Arguing for Rural Health in Medicare: A Progressive Rhetoric for Rural America

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Arguing for Rural Health in Medicare: A Progressive Rhetoric for Rural America

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Introduction:

This paper examines how rural health policy is treated in the broader field of public policy, discusses the role of advocacy in developing rural health policy, and suggests ways to make that advocacy more effective. Rural health policy is the laws, regulations, rules and interpretations that benefit or affect health and health care for rural populations. The ramifications of any label that is applied to an advocacy group and its constituency is of tremendous importance. At the outset of the twenty-first century, it is not clear how the rural health advocacy coalition* is viewed by the professional policy world or the public: either as an issues network pressing for fair and equal treatment or as an interest group seeking special advantages. This paper was written to explore the types of claims that rural advocates make, focusing on the context of Medicare policy, and to determine to what extent those claims reflect a central theme of fairness and inclusiveness in national policies versus claims that benefit special interests. The paper also suggests how the rhetoric of rural advocates can be structured to reflect a progressive sense of fairness.

Rural America is many people—a substantial population unto itself.

The Rural Condition

Rural America is many people—a substantial population unto itself. The nonmetropolitan population of the United States in 2000 was 54,260,000, 19% of the national total. This is almost twice as many people as are in all of Spain or Canada and only slightly less than the population of the United Kingdom. If the land area of the nonmetropolitan counties of the U.S. were a single nation, it would be the 18th largest in the world. Despite its size and scope, rural America is a minority element of this nation's economy and its place in that economy has been changing rapidly. Well into the last half of this century, Americans thought of their country as closely connected to agriculture and the small town life that was supported by farming, but

*This term was introduced by Paul Sabatier to describe fluctuating combinations of interest groups and government agencies which have come together over a single issue (Sabatier 1998; Sabatier and Jenkins-Smith 1999).

that perception is changing. Farm workers and livestock are now less likely to be a big part of the vision Americans have of "the country" when they think of America beyond the suburbs. The vision is now of a recreational area or some form of escape route to either adventure, exercise, or a psychic break from the pressure of urban life. Jedediah Purdy calls these new ruritanians "Patagonians" after a trendy brand of adventure clothing and gear (Purdy 1999). Agriculture is now a highly concentrated industry with large scale meat and grain enterprises replacing diffuse family and small-business farms. Scale of operation has become important and the multi-skilled farmer has been replaced in the main by low-skill workers, many of whom are immigrants or contract laborers (Aleinikoff 1999).

In fact, only a small part of the rural population nationally, 5.7%, is directly employed in agriculture. Most rural residents are employed in service jobs, or in producer and manufacturing firms often affected by or dependent upon agricultural production, but the majority of the non-farm rural economy must compete with urban producers and manufacturers (Economic Research Service USDA 2000). Job growth in nonmetropolitan counties fell behind urban areas in 1995 and has been substantially slower ever since (Gale and McGranahan 2001). Overall, rural areas are falling behind in the new economy, but there are some rural areas which are deeply mired in an almost permanent recession. These counties are characterized by higher rates of poverty, low or no population growth and a higher proportion of the existing jobs in low-wage industries. Part of rural America is characterized by the term "persistent poverty" which describes the status of 300 counties (Rural Sociological Society Task Force on Persistent Rural Poverty 1993) located throughout nonmetropolitan U.S. but clustered in the Great Plains and the South. The problem of persistent poverty in some rural places was made worse by welfare reform in the 1990s, as incomes from the Temporary Assistance for the Needy (TANF) and Supplemental Security Income (SSI) programs declined more rapidly in rural than urban areas.

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from use of farm and garden equipment is much more likely in rural areas; chronic diseases related to pesticide and herbicide exposure more prevalent; and trauma from snowmobile, off-road vehicle and boating crashes are far more common in rural than urban places. The severity of automobile crash injuries has been demonstrated to be much greater in rural places due to higher speeds and poorer roads and trauma mortality, especially for motor vehicle crashes and gun related reasons, are disproportionately higher in rural areas. (Chen et al. 1995).

The health disparities that most often stimulate policy discussions are, appropriately, based on race, ethnicity, income, and health insurance coverage. In 2001 the National Center for Health Statistics included a rural-urban comparison in their Healthy People series. The NCHS report found:

> The Americans who generally fare best on the health indicators are residents of fringe counties of large metro areas …many measures of health, health care use and health care resources vary by Urbanization level … the data reconfirm the existence of regional variation.
>
> Nationally, residents of the most rural counties have the highest death rates for children and young adults, the highest death rates for unintentional and motor vehicle traffic related injuries, and, among men, the highest mortality for ischemic heart disease and suicide. (Eberhardt et al. 2001)

There are clear regional patterns of rural disadvantage—much higher infant mortality in the rural southeast, for example.

That comparison, while troubling, did not compel an immediate response on the part of the administration and did not dispel the observations made by some researchers that, when compared to urban, rural populations do not show an overall disadvantage for rural places plagued by the problem of aggregation of widely divergent nonmetropolitan populations and communities into large, gross classifications that are meant to be consistent across the nation. There are clear regional patterns of rural disadvantage—much higher infant mortality in the rural southeast, for example—and those conditions are clearly related to the income and education differences between those

rural regions and other parts of the nation. Geographic patterns of morbidity and mortality vary by race and ethnicity (Albrecht, Clarke, and Miller 1998) and these differences are sometimes reinforced by rural location; blacks and whites living in nonmetropolitan counties have higher death rates from diabetes (Ricketts 2001) and heart disease (Slifkin, Goldsmith, and Ricketts 2000).

Access to health care services in rural versus urban areas has been explored by health services researchers for decades. Rural residents are, on average, poorer, older, and, for those under age 65, less insured than persons living in urban areas (American College of Physicians 1995; Hartley, Quam, and Lurie 1994; Braden and Beauregard 1994; Schur and Franco 1999) and these are factors that impede access to care. In the theoretical framework of access proposed by Ron Andersen and Luann Aday, these are "enabling" conditions for use of services (Andersen 1995). Rural Americans also report more chronic conditions and describe themselves in poorer health than urban residents, again, in the Andersen framework of access, these are "predisposing" conditions which reduce access. MedPAC, in their June 2001 Report to Congress reported that Medicare beneficiaries living in the most rural counties experienced more difficulty in seeing a doctor and lacked a usual source of care more often than urban or other rural beneficiaries (MedPAC 2001). This analysis was based on an original examination of the 1999 Access to Care files of the Medicare Current Beneficiary Survey.

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In sum, there is credible evidence that being in a rural place has a strong and relatively consistent negative effect on one's economic chances but there is some difficulty in creating a strong claim that rurality has an independent and significant impact on people's health. The problem, it seems, is that the definitions of what is rural and nonmetropolitan are more closely tied to factors related to population and its density which have a consistent economic effect but an inconsistent health effect. Unfortunately, a definition of medical rurality isn't at hand, what is available are various measures of medical underservice, health professional shortages and vulnerability. While those measures are place-specific and tend to be more rural, they are

also applicable in urban, even the most urban places. The search for a perfect measure of rurality that will capture its health effects may be a useful exercise if the strong prejudice toward the existing, well-documented, and relatively consistent systems of classification were ignored.

The Special Conditions of Medicare and Rural Health

A central element of rural health policy, indeed a dominant part of rural health policy debate focuses on Medicare payment for health care services provided in rural communities. Since the inception of the Prospective Payment System (PPS) in the early 1980s, Medicare has been a central issue to rural health stakeholders, due to the very heavy dependence on Medicare revenues of most rural hospitals and health care delivery systems. Indeed, rural providers, especially hospitals, depend more on Medicare than urban and suburban providers. In seeking redress for the administrative decision to differentiate payments to rural and urban hospitals, rural health stakeholders and advocates sought some statement of the intent of the Medicare program to justify their calls for fairness, equity, even equality. However, no such statement existed. The Medicare law starts with the unique statement: "Nothing in this subchapter shall be construed to authorize any Federal officer of employee to exercise any supervision of control over the practice of medicine…" (42 USC § 1395). The conference reports that accompanied the legislation to the floors of the House and Senate were largely stripped of any mention of a greater social purpose for the program. Subsequently, courts have stretched to develop a statement of purpose for the law. For example one court ruled: (the) "purpose of this subchapter is to insure that adequate medical care is available to the aged throughout the country." (Hultzman v. Weinberger, C.A.Pa. 1974, 495 F.2d 1276). Another that the "Purpose of this subchapter is not merely to protect its beneficiaries against major health care expenditures but to make the best in modern medicine more available." (Rastetter v. Weinberger, D.C. Ariz. 1974, 379 F.Supp. 170, affirmed 95 S. Ct. 767, 419 U.S. 1098, 42 L. Ed.2d 795); or, "One purpose of this subchapter is to insure the availability of adequate medical care for the aged." (Lord v.

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Richardson, D.C. Ind. 1972, 356 F.Supp. 232). Marmor and Mashaw describe the origins of Medicare as pragmatic accommodation of the prevailing interests of organized medicine and hospitals with the desires of progressives to:

> … reduce the risks of financial disaster for the elderly and their families. And the clear understanding was that Congress would demand a largely hands-off posture toward the doctors and hospitals providing the care that Medicare would finance. Thirty years later that vision seems odd. (Marmor and Mashaw 1997).

The National Academy of Social Insurance in its report, *Medicare and the American Social Contract*, could not point to a clear purpose for the Medicare program that could be used to justify some standard of equity among beneficiaries. They could only describe how Medicare was entwined in a "broader social contract" and its role and its future depended upon a complex accommodation of many pragmatic elements that could cope with rising costs, an expanding beneficiary population and a changing national sense of social protection (Study Panel on Medicare's Larger Social Role 1999).

(Medicare) drifted from a universal benefit for a specific class of Americans, to a program that paid providers for what they felt they should make available to beneficiaries.

It is ironical that the Medicare program, meant to have no effect on the practice of medicine or of hospital care, has been able, through incentives or administrative decisions, to essentially revolutionize the practices of physicians and the operation of hospitals largely through efforts primarily intended to keep the program's expenditures in balance with its revenues. The program drifted from a universal benefit for a specific class of Americans, to a program that paid providers for what they felt they should make available to beneficiaries. This moved Medicare away from principles such as geographic equity in access, that put the beneficiary at the center of Medicare policy. Those policies that spoke more to equality were long considered to be an implicit goal of the legislation. To control the program's growth, policy changes have focused on providers and that focus has moved the Medicare program to a place where principles that speak to justice for beneficiaries are subsumed under principles that speak more to efficiency in provider payment. When the Medicare program was spending more than

Congress felt it should, the brakes were placed on provider behavior; there were seldom efforts to change beneficiary demand for care or use of services—until recently when managed care options have been proposed. Ironically, the push for Medicare+Choice is the first really important effort in the program to think primarily of the beneficiary as the motivator of program allocation. Unfortunately, the degree to which beneficiaries can appropriately value and demand services is severely limited by the nature of medicine and illness. To ask markets to provide justice in Medicare will be as frustrating as looking to principles of efficiency to create equality of access. What is needed is a clear statement of principles for the program that set as their goal equal access to services for beneficiaries.

Bruce Vladeck, past administrator of the Health Care Financing Administration, views the political economy of Medicare through three interpretive perspectives: as distributive, interest group or redistributive politics (Vladeck 1999). Medicare is a "mildly progressive" income transfer program which is designed to give the greatest net benefit to middle-income people. This ensures broad support for the program Vladeck sees the progressivity of the program as inviting ideological attacks that play upon manufactured perceptions of the program going broke to justify program changes that reduce the income transfer. The current urgency to reduce the progressivity, he feels, is due to the inevitable fact that more and more baby-boomers will soon become Medicare beneficiaries, and thus be more likely to protect a system that benefits them. On the other hand, the middle class nature of the program has kept its support strong but also has tended to deflect any perception that Medicare is to be a force for expanding equality. Medicare hints at being a force for equality but never reveals its commitment. Vladeck points to rural advocates as being one beneficiary of the PPS system which allows central policies to shift payment rates toward one or another favored class of providers; his other example of a favored group are teaching hospitals. He doesn't provide specifics but when he refers to rural benefits he is talking about the special classifications of Rural Referral, Sole Community, Rural Primary Care, Medicare Dependent, and, now Critical Access Hospital

designations that allow for some exception to the otherwise unequal payment levels. The justification for these exemptions is, in his words, the fact that "Rural hospitals play an important role in their communities and are especially dependent on Medicare," but, he also recognizes an often unspoken political fact that "the basic Madisonian formula for representation in the U.S. Senate does them no harm" (Vladeck 1999; p. 27). In his description of the redistributive properties of Medicare, Vladeck is most specific, offering a table that shows the very wide range of net payment benefit states experience from the Medicare program. The geographic comparison here is among states, not rural-to-urban, although he does comment on the way in which the AAPCC system provoked a response from rural interests. Two states, Florida and Louisiana, receive more than $1.50 for every dollar paid into the Medicare system on behalf of or by their residents, while 7 others receive less than $0.75 on the dollar; Colorado, Minnesota, Utah, Maryland, New Hampshire, Hawaii, and Virginia.

Rural advocates cannot point to Congressional intent that clearly says that Medicare is meant to provide even a minimal level of access to rural residents.

Rural advocates cannot point to Congressional intent that clearly says that Medicare is meant to provide even a minimal level of access to rural residents. This became more apparent in the fall of 2000 and spring of 2001 as the Medicare Payment Advisory Commission (MedPAC) conducted hearings in preparation for release of a special report on rural beneficiaries and Medicare. That commission has strongly supported the position that the role of Medicare "…is to reimburse the 'efficient case…' " (Frankford 1993) rather than to meet any standard of equity. This was driven home by the Minnesota District Court's decision to dismiss the suit brought by the State of Minnesota, the Minnesota Senior Federation and Mary Sarno against the federal government, seeking to eliminate the geographic payment differences in the managed care payment formula created under the Balanced Budget Act of 1997 in the Medicare + Choice program (102 F. Supp. 2d 1115). The plaintiffs pointed to wide differences in payment levels between states and counties, differences that the court found to be "wrong" and an "injustice," but nevertheless weren't unconstitutional or beyond the authority of Congress or the U.S. Department of Health and Human Services.

The plaintiffs could find no basis in Medicare legislation or case law to develop an effective challenge. Instead, the suit based its arguments for geographic equity on three points: That the formula denied persons due process; that the formula was an unconstitutional infringement on states' sovereignty; and that it restricted citizens' right to travel. The Federal District Court of Minnesota rejected the suit, rebutting these premises and finding that Congress could create unfair laws and the administration could promulgate unfair rules given the need to wrestle with the demands of a massive program such as Medicare with its many contending elements.

Arguments for payment policies that … can be viewed as favorable to rural health systems can be interpreted in two ways: as calls for subsidies or as equal policy treatment based on principles of fairness.

Medicare and Equity

Arguments for payment policies that either are or can be viewed as favorable to rural health systems can be interpreted in two ways: as calls for subsidies or as equal policy treatment based on principles of fairness (Size 2001). Those who see arguing for rural health as a claim for subsidy are viewing payment policies for federal programs as "redistributive" or "zero-sum" games. They see that the provisions in Medicare that allow for geographic distinctions in payment rates rest on principles of economic efficiency. Those who see it as a plea for fairness are asking for a form of distributive justice based on the notion that all citizens and Medicare beneficiaries should be treated equally.

Arguments based on fairness are fundamentally different than those based on economics, but the two can be confused. A call for economic efficiency can be seen as maximizing the utility for all beneficiaries and therefore "more" just while a call for level payments can invoke strong principles of equality under the law. Stakeholders ideally want to see principles of efficiency, equality, and justice combined in the cases they present, but that is often not possible. The standing of the claimant can also influence whether an advocate is viewed as seeking fair treatment compared to special treatment (Schneider and Ingram 1993).

As Medicare has changed away from a program whose "product" was largely constant to a system that is attempting to vary its

services according to local markets through a new variety of financing arrangements, the sense of a core value to Medicare is disappearing. Where once there was a system of payments based on usual, customary and reasonable costs or prices, there is now a variety of organizational-financial options for Medicare providers which base pricing and service mix on principles other than the balance of patient needs and provider capability. Those options in the form of managed care alternatives, most recently Medicare+Choice, are enlarging the differences between markets by tightening the link between economic efficiency and the mix of service options. The emerging response on the part of rural advocates has been to seek a new central value to argue for redress and this has become "equity."

The Rural Policy Research Institute (RUPRI), in early 2001, issued a set of principles for the redesign of Medicare and central to that was the idea that all Medicare beneficiaries were entitled to equitable treatment.

> "Equity, a fundamental philosophical concept of social justice, serves as the rural cornerstone of the Medicare redesign dialogue. Since all Medicare beneficiaries should have equal opportunity to maximize health, the goal of Medicare equity seems inarguable. Yet the dialogue raises critical questions about Medicare equity. How do beneficiary demographic characteristics determine rural health care utilization and reimbursement patterns? Are we unsuspectingly rationing health care by making it less accessible or less affordable to rural populations? Is the burden of payment for Medicare services appropriately distributed? Do options for more generous Medicare benefits in certain geographic areas conflict with original Medicare intent? In sum, does Medicare treat all beneficiaries with fairness and justice? Many current Medicare redesign proposals rely on market- based competition to achieve Medicare equity." (RUPRI Rural Health Panel 2001)

The assumption that equity is the standard for Medicare is not easily accepted by the staff of CMS or the Congressional staff who write

amendments to Title XVIII; this is due, in part to their focus on and comfort with the technical aspects of the program. That is discussed in more detail below. But the more important issue is whether equity should be the central value in overall rural health advocacy? If the goal is a sense of social justice, then this may be appropriate, but arguments for justice, especially justice in health care, may eventually produce a resulting policy prescription for "a decent minimum" rather than any level of comparability or equality (Daniels 1985). That is the lesson one can draw from reading Norman Daniels and his logic in setting some form of floor for justice in the distribution of basic medical care. The "decent minimum" he sees as a social obligation could leave rural America well behind even its current condition in the distribution of resources.

How rural health advocates currently express their claims for equal treatment can be seen in two ways: Either in terms of seeking justice for their treatment as equals in a full sense, or for justice in the distribution of resources that are provided through the "beneficence" of the national government (Jecker and Berg 1992). Asking for justice within a framework of beneficence means that the resources which are claimed are a portion of what Congress chooses to give to its less advantaged citizenry out of a sense of "kindness and compassion" rather than as what is due to equals. The fundamental nature of the claims for better treatment under a policy that is focused on underservice, for example the current debate over the reconstruction of the HPSA/MUA designation process, may need to be explicitly contrasted to claims for fairness under the Medicare program. At the national level, the former rests on a beneficence justification ("The Safety Net") while the latter relates more to a claim of justice ("getting what is due to us"). The arguments for special treatment of frontier areas in the former may depend on different principles than the geographic equalization of PPS rates. A complication to this parsing of arguments is the desire on the part of the advocacy network to function as a unified community which makes it more effective in its role in affecting specific policy development (Peterson 1997, 1993).

The development of policy for rural health care in the United States has occurred in a reactive manner. The subsequent creation of a relatively potent advocacy network for rural health was largely due to the discriminatory policies of the Medicare Prospective Payment System (Mueller 1997). The creation of the federal Office of Rural Health Policy came via an appropriation for rural health services research as part of an Omnibus Budget bill and Congressional support for a broader set of programs for rural communities came after its organization. The arguments for reallocation of resources to rural health have largely been ones that paint rural communities as victims of external forces (Amundson 1993). Amundson pointed out that the logic of claims for resources or special treatment were often circular and seldom did rural communities and institutions look inward for the causes of their problems.

The rural claim may better be expressed as one of parity in treatment in policies that have been redistributing benefits based on the claims of the more powerful, urban components of the health care system.

Rural communities may be better served by a progressive logic and accompanying rhetoric that makes their claims. Rural communities may be treated unfairly due to the special treatment of urban places and accommodations made for the urban social ecology rather that overtly discriminated against. The rural claim may better be expressed as one of parity in treatment in policies that have been redistributing benefits based on the claims of the more powerful, urban components of the health care system: large, teaching hospitals, researchers, managed care systems that depend on high turnover and low margins, and a technology-driven health care delivery structure with very high fixed costs that requires high rates of utilization to justify investments. The favorable treatment that urban health systems receive can be pointed out in the context of a progressive rhetoric that focuses on bringing the nation together as one community.

Progressive Rhetoric for Rural America

What can be the theme of a progressive rhetoric that argues for fair policies for rural America in the Medicare program? Potential themes might be those of national unity and identification that builds toward progressive, pro-active policy directed to elements of the nation

that are left behind or left out. Our vision of America as a diverse nation is well embedded in the "melting pot" and even the "tossed salad" metaphors that stand in for the assimilation of cultures or a shared space for many distinct cultures. We regularly visualize and express our sense of a continental nation with vast natural beauties that we all can share as Americans. These American visions are often enlisted to motivate political interest and participation but are less often tied to an issue so specific as assistance to a select portion of the population. Rural America is represented by national metaphors that seem to be inclusive but really divide us or misrepresent the reality of rural America. For example, painting rural America as bucolic farmland neither reflects the true state of the 54 million nonmetropolitan citizens nor does it provide the basis for appropriate policy, for Medicare or the economy. More potent emblems of unity should be invoked to promote what must be a national rural policy that encompasses all the elements that will make for health and well-being.

Potent emblems of unity should be invoked to promote what must be a national rural policy that encompasses all the elements that will make for health and well-being.

It may be that our national political discourse that shapes Medicare and other policies that affect rural America is so laden with symbols that there is no room to express succinctly and effectively that we are leaving behind a large portion of our society. The larger metaphor of Medicare, health care for older Americans, may somehow convey the idea that we could not possibly treat our seniors unfairly. Alternatively, Medicare may be so powerful a positive element of American policy making that complaints that it is fundamentally unfair to a particular minority of Americans may be rejected as the broader program energizes support for its own extension, even survival. The largely partisan clamor for privatization of Social Security and the opening of Medicare to market discipline has not played well in the economic stagnation of the new century. The stronger progressive arguments surrounding Medicare seem to be to efficiently expand Medicare to cover pharmaceuticals and new treatments. At the core of that argument is one of fundamental fairness for generally low-income elderly people whose fixed incomes cannot support the costs of drugs for which they often pay directly. But it is rural older people who are more likely poor and more likely to be hurt most by rising drug costs.

Medicare policy in the Congress has repeatedly responded to calls for expansion of the program to pay for things that are effective and necessary parts of a reasonable standard of care for beneficiaries. Including new procedures and strategies can be as broad as bringing in all end stage renal disease patients or as focused as determining whether or not a specific procedure should be covered. For the former, Congressional action is required, and Congress has been aggressive in including detailed prescriptions for coverage, breast cancer treatment being one example. However, many more decisions that determine allocations are made within the bureaucracy that administers the program Medicare policy making within CMS and, previously, HCFA has been dominated by pressures to maintain fiscal solvency across the program. It is not clear that one system dominates the other in their consequences. The rural argument, then, ought to accommodate both of these mechanisms and provide support for each of their dominant impulses.

In the Congress, fairness in payment systems can be expressed as a reasonable enlargement of the benefits of Medicare as necessary to give rural beneficiaries reasonable access to a reasonable standard of care.

Rural health systems have been less costly than urban system due to lower patterns of demand and use, not necessarily because of lower provider costs. In the Congress, fairness in payment systems can be expressed as a reasonable enlargement of the benefits of Medicare as necessary to give rural beneficiaries reasonable access to a reasonable standard of care. That access can be shown to be an effective way to ensure that all Medicare beneficiaries have equal access to the program, while creating administrative efficiencies by providing the mechanism to support providers that have proven to draw less on the system than urban providers. The costs of care in rural places and for rural beneficiaries overall is the same or nearly the same but rural health systems and rural Medicare beneficiaries manage to use fewer overall resources than urban systems. Why, then cannot this efficiency be rewarded?

The arguments for greater equity in the Medicare system for rural populations can show that rural systems are different. To quote Joseph Newhouse: "…the market for most medical services is local; inherent differences in scale and modes of treatment complicate comparisons of the efficiency of a small rural hospital with that of a

large teaching hospital, not to mention a solo general practitioner with a subspecialist in a large group." (Newhouse 2002, pp. 14-15) The fundamental differences between urban and rural health care delivery have not been explored as well as they ought because, as much as anything, we have structured a Medicare system that is as uniform as it can be across the very complex system of care we have. We have recognized differences of other types: mental versus somatic health; health care in long-term settings versus acute settings and the home; and care provided by different practitioners. Each type of provider is defined in the rules and there are specific regulations that apply to each type of care. Each of these sets of rules has tried to accommodate the specific conditions and professional skills that make each unique. Contrast, for example, the Medicare rules that govern care in a skilled nursing facility versus those that apply to an acute care hospital. Such accommodation is not made for the differences in scale, scope and culture of care between small (and large) rural providers and their urban counterparts. To develop the rules necessary to make those accommodations we do not need extraordinary research efforts to identify the basic differences between rural and urban providers, but a recognition that the burdens of rural-located care giving are at least equally unique as they are to urban places where, for example, significant accommodations are provided for medical education. The infrastructures and cultures surrounding those rural places provide different incentives and barriers to urban health care delivery that are no less real and no less costly.

To develop the rules necessary … we do not need extraordinary research efforts to identify the basic differences between rural and urban providers, but a recognition that the burdens of rural-located care giving are at least equally unique as they are to urban places.

Asking for recognition of the differences between care giving in rural and urban places may seem like a call for distinction, even, division in a national system like Medicare. It is not, it is a call to provide equal consideration in the struggle to provide equal treatment for Medicare beneficiaries, no matter where they live but adjusting to the realities of the systems of care that are available. The progressive rhetoric is in the emphasis for equality of care opportunities for Medicare beneficiaries. The focus should be on equality of opportunity to achieve the same outcomes, no matter how differently the system is arrayed from place to place. The risk in making this form of argument

is that policy makers often see it as easier to try to equalize resource distribution, in this case setting equal rules for provider conduct, rather than seeking equal outcomes or opportunity for equal outcomes, accepting that there are reasonable differences in the care giving structure that must be accommodated or adjusted for. Rural health systems must accept their limitations but not the limitations that are imposed because they are forced by Medicare to act like urban health systems in ways that they cannot. Rural health systems have the same goals as urban systems, to provide the best care for Medicare beneficiaries as possible; that goal is achievable but under different conditions.

References

Albrecht, S.L.; Clarke, L.L.; and Miller, M.K. 1998. Community, family, and race/ethnic differences in health status in rural areas. *Rural Sociology* 63 (2):235-52.

Aleinikoff; Alexander, T. 1999. The green card solution. *The American Prospect* 11 (3):32-37.

American College of Physicians. 1995. Rural primary care. *Annals of Internal Medicine* 122 (5):380-90.

Amundson, B. 1993. Myth and reality in the rural health service crisis: Facing up to community responsibilities. *The Journal of Rural Health* 9 (3):176-187.

Andersen, R.M. 1995. Revisiting the behavioral model and access to medical care: does it matter? *Journal of Health and Social Behavior* 36 (1):1-10.

Braden, J.J.; Beauregard, K. 1994. Health Status and Access to Care of Rural and Urban Populations. Rockville, MD: Agency for Health Care Policy and Research.

Chen, B.; Maio, R.F.; Green, P.E.; and Burney, R.E. 1995. Geographic variation in preventable deaths from motor vehicle crashes. *Journal of Trauma* 38 (2):228-32.

Daniels, N. 1985. *Just Health Care*. Edited by Winkler, D.I. *Studies in Philosophy and Health Policy*. Cambridge: Cambridge University Press.

Eberhardt, M.S.; Ingram, D.D.; Makuc, D.M.; Pamuk, E.R.; Freid, V.M.; Harper, S.B.; Schoenorn, C.A.; Xia, H. 2001. *Urban and Rural Chartbook. Health United States, 2001, Health, United States.* Washington, DC: U.S. Government Printing Office.

Economic Research Service USDA. 2000. Favorable rural socioeconomic conditions persist, but not in all areas. Overview Article. *Rural Conditions and Trends* 11 (2):4-9.

Frankford, D.M. 1993. The complexity of Medicare's hospital reimbursement system: paradoxes of averaging. *Iowa Law Review* 78:517-668.

Gale, F.; McGranahan, D. 2001. Nonmetro areas fall behind in the "new economy". *Rural America* 16 (1):44-52.

Hartley, D.L.; Quam, L.N. 1994. Urban and Rural Differences in Health Insurance and Access to care. *The Journal of Rural Health* 10 (2):98-108.

Jecker, N.S.; Berg, A.O. 1992. Allocating medical resources in rural America: alternative perceptions of justice. *Social Science and Medicine* 34 (5):467-474.

Marmor, T.R.; Mashaw, J.L. 1997. The case for social insurance. In *The New Majority: Toward a Popular Progrsssive Politics*, edited by Greenberg, S.B.; and Skocpol, T. New Haven, CT: Yale University Press.

MedPAC. 2001. Report to the Congress: Medicare in Rural America. Washington, DC: Medicare Payment Advisory Commission.

Miller, M.K.; Farmer, F.L.; Clarke, L.L.; 1994. Rural Populations and Their Health. In *Rural Health Services. A Management Perspective*,

edited by Beaulieu, J.E. and Berry, D.E. Ann Arbor, MI: AUPHA Press / Health Administration Press.

Mueller, K.J. 1997. Rural Health Delivery and Finance: Policy and Politics. In *Health Politics and Policy*, edited by Litman, T.J.; and Robins, L.S. Albany, NY: Delmar.

Newhouse, J.P, 2002. Why is there a quality chasm? *Health Affairs* 21 (4):13-25.

Peterson, M.A. 1993. Political influence in the 1990s: from iron triangles to policy networks. *Journal of Health Politics, Policy and Law* 18 (2):395-438.

———. 1997. Community: meaning and opportunity, and learning for the future [editorial]. *Journal of Health Politics, Policy and Law* 22 (4):933-6.

Purdy, J. 1999. The new culture of rural America. *The American Prospect* 11 (3):26-31.

Ricketts, T.C. 2001. The Rural Patient. In *Textbook of Rural Medicine*, edited by Geyman, J.P.; Norris, T.E.; and Hart, L.G. New York: McGraw-Hill.

RUPRI Rural Health Panel. 2001. Redesigning Medicare: considerations for rural beneficiaries and health systems. *Rural Policy Brief* 6 (6 (PB2001-6)):1-4.

Rural Sociological Society Task Force on Persistent Rural Poverty. 1993. *Persistent Poverty in Rural America*. Boulder, CO: Westview.

Sabatier, P.A. 1988. An advocacy coalition framework of policy change and the role of policy-oriented learning therein. *Policy Sciences* 21:129-68.

Sabatier, P.A.; and Jenkins-Smith, H.C. 1999. The advocacy coalition framework, an assessment. In *Theories of the Policy Process*, edited by Sabatier, P.A. Boulder, CO: Westview Press.

Schneider, A.; Ingram, H. 1993. Social construction of target populations: Implications for politics and policy. *American Political Science Review* 87 (2):334-347.

Schur, C.L.; Franco, S.J. 1999. Access to Health Care. In *Rural Health in the United States*, edited by Ricketts, T.C. New York: Oxford University Press.

Size, T. 2001. Fair Medicare Payments are Not Subsidies. *Rural Wisconsin Health Cooperative Eye on Health*, February 1, 2001, 1.

Slifkin, R.T.; Goldsmith, L.J.; Ricketts, T.C. 2000. Race and Place: Urban-Rural Differences in Health for Racial and Ethnic Minorities. Chapel Hill, NC: Rural Health Research and Policy Analysis Program, University of North Carolina at Chapel Hill.

Study Panel on Medicare's Larger Social Role. 1999. Medicare and the American Social Contract. Washington, DC: National Academy of Social Insurance.

Vladeck, B.C. 1999. The political economy of Medicare. *Health Affairs* 18 (1):22-36.