changed over time. Further compounding the problem from the perspective of the local community, several of the regional offices of the federal government seem to have encouraged local communities to pursue certain approaches at the expense of others.

In the eighties the trend has been retrenchment. The Reagan Administration attempted to curtail the Community Health Centers programs but the Congress and the program's advocates were able to resist this attack and maintain stable, though reduced funding for the projects. The dominance of the urban and inner city influences in the program caused a shift of the share of resources away form rural centers. Many were closed or incorporated with other programs, often independent rural clinics coming under the control of central, urban centers. The Area Health Education Centers Programs have persisted where they were established with institutional support from their hosting medical schools and somewhat generous state support in several places. Its companion health professions initiative, the National Health Service Corps, has died a slow death to the point where its money and placements have been reduced to a very small trickle into rural communities where once it supported upwards of one half of all providers in rural underserved communities.

A number of state governments developed their own programs to increase the availability of health care services in the rural areas of their jurisdictions. Notable in this regard has been the

---

[20]Consult, for example, the following: Coleman, S. Physician Distribution and Rural Access to Medical Services. Santa Monica: Rand, 1976.

Office of Rural Health Services in North Carolina which among other measures has assisted 35 communities to develop local health centers. A number of other states developed their own programs to reduce the problems of those rural areas most affected by a maldistribution of health personnel. In addition to government, private philanthropy and a number of church groups have been actively involved in providing assistance for the development of rural health programs. In 1976 the Robert Wood Johnson Foundation, for example, provided support for a rural practice project which led to the establishment of 12 model rural practices in different parts of the country. Also at this time, the W.K. Kellogg Foundation provided support for a project that was designated as Innovations in Ambulatory Primary Care. Other foundations and church groups provided lesser amounts of assistance to specific health related projects in rural areas in various parts of the country. The Johnson and Kellogg Foundations continue their support of individual projects with some attention to program support with the intention of creating models. Johnson is sponsoring a rural hospitals program; Kellogg is supporting community oriented rural practices.

Inevitably the existence of so many potential sources of support for rural community-based health endeavors during this period served to foster what can best be characterized as public entrepreneurship. This placed a premium upon the ability to assemble proposals, mobilize and coordinate local interest groups, mediate between the requirements of outsiders providing financial and other types of assistance and the concerns of community residents, and give direction to programs once started. It does not seem surprising that the skills such a demanding role entails were not often encountered among the residents of rural areas. Nonetheless, many rural communities were able to respond to the opportunities that were created for them to develop health service programs. And in some settings local people proved to be apt learners and rapidly qualified themselves to function effectively in this role. Unfortunately, however, there seems to have been little correlation between the emergence of such leadership cadres and the degree of need of a community for a health service program, however that need might be measured.

Nonetheless, approximately 800 rural health care programs were established during these years as a result of these various initiatives. The diversity of these programs is striking. They differ in terms of how they were organized, whom they were intended to serve, and what they sought to accomplish. Collectively, these programs constitute an impressive store of experience and experimentation. Many were started with the hope that they would serve as demonstrations and models that would be replicated in other rural communities across the nation. For a variety of reasons this has not often taken place. Drastic reductions have occurred in the availability of financial support for the development of additional rural health programs. Concurrently, the social and political context which legitimated these developments has undergone a major modification. However, much can still be learned from an analysis and assessment of this experience.

In order to understand the changing context for the provision of medical care to rural America, it is necessary to recognize how the relevant attitudes and expectations of the public have been altered during recent decades. This, like the emergence of the focus of attention on primary care, occurred as a pervasive national development; although not inspired by concern about rural medical services, it has had significant consequences for the residents of such areas. Most of the American people want medical services, there is consensus that they often need medical care, and given this nation's wealth and its commitment of resources to the health care field, few would question that the capacity exists to make such care available to all. Where once medical care was assumed as a privilege, with the indigent provided for as a charitable indulgence on the part of the hospital and the medical profession, medical care has increasingly come to be viewed by many as a right. The provision of renal dialysis services to all and the enactment of Medicare and Medicaid in 1965 entailed the creation of entitlements of sorts for certain segments of the population for such services. However, control over the provision of medical services through the operation of market forces had already been significantly modified prior to the passage of such legislation. This was the result of such developments as the intervention of third parties between the providers of medical services and their clients, the coverage of much of the labor force with medical service benefits, either voluntarily offered by management or obtained through negotiation, and the increasing institutionalization and depersonalization of the "medical care industry."

The ferment of the sixties, however, did not result in the universal assertion of medical care as a basic human right. In the course of American history, it is possible to identify points in time when after long agitation, new rights come to be proclaimed as part of our national heritage. This involves a transformation of popular consciousness, the new right being accepted as obvious and irrevocable and its absence in the past an inexplicable omission on the part of American society. Thus, when the abolitionists finally succeeded in securing the emancipation of America's slaves, the notion that human beings could be held as chattel became unthinkable. Similarly, when women were finally enfranchised, it became difficult if not impossible to understand how they ever could have been denied the right to vote. And when American workers secured the legal right to join unions of their own choosing a half century ago, such previous management practices as blacklisting union activists and forcing employees to sign "yellow dog contracts" became unconscionable.

Although health care has come to be unequivocably accepted as a right guaranteed to all in most of the western democracies as well as in the socialist world, this is not the case in this country. Some of the legislation that the Congress had enacted in the last two decades to increase the availability of medical services to rural residents and to others and to expand their scope and improve their quality has at least by implication assumed that the American people have a right to such care. However, most measures undertaken by the federal government have accepted the

longstanding visualization of medical care as an economic service subject to the operation of the law of supply and demand. And today the marketplace is increasingly being looked to as the source of solution to whatever problems rural America today faces in obtaining medical care.

A meaningful summation of the present situation in regard to the provision of health services in this country's rural areas is not forthcoming so much from a consideration of statistical aggregates as by assessing the situation of individual communities. There is little which can be identified as a common denominator of rural America today. Rather, attention should be given to the tremendous cultural and socio-economic diversity of those communities which are classified as rural. Much of the nation's rural population continues to live under conditions of acute poverty but some enjoy comparative affluence. Many rural communities are highly stable and despite major change economically viable; others are transient and are experiencing decline. Local and regional traditions preclude facile generalizations about this segment of the American population as a whole. In terms of securing health care, the one characteristic residents of rural areas everywhere share is their relative geographic isolation. But the ability of rural communities to secure adequate medical services in the face of such isolation varies enormously. That is why the status of each needs to be assessed separately, taking into account the factors that determine its capacity to meet the health needs of its residents as well as its own specific requirements for an efficient and effective service. The experience of recent years has demonstrated that what may be a successful arrangement for the provision of health services in one setting may be inapplicable or inappropriate in another.

Surveying the nation as a whole, it is possible to identify some rural communities which are today fortunate to have quality programs of health care with their residents having ready access to the services they provide. In such settings, care encompasses not merely acute episodic care or medical salvage but such preventive and supportive services as are needed by the local residents. In many communities services may be available, at least to most, but they often seem to be poorly matched with the particular needs of their prospective clients. Finally, a distressing number of America's rural communities lack direct access to front line medical services and remain unable to make effective use of the nation's health delivery system as it currently functions. This is the case even after the substantial measures which have been undertaken by the government, various medical schools and private foundations, the professions and others to make such services universally available. Health care to rural America is a continuing problem.

HISTOMAP OF RURAL HEALTH DEVELOPMENTS

	Federal	Education and States	Private and Other
1900-1910	Sheppard-Turner Act		
1910-1920		Rural Health Depts. formed	Commonwealth Fund Rural Service Obligations initiated
1920-1930	Farm Security Agency Opens Title V, Maternal & Child Health		
1930-1940	Programs started EMICs in War Effort	Practice Commitment and Loan Forgiveness Programs 1942-present	
1940-1950	Hill-Burton Act subsidizes construction and requires free		
1950-1960	care - 1946	New Medical Schools begin to form 92 Med. Schools	United Mine Workers Fund builds clinics and hospitals Sears Roebuck Clinics Program
1961		8,794 1st year med. students	CMAP 1957-1970
1962	Migrant Health Act Passed		
1963			
1964	OEO Neighborhood Health Ctrs Program started		
1965	HMSA Designations begun		Presbyterian Medical Services organized in New Mexico
1966	Medicare and Medicaid Enacted Comprehensive Health Planning Program	93 Medical Schools 9,223 1st year med. students	Tufts-Delta Clinic opens in Miss.
1967	sets up CHCs (314e)		
1968		New Health Practitioner Movement begins	Macy and other foundations support the Student Health Coalition at Vanderbilt and
1969	Neighborhood Health Centers merged into CHC program	Area Health Education Center Programs begin (AHEC)	Meharry Universities
1970		110 Med Schools 12,000 1st year med. students	Activist organizations develop programs in the SE and SW
1971	Federal Funding for Family Practice Programs	State Funding for Family Practice expands	WAMI Medical Education Program begun in the NW
1972	Feds join AHEC movement		
1973	HMO Act targets 20% of funds to Rural areas		Locally-organized coalitions of rural health programs organized
1974	Rural Health Research and Demo. Prog./HURA implemented	123 Med. Schools 16,353 1st year students	
1975	Health Professions Act promotes primary care residency training	Office of Rural Health Services Opens in NC, others to follow	Rural Practice Project started by RWJF Foundation
1976	BCHS-RHI Administrative Changes		Kellogg Innovative Approaches in Primary Care Program begun
1977	Rural Clinics Act allows for midlevel reimbursement		
1978			American Rural Health Association, National Rural Center and the National Rural Primary Care Association act
1979	Primary Care Research and Development Program	140 Medical Schools 18,395 1st year students	as spokesmen for rural health
1980	GMENAC Report issued		
1981	NHSC Continuation and Reagan Block Brant Plan		
1982	Health Promotion Support for CHCs		
1983			Rural Practice Network organized COPC Movement gains strength - IOM
1984	Primary Care support through continuing resolutions	Medical school enrollments begin to level off	Conference on Community Oriented Primary Care