

**Local Control of Rural Health Services:
Evaluating Community Options**

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INTRODUCTION

Faced with the rapid changes occurring in the organization and financing of health services, many rural health providers and rural health advocates contend that retaining local control of health systems is essential to assure that the health care needs of rural residents will be met appropriately. Once local control is lost, the argument goes, decisions about the health care services available to local residents are made according to purely financial criteria of external firms that fail to consider both the wishes of rural residents and the additional costs that may accrue to those residents in terms of out-of-pocket expenses, travel time, lost productivity, and diminished health status.

While rural health providers and advocates admit that external ownership of rural health services may produce some short-term benefits to rural residents, such as lower costs and access to a wider variety of services, they maintain that these gains are ephemeral. The prerogatives of ownership, they assert, include not only offering services, but also reducing the services offered or closing them altogether. Because the risk of service contraction is too great to bear, many rural communities believe that they must control their own destiny by retaining authority over the local health care system.

The purpose of this paper is to provide rural communities and providers with a framework for thinking about the issues related to local control of rural health services and to formulate the questions they should consider when negotiating with external providers, suppliers and insurers. To elucidate the issues, we begin by expanding briefly on the arguments made by rural health providers and rural health advocates for maintaining local control of health care services. The next section, presented in the form of a dialogue, explores issues of control and availability of rural health services from opposing points of view. The presentation of the issues

in this informal manner is intended to stimulate discussions among interested parties around the country concerning the various meanings and consequences of local control. Next we review four different perspectives on local control. Each of these perspectives is informed by the literature of a specific academic discipline: sociology, political science, economics and business, respectively.¹ In the final section, we consider environmental factors that might affect local control of decision making, and propose a list of questions readers should ask when evaluating local control options in their communities.

THE CASE FOR MAINTAINING LOCAL CONTROL OF RURAL HEALTH SERVICES

Local control may be defined as a situation in which persons most affected by decisions have the greatest voice in making those decisions. The decisions that the proponents of local control wish to make or greatly influence include the allocation of health care services within a given rural area, the amount of resources dedicated to providing these services, the management of health care services within the area, and the amount and distribution of profits resulting from the sale of health care and insurance services. Retaining decision-making authority in the local community by no means assures that the right decisions will always be made. Certainly, polities are known to err. However, local decision makers, over time, within the constraints of their resources, will tend to promote the interests of some, if not all, of the residents of the area.

¹ The preparation of this section benefitted substantially from input from six members of an expert panel who participated in a colloquy about local control of rural health services. Panel members were Bruce Amundson, M.D. (Community Health Innovations, Seattle, WA), Michael Arvin (Columbia/HCA, Dallas), Dean Coddington, (MFC, Denver, CO), Joseph Engelken (Community Healthcare Systems, Onaga, KS), Lyle Munneke, M.D. (Family Practice Medical Center, Willmar, MN), and Max Quass, M.D. (Mayo Clinic, Decorah, IA).

On the other hand, the loss of decision-making authority by rural residents does not mean that their interests will be harmed in every case: Rural residents can and do benefit from decisions made by persons living outside of rural areas. There is, however, no guarantee that extra-local decision makers will continue to confer benefits on rural residents. It is this uncertainty in an increasingly turbulent and seemingly hostile environment that makes the issue of local control so urgent in many rural areas. Maintenance of local control can be seen as a strategy for reducing uncertainty.

Fear that services will be discontinued is not the only issue in the local control debate. The use of profits earned in the rural community and extra-local control of rural provider clinical decision making are also issues. Ownership of health services suggests dominion over the profits earned from the sale of those services. Rural health providers and advocates claim that when locally available health care services are owned by individuals or corporations (either for-profit or not-for-profit) external to the community, there is a high probability that profits earned in the community will flow out of the rural area. In contrast, it is suggested, local ownership of health services helps assure that, to the extent possible, health care services are provided locally and that profits made on the sale of services are reinvested in the community. Potential reinvestment options include creation of new services, provision of free or subsidized services, and maintenance of health-related plant, grounds and equipment. Even if local owners do not reinvest their profits in health-related services, they are more likely to spend their profits in the community, thereby bolstering the local economy.

A corollary argument in the local control debate focuses on providers. Rural advocates say that loss of local control may negatively affect the income of rural providers and limit their clinical autonomy, resulting, ultimately, in a shrinking supply of local providers as providers

leave the community for more favorable practice sites. Loss of control occurs not only in situations where providers (e.g., physician practices and hospitals) are owned by outsiders. Control may also be bargained away in contract negotiations. For example, providers who contract with managed care organizations may agree to practice according to clinical guidelines or to limit referrals to a panel of urban specialists in exchange for payments and an assured stream of patients from a health plan. In these situations local control is construed to be a function of the autonomy of rural providers rather than the rural community as a whole.

The issue of local control of rural health services in one sense appears to center on the character of the relationships that rural communities have with providers, suppliers, and insurers residing outside of the community. These providers, suppliers, and insurers are often located in urban areas, but they may also be located in other more populated or more prosperous rural communities. In many areas of the country, these inter-community relationships have existed unchanged for a number of years. However, the consolidation of urban health care systems and the velocity of change within urban markets recently has altered or has threatened to alter the nature of these relationships. To no small degree, the issue of local control of rural health services hinges on how the informal relationships between local communities and outside providers, suppliers, and insurers are formalized and who is involved in the process of formalization.

Many rural communities face or will soon face the dilemma of deciding how to negotiate new relationships with organizations in their environments that are external to the communities themselves. Within rural communities, there is general agreement on the desired outcome of these negotiations. Rural residents of communities want access to a variety of high quality services at a reasonable cost. The best way to achieve this outcome, however, is less clear. A

thoughtful discussion of how best to satisfy the goals of rural residents will include consideration of questions such as: Is it necessary to relinquish some amount of control over the local health care system to obtain access to the services needed and desired by rural residents? How much control is too much to surrender to external sources? Who currently controls the local health care system? Who in the community should make decisions about the health care system?

EXPLORING LOCAL CONTROL: A DIALOGUE

The local control or rural health services debate has several facets. The opinions one holds in regard to the various issues nested within the topic of local control will be shaped largely by one's experiences and place of residence. To illustrate on the complexity of the issue, in this section we represent the differing points of view in the form of a dialogue between a person who claims that the market is the best arbiter of the needs and desires of rural residents and another person (whose words are printed in italics), who believes that political control at the community level of the health services provided in rural areas is essential to the welfare of the rural community.

▲ Health care is no different than any other economic enterprise. Other private enterprises are not subject to local control whatever that is. We never talk about local control of a Pizza Hut, for example. Why do we talk about the need to maintain local control of health care delivery systems? People exercise control over private businesses by casting their dollar votes. If a provider *C* regardless of ownership *C* meets the needs of the people in a community the residents *A* vote for it by using the services the provider offers. If it doesn't meet the needs, they cast their *A* vote elsewhere by seeking services from a competitor. That's the nature of the market.

▼ *Health care is different. It is a unique business that isn't and shouldn't be subject to the market. Health care is highly regulated at the state and national level. Why is it unreasonable to bring some of that regulation down to the local level, by giving rural residents the political power to determine who provides what services where in the community. The health care system in rural areas is a community asset. Communities own their health care systems whether they hold title to them or not. They contribute the capital and funds for operation of the system in the form not only of fees but also in taxes and gifts. As owners, they have a right to say how the system is used, including when and to whom parts of it are sold.*

▲ That might be true of hospitals, but it is not true of physician practices, for-profit nursing homes, or pharmacies. There is no *community ownership* of purely private enterprises even though the community may contribute to the wealth of the enterprise. If you have any doubts, watch what happens when the community attempts to exercise its *control* by setting prices as the doctor's office or at the local nursing home. Physicians and health services managers won't stand for that kind of populist interference. Communities that try to exercise that kind of control may succeed in harming the local health care system. The truth is, there is no local control of health care presently in rural areas.

▼ *That is not true. Local control is not a question of consumers or residents controlling providers in rural areas. Local control means consumers and providers working together to retain decision making locally. I emphasize *retain*, because many rural communities do have this shared responsibility. I can think of several rural communities where decision making is shared and at least two grant programs *C* one Colorado and one in Kansas *C* that promote community health care decision making in rural areas.*

▲ When consumers and providers make decisions together, the providers dominate the consumers. Most rural providers C doctors, hospital administrators C may reside in the community but they are not of the community. They immigrated in from somewhere else and are likely to be moving on in the next few years. I doubt that many sincerely have the interests of the community in mind. These providers are driven by the same economic and political motives as urban providers. The local control issue in many ways is simply a way for rural providers to protect their interests by keeping competitors out.

▼ *There is a check on the behavior of rural providers who only want to feather their own nests, and that check is the community. The community exercises that check both politically and economically. The political check comes in the form of hospital boards exercising their fiduciary responsibilities to the institution and the community. The economic check comes in the form of the Adollar vote@that you extolled earlier. If a provider is doing something in his or her interest that is not in the interest of the community, community residents will simply use another provider.*

Providers, by virtue of their expert knowledge, do wield disproportionate power in group decision making. However, that influence can be controlled and channeled by proper community leadership. The proper role for providers is to educate residents and help them make decisions. Local control should be a democratic exercise, not an oligarchic one.

▲ I have real concerns about this Ademocratic exercise.@ Isn't part of the problem in rural areas that providers are too busy and residents either uninterested or too ill-informed to be able to provide leadership? Rural advocates themselves say that lack of local leadership is among the primary problems of rural health systems. How valuable is democracy without leadership? We

know that when the public is consulted on a health issue, the answers are different depending on what segment of the public is consulted. The general public has different views often more conservative views than patients (people who use the system) about the health care resources that should be available. Patients with specific conditions have resource opinions that are different from other patients. How is the public to be defined, and how representative is it?

▼ *First, we are talking about governing the system, not conducting a survey. Governing is messy; it's a process with a cybernetic loop. It tries to correct its earlier errors based on new information. It's not perfect, but we are learning how to govern local health systems better all of the time. The experience of several rural health grant programs in recent years have shown that a combination of public participation, education, and facilitation improves rural health decision making.*

▲ I'll tell you who the real health care decision leaders are in rural communities employers who offer their employees health insurance benefits. We are no longer a nation of independent farmers and ranchers. Even in rural areas there has been a tremendous consolidation of employment. It's not unusual for a local employer to be part of a larger multi-state or international firm. These employers are important, because, typically, they employ many people and because their health care purchasing decisions are made outside of the community or at least on externally established purchasing criteria. These are the people who really purchase health care in rural areas. They are the leaders. And they are looking for good products at low cost. Increasingly, they are offering their employees managed care products. Local providers are forced to contract with these managed care organizations to keep their patients. If leaders are people who can promote change, then these employers are community

leaders. Their vehicle for making the change is the market, and the market extends beyond the limits of individual rural communities.

▼ *The market doesn't promote the welfare of the entire community, just the welfare of employers involved. If anything, allowing employers to make all the health care decisions for a community exacerbates the divisions in the community. It sets providers against insurers (and, by extension, employers) and often pits employees against employers. Employers are only interested in the cost of the premium. Employees don't care about the overall cost of the premium, just the portion they have to pay and any other out-of-pocket expenses. They are also very interested in maintaining access to the physicians they currently use and in having freedom to select specialists and referral hospitals of their own choosing should the need arise. Managed care may satisfy the needs of employers, but doesn't always satisfy the needs and desires of employees or people who aren't employees. Taking people where they don't want to go is not leadership.*

▲ If employees' needs are not met, they will seek employment elsewhere. It's in the best interest of employers to look after the interests of their employees. Otherwise, skilled labor and the employer loses out too.

O.K., for the sake of argument, let's assume all control is vested in the community. How can that community provide what its citizens want and need? Aren't rural communities at the mercy of their financial resources?

▼ *Obviously, communities have financial limitations. We realize that we have to rely on outsiders to provide some services and resources. We simply want to assure that whoever*

provides services in the community has values that are consonant with our community values.

We want to select our partners, not have them forced on us.

▲ Values are reflected in the way the business is conducted. If people don't agree with the values of outside providers, they hold them accountable by taking their business elsewhere. That's real local control. Ownership doesn't really matter that much. If you meet community needs, you stay open. If you don't, you close.

▼ *I disagree. Values are important, because they serve as an indicator of future behavior. Simply because an outside provider is a "good citizen" at first doesn't mean that providers will be in the future like when current circumstances change. When we seek partners, we take the long view. We are more interested in a until-death-do-you-part marriage than we are a weekend fling. You wouldn't marry someone who didn't share your values. Or if you did, you wouldn't stay married long.*

▲ What would you look for in an ideal partner? And don't start with that values stuff. It's a little too "warm-and-fuzzy." Be specific.

▼ *Well, I think most rural communities would like a partner who is strong and has a history in a good history in the area or a comparable rural area. Rural communities want a partner who is likely to have some permanence in the area. We would like the provider or plan to acknowledge that rural health care is not simply urban health care in miniature and that some of our issues are unique. Once they recognize the uniqueness of the system, they should be willing to work with us. I think we would appreciate a willingness on behalf of urban providers and health plans to move in incremental stages. We don't want to be bull-dozed. If someone approaches rural communities like a juggernaut, they will likely be met with resistance,*

regardless how good the product may be. We want urban providers and health plans to acknowledge the value of the existing system. We are not simply a bunch of rubes squeaking by. Most of our problems are not of our making. We are proud of what we have and what we have done, and we resent it being devalued by urban providers and health plans who want to save rural America. Finally, we want partners who will be subject to public accountability and who will be organized as not-for-profit corporations.

▲ Why not-for-profit? The only difference between a for-profit and not-for-profit firm is its access to capital. Both are driven by the same profit-making impulses.

▼ *It's a question of values again. Forced to choose between the charitable mission of not-for-profits and the profit-maximization rationale of for-profits, we'll come down on the side of not-for-profits every time.*

▲ I think you have a very naive sense of what business is all about in the waning days of the Twentieth Century. I can envision many circumstances under which the profit motive actually benefits rural communities -- like Wal Mart⁷, for example.

▼ *I can't believe you said that. Wal Mart⁷ has destroyed Main Street in many rural communities and has limited the choice of local merchants in rural communities.*

▲ Wal Mart⁷ is a model of efficiency and community responsiveness that brought rural communities lower prices and a wider variety of products. If it didn't respond to the needs of rural residents, it wouldn't be as successful as it is. The only people Wal-Mart⁷ hurt were the merchants who charged more and provided less variety. Everybody else won. Let me give you

another example: Doesn't a for-profit health plan benefit from keeping the entire community healthy?

▼ *The payoff of the actions that a health plan would have to take to reap those benefits would be a long time in coming. Income statements are prepared quarterly & the time horizon for for-profit decision-making is extremely short. Also, your example is flawed. A community health perspective on managed care is effective financially only if an HMO has a monopoly in an area. Why would an HMO fund someone else's savings?*

▲ *It's clear that we are moving into another era in health services delivery and financing. It will be difficult for many rural areas to change. Given what you know about the problems of cultivating leadership in rural areas and the lack of resources (not the least of which is information), wouldn't you concede that an outsider & say an urban provider or a national hospital chain & can serve as a change agent to move rural areas into this new era?*

▼ *Perhaps, but all change is not for the better. What are we changing to? Whatever we do, we must assure that the focus stays on the patient.*

▲ *What does the patient want? I'll tell you. The patient wants low cost or reasonable cost services that are of high quality and that are delivered in a convenient location and a pleasant environment. The resources of outsiders can allow these needs to be met more fully than rural providers.*

▼ *Maybe in the short-term, but there is no guarantee that outside providers & especially for-profit ones & will be there for the long haul. We perceive that the commitment of these outside providers to rural areas is not deep. They do not have tolerance for losses. If rural areas or*

certain services in rural areas prove to be unprofitable, these outsiders would have no compunction about pulling the services C leaving rural residents high and dry. The worst-case scenario is where all of the health care services of the community are owned by the same outsider. In these cases, the community can be worse off rather than better off, because it is so vulnerable: All of its services are at risk of immediate closure. Moreover, local services could be pulled for a variety of reasons that have nothing to do with local profitability. For example, the outside company could be sold to another company that has no interest in rural areas and decides to close all services. Or the urban services of the company could be unprofitable and it decides to close its rural services to reduce overall system expenses. We don't want to be subject to these kinds of vagaries.

▲ No one would choose to be, but that is the price of living in a free society with free markets. Anyway, what protection do you have now? Doctors retire, die, quit and leave town. Hospitals close. At the most, some people may be inconvenienced, but there is no material effect on health care status. People simply get in the car and travel to the next place where there are health care services. In fact, many C if not most C rural residents already travel for health care.

▼ *In the first place, when a doctor announces his or her intention to leave the community we start recruiting immediately. So the loss of the physician is usually a temporary situation. (Although I'll admit that it is a chronic problem.) Second, hospitals don't just close; their communities allow them to close. Many unprofitable hospitals are kept open by the largesse of the community residents pouring money into the place. As I said, hospitals that close are allowed by their communities to close. Those institutions are either 1) too expensive for the community to maintain and therefore inappropriate, or 2) close enough to another hospital that*

most residents are not unduly inconvenienced by the closure. Hospital closure, in many ways, is an affirmative act of local control. It is a community saying that the hospital is not needed or not affordable.

Your point about most people already traveling for care may be true, but the ones who don't travel are among the most vulnerable of rural populations C the frail elderly and the poor. We need to take steps to assure that their welfare is protected.

▲ Maybe what we need is not more doctors and hospitals in some rural areas, but a better non-emergency transportation system. And, what about telemedicine? How does telemedicine fit into this local control puzzle?

▼ *Well, the effect of telemedicine on local control isn't so clear. Telemedicine increases the referral and treatment options for local residents and providers, but it is not clear who has control of the technology. Certainly, telemedicine doesn't work unless local providers choose to use it. So in one sense the local provider controls the technology by choosing to turn it on. Once the decision is made to use the technology, however, ABig Brother@on the other end of the line takes over. Telemedicine could be an example of shared control, I suppose.*

▲ Telemedicine certainly alters our conceptions of time and space. That brings up another issue: the meaning of Alocal.@ Rural communities don't exist as islands unto themselves. They exist in a dynamic market. Urban-based health companies are reaching out to rural areas not because those companies are evil, acquisitive monsters, but because rural areas have something urban providers need C patients who need secondary and tertiary services. By reaching out to rural areas, urban providers are attempting to assure that they have a supply of needed Ainputs@to their system. Rural primary care providers produce secondary referrals. In an exceedingly

competitive urban environment, urban providers want to remove the uncertainty over the supply of these resources. Therefore, they buy and contract with rural providers where they can, and where they can't, they compete head-to-head. In a sense, urban competition is the best thing that has ever happened to rural providers. Rural providers were going to refer patients anyway; now they have the opportunity to receive something of value for the referral in the form of practice management services, income stability, clinical support, time off, continuing education, improved collegiality, and so on from an urban partner. All of this helps improve physician retention in rural areas, slowing that revolving door.

▼ *I think you paint a picture that is too rosy. Income stability can mean an overall reduction in income. Clinical support can mean practicing according to inflexible protocols. Once rural providers acknowledge that they are part of a larger system, they acknowledge their powerlessness within that system C they simply do not have the numbers or the clout to make their concerns known. That is why they want local control C to control their own destiny. Take managed care, for example. If an HMO contracts with individual rural physicians unilaterally, all of the control is vested in corporate office in Minneapolis or Boston or Seattle. Rural providers can wrest some of that control back by organizing into IPAs and PHOs, accepting a capitated rate, and establishing their own utilization and quality standards. Local organization should produce a win-win situation. The managed care organization limits its risk by shifting most of the burden to a rural IPA or PHO. The local providers are able to make their own decisions about how to manage their cases. While they are at risk for earning less, they also have the potential for earning more. The local providers have taken charge of the managed care system C at least to the degree that it affects them and their patients.*

▲ I can't understand why controlling managed care is so important to you. For the last 60 years, indemnity insurance was controlled outside of rural areas and no one said a word. Medicare and Medicaid are controlled outside of rural areas. I think that this desire on behalf of rural providers to control managed care is just so much Chicken-Littleism.

▼ *No. Managed care differs from indemnity insurance in that indemnity insurance didn't channel enrollees out of rural communities. Because managed care relies on networks of providers, managed care organizations tend to send some patients out of the community for certain services. If we control managed care, we may be able to provide many more of those services locally. Managed care with a capitation form of payment offers an opportunity to regulate the entire rural health system from the inside. If we control managed care, we control the flow of dollars out of the community. If we keep a larger proportion of the dollars local, we not only improve the financial climate (and availability of services locally), but we also improve the economy of the entire community. Control of managed care is a real economic development opportunity for rural communities.*

▲ What certainty do we have that these new revenue streams won't accrue to the benefit of only a select group of residents and providers and that the expenditures they make on Mission furniture, speed boats, vacations to Cancun may also flow out of the community, resulting in no net local gain?

▼ *There are no guarantees.*

▲ O.K., let's look at this from a different angle. Rural areas need resources in the form of capital and expertise that urban or large rural providers possess. Urban providers need resources

in the form of secondary referrals that rural areas possess. Both are mutually dependent upon the other, and their individual competitive success depends on finding a solution to their resource dependence. This seems to me like perfect grounds for arriving at some sort of accommodation between urban areas and rural providers. How do we get there?

▼ *I agree. We both need each other, but the only way we can reach this accommodation is if we are mutually respectful and tolerant of our differences. And I still maintain that respect and tolerance are built on the bedrock of shared values.*

▲ You make it sound like the burden is all on urban providers. It sounds like you are saying, **A**lf you act this way, we'll deign to let you let you enter our town **C** but don't mess up!@ I think it's a two-way street. If we both benefit by associating with each other, why shouldn't both of us be willing to give a little to make it work?

▼ *You're right that collaboration is based on compromise. However, it is very easy for rural folk to be overwhelmed by urban people. Whether it's real or not, we sometimes feel inferior to urban people and we are **C** culturally, constitutionally **C** fearful that we are going to end up on the losing end of any rural-urban bargain. We would like to structure all of our dealings with urban providers and health plans in such a way that they would commit in writing to their current and longer term plans. That document should also outline what their exit strategy would be if they ever had to leave the community. Then we could periodically verify that they are doing what they said they would do. Our level of trust is not sufficient to just open the doors to the community.*

▲ I think that most providers acting in good faith would be willing to spell out their current plans. For example, I think it would be reasonable for an urban provider to state whether or not it intends to include rural residents in decision making and, if so, how. I think an urban provider also might be willing to give community members the first option on acquisition of its rural assets, should it decide to quit the community. This exercise might help to make urban providers more sensitive to the interests of rural residents.

DIFFERENT PERSPECTIVES ON LOCAL CONTROL

Many of the issues inherent in the popular discussion of local control of rural health services are found also in academic disciplines. In this section of the paper we explore ideas and findings from sociology, political science, economics, and business that help shape our understanding of local control.

A Sociological Perspective

Local control is a term often used to connote the will of the people in rural areas, although rural residents rose from a common source and share common attributes and values. Sociologists who have studied the culture and demographics of rural areas, however, suggest that although persistent strains of American thought continue to permeate rural areas, there is a high degree of diversity among rural populations.

If rural culture is sufficiently different from that of mass society to be considered a subculture, its heritage has been influenced greatly by two closely related but independent streams of American thought: the agrarian ideology and the frontier hypothesis (Hassinger, 1978). The agrarian ideology most frequently associated with the writings of Thomas Jefferson suggests that rural life is morally superior to urban life (Jefferson, 1781). The frontier thesis was postulated first by Frederick Jackson Turner, who, in 1893, explained the

significance of the frontier in American history by saying, "The existence of an area of free land, its continuous recession, and the advance of American settlement westward, explain American development" (Turner, 1893). Due to the isolation of the frontier, mutually dependent pioneers came together to provide for themselves the services of government, education and religion. The frontier, Turner claimed, gave rise to characteristics such as self-reliance, pragmatism, egalitarianism, and social mobility that influenced all of American life.

Although somewhat diminished by time and in-migration from urban areas, the agrarian ideology and the frontier thesis continue to exert an influence on rural culture. (So pervasive is the belief in these tenets that urban dwellers express many of the same values about rural life that rural residents do, e.g., rural areas are a superior to place to raise children, rural residents are more active in community affairs (International Research Associates cited in Hassinger, 1978; see also Pooley, 1997).) The frontier thesis today is related closely to the institutions of rural society that emphasize individualism, equality of relationships, local control, self-sufficiency of institutions, and the simplicity of organizations (Hassinger, 1978). The agrarian ideology continues to influence a belief among urban and rural Americans alike that rural life is morally superior to life in cities.

Juxtaposed against this common cultural heritage is the growing heterogeneity of rural populations and occupations. In the 19th century, many small American communities developed to support a single dominant industry such as farming, ranching, mining, or timber. Over time, however, the economies of these rural communities diversified. For example, agriculture, once the leading industry of rural America, today is the principal industry in only one of five rural counties (Bender et al., 1985). As rural economies diversified, the core purpose of communities became less clear and the residents of rural communities accordingly less homogeneous.

New industries introduced new residents to the communities and the decline of older industries forced some residents to leave the community. Unfortunately, many of the people who have left rural areas in search of high-skill, higher-paying jobs are young and better educated (Israel and Beaulieu, 1990). Many of the professional and technical leaders of the new rural community – the manager of the local assembly plant, the hospital administrator, the physician, the high school principal – immigrated to the community from elsewhere. The pluralism spawned by industrial diversification further reduced the social cohesion of many rural communities.

Changes in technology also sought to undermine the cohesion of rural communities. Improvements in transportation increased the mobility of rural residents, freeing them from sole reliance on the local community for providing all products and services they consume. Improvements in communications – particularly mass media – introduced ideas from outside the community that influenced the preferences and expectations of local residents. Many rural residents now routinely travel to larger communities for employment, shopping, and entertainment.

Within all communities today there are elements that belong both to the local community and to the extra-community system. Every rural community, therefore,

is subject to controls from within and without, with neither type of control ever operating independently of the other. The local branch of ... the school... [or]...the branch firm are at one and the same time local and extra-local, we-oriented and they-oriented. Depending on the situation, however, in any given instance one set of controls usually carries more weight than another (Gallaher, 1980, p.87).

Control of decisions, then, is never wholly local nor wholly extra-local, but mixed. The larger environment influences local decision making at the same time that local norms, values, and

resources shape the decisions that are made. Both local and extra-local streams of information are used in community decision making.

Rural communities, in summary, are less likely than they once might have been to speak with a single voice on the issues of the day. Today's rural communities are composed of residents with a wide spectrum of opinions and interests

A Political Science Perspective

The sociological perspective suggests that various interest groups exist within a rural community. Political scientists are interested in how these groups compete with each other, how power is shared among them, and how decisions are made. This level of analysis, however, begs the question: Are rural leaders capable of responding to the challenges that face them? A growing number of rural health advocates have suggested that many of the problems of rural areas are the result of poor local leadership (Amundson, 1993; Amundson and Rosenblatt, 1991; Elder and Amundson, 1991). The persistent failure of local leadership across rural communities prompts one to ask: Is poor performance a personal failing of leaders in rural areas or is it symptomatic of a larger structural problem?

Some theorists suggest that the political ethos of rural communities contributes to poor performance. Vidich and Bensman (1958) identify four processes that affect and underpin rural political action: 1) the pervasiveness of politics in rural life, 2) the unanimity of decision making, 3) the minimization of decision making, and 4) the voluntary surrender of power to outside jurisdictions. Politics, Vidich and Bensman claim, is a dominant theme of rural life, but political discussion focuses on personalities rather than on issues; moreover, it occurs in either the presence or absence of issues. Unanimity, they say, is sought for all collective decisions. Questions that are not likely to result in a unanimous vote are seldom called in public meetings.

The dissent, disagreement, and factionalism that may exist in the community are not expressed openly in meetings. Instead, consultation prior to a meeting identifies the positions of various leaders. Because the only questions that are likely to be called are ones that will be unanimously agreed upon, decisions of public bodies tend to focus on uncontroversial housekeeping business (e.g., paying bills, collecting taxes, establishing committees) and tend to avoid new undertakings and new projects. Finally, Vidich and Bensman suggest that, given the opportunity, local leaders will surrender jurisdiction for an issue to an outside agency (e.g., disaster relief).

In the forty years since this theory was postulated, the demographics of rural areas has changed substantially. The increased heterogeneity of rural populations has no doubt diminished some of these tendencies, however, anecdotal evidence gained through field work in rural communities is sufficient to suggest that rural community leaders often still seek unanimity and defer decision making, even in the face of a compelling need to make decisions.

Other rural researchers note a growing sense of powerlessness among rural residents, resulting from their lack of political influence in the larger environment and their limited control over the resources of the environment (Padenfield, 1980; Vidich and Bensman, 1958). This sense of powerlessness spawns a certain fatalism: "Whatever happens will happen." As a consequence of their perceived powerlessness, rural residents may be likely to do nothing when confronted with a political problem.

Some researchers blame the pervasiveness of mass media for the lack of political activism in rural areas. Increasing awareness of national and international events gained from the mass media, they suggest, is gained at the expense of an awareness of local events. Before a problem can become a salient political issue, it must first be recognized as such by a critical mass

of citizens. Due to the lack of authoritative sources of information about local problems, opinions about the issues of concern to rural residents do not form readily (Hobbs, 1997).

These negative assessments of the ability of rural communities and their leaders to solve local problems obviously overstate the extent of the problem: There is also a sizeable and growing literature on effective rural communities. Israel and Beaulieu (1990) report that rural communities that seem best able to act on matters of concern to local residents have leaders who involve diverse sets of actors in decision-making activities, operate on democratic principles, and place the welfare of the entire community above those of special interests. Israel and Beaulieu (1990) acknowledge that coordinated, well-integrated leadership is difficult to achieve in contemporary society; they claim that more and more frequently leadership is dominated by special interest actors, individuals who offer a narrow, subject-matter view of community matters (p. 182).

Hobbs (1997) notes that research on effective rural communities shows that they use not only their own resources better than other communities, but they also use outside resources to solve internal problems. Many rural communities, however, are not able to overcome their antagonism to urban and large rural communities in order to effectively use the resources of these larger communities to their advantage. The observation of Vidich and Bensman (1958) forty years ago still rings true today:

A central fact of rural life...is its dependence on the institutions and dynamics of urban and mass society. The recognition of this dependence and the powerlessness associated with it gives to the agents and institutions of the great society a degree of respect and admiration, which, however, does not always connote approval. Rather, there is a high degree of ambivalence with respect to these agents and institutions. They have respect because of their power and wealth, and because their norms have the legitimacy of acceptance in wide areas of society at large. On the other hand, the very dominance of the mass institutions causes resentments, since, in light of this dominance, rural life in its immediacy is devalued....In response..., the members of the rural community and their political

spokesmen resent their dependency and powerlessness and channelize it into anti-urban politics and policies (pg. 101).

In summary, the political environment of rural communities include conflicts among various interest groups within community as well as conflicts across communities. The intra-community conflicts may be managed by leadership that stresses open participation in the political process and encourages democratic decision making. Conflicts across communities can be reduced by a realistic understanding of the mutual dependency of communities and their institutions and by a concerted effort on behalf of rural community leaders to obtain the resources they need from outside sources at a reasonable and fair cost

An Economic Perspective

Economists attempt to identify who is better and worse off when local control is lost. If the preferences of all of the relevant actors were known, quantification of the effects of these preferences would allow a welfare analysis to be conducted. For example, a new entrant in a rural health market might have superior technology to that of extant health providers. Perhaps the entrant could produce services at a lower cost than the incumbent rival. Thus, consumers would be able to purchase services from the entrant for a lower price (or receive higher quality services for the same price). In such cases, the overall welfare for that system will increase for consumers and the entrant. However, the incumbent producer and some consumers may face a welfare loss due to the entry.

The notions of Pareto efficiency and welfare loss are central to understanding local control from an economic perspective. Pareto efficiency, loosely defined, is a situation in which no one can be made any better off without making someone else worse off (Pareto, 1927). Competitive markets will not necessarily lead to efficient outcomes in Pareto's sense (Koopmans, 1957). A primary difficulty with analysis involving Pareto criteria is the

assumption that economists are able to discern the preferences of all agents. In a theoretical context, the assumption of identical preferences for all agents in the economy is not uncommon. Actual conflict over who controls health care resources in rural areas implies a variety of competing preferences. Some rural residents may wish to have a greater array of services and/or increased access to the nearest urban medical center while others wish to maintain ties to local providers whose resources are limited to those available within the rural community. True economic analysis of the most efficient allocation of resources among local and non-local providers must be non-dictatorial. Thus, the preferences of those who prefer outside health services do not take precedence over those who prefer only local providers, even if there is a majority favoring the outside services.

The overall impact of the loss of local control could be positive for the community (through lower prices, higher quality, greater access), but negative for the prior incumbent. A prime example would be the local pharmacist with a store located on the town square. When Wal-Mart⁷ enters the community with a 24-hour pharmacy, free parking, a location near residential neighborhoods, and lower prices for prescriptions than the local pharmacy, the community at large is better off. If the local drug store goes out of business as a result of this competition, the owner of that business is worse off (as is the agent renting the building to the owner). Businesses located near the failed drug store may also suffer due to less foot traffic by pharmacy customers. In this example, economic efficiency drives the prior incumbent out of business. The economic benefit to the community's consumers, measured in dollars saved or convenience, is expected to outweigh the financial loss to the bankrupt pharmacy due to the outside competition.

Even though the above example could be considered an economically efficient outcome, many communities may not be at ease with the notion of outsiders gaining control of their health care resources. Loss of identity for the rural community cannot be assessed only in financial efficiency terms. This implies that an economic efficiency framework alone is not adequate to fully analyze the issue of local control. Additional welfare economics concepts should also be considered.

In situations involving utility conflict (i.e., when some households are harmed and others gain), analytical frameworks that involve equity, absence of envy, and distributive justice merit consideration (Boadway and Bruce, 1984). Local control of rural health services is such a situation. In a purely equitable economy, each agent possesses exactly the same resources. An argument for equity and envy-free allocation of resources, however, would be inconsistent with the notions of freedom of opportunity and individual achievement upon which American ideology, especially in rural communities, often rests. Thus, we will consider other forms of distribution beyond equity.

Under one ranking scheme, an overall increase in utility is the primary consideration used to determine which social policy is optimal (Boadway and Bruce 1984). Under this approach, all the assets of a society are to be combined and redistributed so as to maximize overall utility. A common application of this philosophy of social welfare analysis is taxing taxpayers according to their ability to pay (Boadway and Bruce, 1984). However, it may also be pertinent for local control if we reconsider the example posed above. If the pharmacist loses out when Wal Mart⁷ comes to town, but the small utility gains by consumers in the community outweigh this one large loss, the optimal outcome for the community would be to encourage outside control of pharmacy services. But, if the large loss by the pharmacist and small losses by the other main

street merchants outweigh the consumer gains, the entrance of the Wal Mart⁷ pharmacy should be hindered.

Even though the market mechanisms will lead to an economically efficient outcome, in this extended example, the community members may be more sympathetic to the local pharmacist (their neighbor) than to a faceless corporation with headquarters outside of the community. Thus, a social welfare function that weighs the loss of the drug store (or the symbol of Main Street) cumulatively with other losses to the symbolic institutions valued by the town would need to be constructed to assess the relative benefit for the community versus the adverse impact for the local pharmacist.

In summary, the analysis of who is better off and who is worse off when local control is lost depends on various factors, such as the composition of the community and the assessment of value by community residents. Local residents, for example, may be willing to pay more for health care services to support local providers or to retain control of health care decision making, provided that they place a higher value on supporting their neighbors and maintaining control than they do the likely savings that may be achievable from more efficient delivery of health services. If the cost of health care services throughout the community is lower when local control is maintained, or if the quality of service is higher, the analysis of who wins and who loses when local control is lost is much simplified.

A Business Perspective

Like the economic perspective, the business perspective on local control is concerned with the notion of efficiency. Large health-related organizations enter rural communities to protect or increase market share or to produce greater economies of scale and reduce the overall costs of the firm by sharing certain expenses of the firm across multiple operating units.

For example, some extra-local health care firms may attempt to control rural primary care practices as part of a strategy of vertical integration. Vertical integration is the coordination or linkage of services that are different stages in the health care production process (Conrad and Dowling, 1990). These firms may consider the primary care services of local providers as downstream products that provide inputs (i.e., patient referrals) for urban secondary and tertiary providers. The principal aims of vertical integration are to enhance coordination among the elements or stages of the production process...and to control the channels of demand for, or distribution of, a firm's core services (Conrad and Dowling, 1990, p. 10). Viewed from this perspective, rural providers and the patients they serve are a vital link in the chain of value of vertically integrated health care firms (Porter, 1980). As such, they have substantial bargaining power with upstream producers who need their resources (patients).

It is important to note that the upstream producer does not have to own downstream producers to remove uncertainty about the supply of downstream products. Other means of controlling products or service lines include informal agreements or affiliation, loan guarantees, contractual agreement, joint venture, franchise, lease or sale/lease-back arrangement, and merger (Conrad and Dowling, 1990).

Many rural health systems lack ready access to capital to maintain equipment and institutional infrastructure. This needed infusion of capital is often supplied by extra-local health care firms entering local markets. To receive this capital, however, rural providers frequently are required to become employees of the extra-local firm. Both rural providers and extra-local health care firms may benefit from innovative ways of injecting capital into rural markets that retain local autonomy (for rural providers and communities) and limit risk (for extra-local firms).

Rural health networks, for example, may be an innovation capable of achieving these common goals.

In summary, health system integration, in theory, will produce better care at lower cost. To integrate, services must be distributed rationally and operated across providers in a functionally and clinically unified way. Large, extra-local health care firms, in many areas of the country, are attempting to build integrated health care delivery and financing systems and are beginning to reach into rural areas to ~~control~~ more ~~down stream~~ resources. Rural residents face the unenviable prospect of discovering ways in which they can benefit from system-wide integration without losing local autonomy.

CONCLUSION

In this paper, we suggested that the issues of local control of rural health services could be viewed from the perspective of four disciplines: sociology, political science, economic, and business. The interplay of these perspectives may be affected by the particular environment in which individual decisions about local control of health services will be made.

For example, three environmental factors that will influence the urgency with which decisions about local control are made are: 1) the rural community's distance from an urban community or a large rural community, 2) the perceived threat local providers feel from extra-local competitors, and 3) the regional managed care environment.² The issues of local control of health care service likely will be more salient in communities that are located close to more dominant communities, that are engaged in sharp competition, or that feature an active managed care environment. Conversely, local control may be less of an issue in geographically isolated

² Other environmental factors are also germane to the local control debate. They include the population of an area, its demographic composition, and its economic climate.

communities, in communities that perceive a low level of threat from competitors, and/or that have little or no managed care.

The stress associated with making decisions in a highly turbulent environment may lead community leaders to display a variety of counterproductive behaviors, from resisting all externally proposed changes to accepting any and all offers to enter the community by urban health providers and health plans. The ready acceptance of such offers can be motivated by a fear that any delay in decision making may result in all of the good partners being committed to other rural communities.

Whether local control becomes an issue and the handling of that issue within a community both depend on several factors. Two of the more important factors are the quality of leadership within a community and the degree of organization of local providers. Evaluating rural community options will be less difficult in communities with leaders who can articulate community goals, identify problems and opportunities, and mobilize residents to pursue specific courses of action. These leaders will be able to focus the discussion and direct a process of rational evaluation of alternatives. Communities whose providers have coalesced into clinics, independent practice associations (IPAs), and physician-hospital organizations (PHOs) also may be in a better position to manage the evaluation of strategic options. The formation of these organizations implies some unity of purpose that may be lacking in a more atomistic provider community. Local provider organizations tend to focus provider opinion and to serve as vehicles for the expression of provider preferences. One or two provider organizations can clarify the goals and interests of the rural health care community more quickly than can a variety of independent providers.

The perspectives put forth in this paper are offered by the authors to help communities evaluate various local control options. These perspectives may lead community leaders to examine the composition of their communities, the decision-making processes employed, the goals of decision making, and the resource capabilities of their communities. Below we propose an issue-oriented list of questions that rural communities can ask themselves when considering local control issues and health care options.

Sociological Perspective

- ! How is the community defined (geographically and demographically)?
- ! What groups comprise the community?
- ! Who in the community currently participates in health care decision making?
- ! Who in the community should participate in health care decision making? How can these residents best be involved in health care decision making?
- ! What values and biases do each of the community decision-making groups possess?
- ! What values does the current community health system project?
- ! What values should the community health system project?
- ! What values does the community look for in an extra-local linkage partners?

Political Science Perspective

- ! How are decisions made about the availability of health care services in the community and the conduct of providers?
- ! How should health care decisions for the community ideally be made?
- ! Who benefits, and in what ways, if extra-local health care firms are excluded from the community?
- ! Who is harmed, and in what ways, if extra-local health care firms are excluded from the community?
- ! Who benefits, and in what ways, if extra-local health care firms enter the community?

- ! Who is harmed, and in what ways, if extra-local health care firms enter the community?
- ! How do the benefits compare to the harm that is done when extra-local health care firms enter the community or are prohibited from doing so?
- ! How might it be possible to share decision-making power with extra-local health care firms in the future?
- ! If you were seeking written guarantees of future behavior from an extra-local health care firm, what would you ask for?
- ! Would a disinterested third-party help or hinder the community's negotiations with extra-local health care firms?
- ! Does the community have bargaining power? What is its source and how strong is it?

Economics Perspective

- ! What health services are needed by the community's residents?
- ! What health services are currently provided within the community?
- ! What options are available for supplying the needed services?
- ! What does the community stand to gain by allowing extra-local health care firms to provide services in the community?
- ! What does the community stand to lose by allowing extra-local health care firms to provide services in the community?
- ! What ways are possible to minimize possible losses to the community if extra-local health care firms begin to provide services in the community?
- ! What are the likely economic consequences of excluding extra-local health care firms from the community?
- ! How much is the community willing to pay to maintain its autonomy?

Business Perspective

- ! Who are the current competitors of local health care providers?
- ! What services do competitors offer?
- ! How do the services of competitors differ from those of local providers and insurers (e.g., availability, quality, cost)?

- ! In what ways can the services of local providers and insurers compete with extra-local health care firms?

The health care industry is in flux, searching for new ways to deliver and finance health care services. One outcome of this period of change is a consolidation of providers in many areas of the country through acquisition, merger, or strategic alliance. Long ignored by urban and national interests, rural areas now are becoming attractive markets. Rural areas not only provide Adown stream@resources in the form of referrals to specialists from primary care physicians, but they also represent relatively untapped markets for the sale of health care and insurance services that may have reached the saturation point in urban areas.

How does and how should rural health fit into the overall health care system? What issues need to be considered at the local level? Do these issues differ from those at the regional or national level? The ways in which rural communities define Alocal control@and the actions rural decision makers take to preserve that control will greatly influence the answers to these questions.

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