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THEME OVERVIEW: IMPLICATIONS OF HEALTH CARE REFORM FOR FARMERS AND RURAL RESIDENTS

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Health care is critical to our quality of life and literally a life-and-death issue. Therefore, it is not surprising—and would even be worrisome if it were not the case—that reform has generated much interest among the public. Americans understand that this not just a political debate or a conceptual debate about values. This is a debate that could conclude with a set of reforms that may have an effect on where we live, how we choose to make our livelihood, our lifestyle and health promotion behaviors. There are many dimensions to a comprehensive reform, such as determining who among the 46.3 million who are currently uninsured will be insured, who pays for the increased coverage, and from whose pockets or what efficiencies will the cost savings come to pay for the newly insured. With our current health care system composed of a highly complicated set of private and public reimbursement rules, the devil is certainly in the details. But, the issue is much more than reform of health care insurance, it is about health care reform more generally. Health outcomes matter.

Some of the details of reform will have important implications for farmers and rural residents. Approximately, 17% of the U.S. population resides in nonmetro areas, which account for 75% of U.S. land area, and 5.5 million persons are a part of farm operator households. The implications of remoteness for the cost of delivering rural health care underlie many of the issues addressed in this Choices theme. In his brief note, Tim Parker provides the nonmetro per capita transfer payments compared to metro areas. Nonmetro payments have been rising faster than metro since 1978, and the majority of this increase is due to the rising cost of medical care. Articles in this theme highlight important implications of health care reform for the farmer and rural populations, such as extending health care insurance to the uninsured, physician retention/attraction, and access to hospital services in rural areas. The articles are grounded in the current state of health care, in some cases drawing lessons from current programs targeted to rural areas. In spite of conclusions rooted in analysis, the articles also leave the reader with a strong sense that any post-reform era in health care will hold a great deal of uncertainty for health outcomes for farmers and rural residents.

With the lion's share of the discussion on how to offer health insurance to the currently uninsured, much of the discussion of reform has been on insurance markets. Keith Mueller searches for lessons from current insurance programs and asks, what do potentially successful insurance markets look like for rural areas? Such a market must consider the distances of rural residents from urban medical centers, the higher costs of obtaining care in rural areas, and whether the extent of the rural market can support competing plans. Approaches to meeting the challenges discussed by Mueller include expanding the market to one large enough to encourage competition and a combination of regulation and subsidies to keep insurance plans affordable. Martin Shields focuses his article on the decline in employer-based health insurance over time, especially in rural areas, and the correlation between education and insurance type. Even with reforms that provide tax credits or other incentives to employers for providing insurance to workers, employer-based insurance is likely to continue its decline.

Two articles focus on insurance of the farmer population and health care reform to offer some insights. Farmers are more likely to purchase insurance directly from the individual insurance market. Also, there are examples of farmers purchasing insurance through cooperative organizations, a form of organization that offers a possible new alternative for obtaining insurance. In the first of two farmer-oriented articles, Mary Ahearn and Ashok Mishra consider the access of farmers to health care. Farmers are more likely to live in

areas that are identified by the Department of Health and Human Services as medically underserved areas, but on surveys they do not report that they are any more likely to go without care. Farmers are just as likely as the general public to be insured, although they are more likely to purchase the more expensive individual policies. There is evidence that insurance coverage is less for those with farming as a major occupation and that, in low-income years, farmers may drop their insurance coverage. Reka Sundaram-Stukel and Steve Deller draw lessons for reform from the Farmers' Health Cooperative of Wisconsin. The authors review the evidence on market outcomes from this particular health cooperative and find outcomes are generally positive, except that the cooperative model does not solve adverse selection problems. If some form of health cooperatives continues under future insurance reform, the government may need to serve as an arms length reinsurer for unforeseen high claims or a subsidizer of high risk claimants.

Besides slowing the rate of increase in health are costs, a motivation behind reform is to reduce health outcome disparities among populations. Hence, there has been a great deal of focus on how to increase health insurance coverage among the uninsured. But, Tracey Farrigan causes us to look beyond health insurance to the survey evidence that suggests that the relationship between poverty status and health status remains unchanged after controlling for health insurance, especially for children. Her analysis broadens the discussion to include the adoption of health promoting behaviors and the need to improve economic status to address children's health issues.

It is well-documented that health care providers make an important economic contribution to many rural economies, including providing local jobs and attracting and retaining residents. The ability of communities to attract physicians and other health providers has been a long-standing rural development challenge because of the economies of size in health care provision and the relatively more lucrative returns available in more densely populated areas. Two of the papers address the issue of how reform is likely to affect the attraction and retention of medical resources. Paul McNamara considers what impact reform will likely have on rural hospitals. He draws lessons for reform through the case of the 1997 Rural Hospital Flexibility Program that established Critical Access Hospitals. Under this program, hospitals with 25 or fewer beds—and other criteria relevant to rural areas—are allowed to receive cost-based reimbursement from Medicare and Medicaid. According to McNamara, expansion of health insurance coverage, a major focus of the current reform effort, is likely to improve the revenues of small rural hospitals, although the level of Medicaid reimbursement will be a critical determinant of their viability. JamesBarnes and Matt Fannin consider how possible future restrictions on physician ownership of medical facilities will affect the ability of rural areas to retain and recruit physicians. Ownership of health assets is sometimes used as a physician recruitment tool by rural communities and hospitals. Ownership restriction is on the table as part of a reform package because research suggests that when physicians own health care assets, patient Medicare costs are higher than if physicians have no ownership stake. Barnes and Fannin present evidence to suggest that this relationship may not hold in rural areas and may come at too high a cost in terms of physician recruitment.

Together, this set of articles addresses the challenges and concerns affecting farmers and rural citizens that must be given attention in designing and implementing health care reform. There are important lessons that, if incorporated, would likely lead to better health outcomes.

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