

INTRODUCTION

Policy Forum: *Contemporary Issues in Rural Healthcare In Honor of James D. Bernstein (1942-2005)*

To a state like North Carolina, there are few topics as central to the concerns of those responsible for the development of health and healthcare policies as rural health. But even in North Carolina, where a number of innovative approaches to the delivery of personal healthcare services and the education of healthcare professionals have been developed, special arrangements have been necessary to ensure rural residents could access care and that adequate numbers of professional healthcare providers were available.

Most of the nation sees North Carolina as a state that has embraced the challenges of rural healthcare and made substantial progress in addressing the most pressing problems in rendering services to the state's rural populations. Many other states have looked admiringly at the accomplishments of North Carolina's four medical schools in training a generation of physicians who have chosen careers in primary care and to practice in North Carolina. Many of our state's graduates locate in smaller, non-metropolitan communities. Likewise, the state's Area Health Education Centers Program has become the national model for how to organize regional systems to: provide continuing education for healthcare professionals, bring the benefits of specialty consultation to smaller communities, and educate students from multiple disciplines in community-based settings to help attract newly educated healthcare practitioners to become permanent community members and participants in local healthcare delivery systems. But, perhaps the single reason North Carolina is so highly respected for its accomplishments in the arena of rural health and healthcare derives from the efforts led by James D. Bernstein (1942-2005) and the program he began in the early 1970s, then known as the Governor's Rural Health Program (and the North Carolina Office of Rural Health).

In contemplating a special issue of the *North Carolina Medical Journal* in which we would take stock of lessons learned over the past three decades or more about the problems of assuring access to quality healthcare for rural communities, and reflecting on current issues and problems in relation to rural health still needing attention, the Editors of the Journal decided to dedicate this installment of the Journal in honor of Jim Bernstein, our beloved colleague, friend, mentor, and national leader. Jim set the pace and defined the direction of much of what we would consider the nation's rural health agenda for the 21st Century. Jim's untimely death this past year brought to Chapel Hill hundreds of individuals who wanted to visit with Jim one last time, to share his wisdom and good humor, to share stories of battles won (and lost), and efforts made in behalf of rural communities in North Carolina and elsewhere. Several hundred of his friends and admirers attended the memorial service in his honor. For all of this, Jim would have been (and was) very grateful. But, he would be most pleased to know that we took this opportunity to reflect on what has been learned from our years of concentrated effort, to analyze current issues still needing attention, and to re-dedicate our individual and collective efforts to keeping these issues in the forefront of national, state, and local health policy deliberations for the decades ahead. It is our hope that this issue of the Journal will be an additional step in that direction.

A Personal Reflection on Jim Bernstein

I hope that our readers will allow me this brief opportunity to print a few words about a close friend and colleague, who has been a constant source of inspiration and intellectual stimulation throughout my 35 years in North Carolina.

When Jim arrived in North Carolina near the beginning of the 1970s, there was no way that he

could have known what a tremendous influence he would have in this state, in the nation, and among his colleagues at the University of North Carolina at Chapel Hill (UNC-Chapel Hill). Although he knew he wanted to work on the special problems in rural healthcare, he could not have known what serendipitous events would give him the opportunity to launch *the single most extensive and effective program in rural health anywhere*. Nor could he have known what great personal influence he would have on the people served by the program he spawned or among the colleagues he assembled to make these things happen.

Jim did not begin the program in rural health in North Carolina by writing on a “blank slate.” There was a rich history of efforts to develop the resources and capacities of several communities and prominent healthcare facilities in this state, which he and his colleagues were able to bring into closer working relationships with one another. Moreover, there were a number of outstanding health professionals with whom Jim established personal relationships, and together, they forged an effective alliance that worked well for many years. Thomas Ricketts, himself a national figure in rural health research at the Cecil G. Sheps Center for Health Services Research at UNC-Chapel Hill, offers a detailed overview¹ of this history and the pillars of personality and professional esteem on whose shoulders Jim was able to stand in building the program for which he is so well known.

Jim Bernstein managed to make the task we were all engaged in, and the process of getting the job done, both stimulating and fun. There are few people like Jim Bernstein we will meet in this life, and we are fortunate to have been some of the many who have known him well. He will always be a part of our lives and careers, despite how much we will miss him every day, and for that, we must be very thankful.

Jim was always an unselfish person—willing to share (or *give*) the credit for almost everything he did to some other member of his colleague group. Even as he “retired” from some of the roles he previously played in North Carolina state government, he had a hard time taking credit for many of the things he caused to happen. He only wanted to talk about his colleagues and the pride he had in assembling such an effective team.

Jim was one of the two or three people I met and got to know well when I arrived in North Carolina in 1971. A year or so after my arrival here, Jim “decided” (and then *gently* told me) that now that I had a PhD *degree*, what I needed was a “real education” because I knew “next-to-nothing” about contemporary healthcare policy and program development.” He proceeded to help me acquire the understanding clearly missing from my previous degree program and my brief professional experience in medical sociology. He set up a series of luncheon discussions for the two of us with Glenn Wilson, then the Associate Dean of the UNC School of Medicine. The *quid pro quo* in all of this was that Jim and I would get a chance to ask questions of one of the most knowledgeable people in American healthcare, and Glenn would get lunch prepared by the two of us. It was a wonderful education for us, but Jim was ahead of me in that he had come to know Glenn in Cleveland when Glenn was Vice President of Kaiser, and he had experienced a couple of years of service with the Indian Health Service before coming to Chapel Hill. He had far more information and background than did I, so I learned from the *two of them* ... something I have continued to this day. In a very real sense (and this is something I said to him, but to few others until now), were it not for Jim Bernstein, I think I would have spent my career very differently. One can never repay that level of influence.

Over the years, as I have tried to make my way in the field of health services research, Jim and I teamed up on many levels to obtain grant funding, to lend technical assistance to various organizations, to address policy issues at the state and county levels, or just to share our interest in several areas of our work.

I only regret that I did not help get him appointed to more boards and committees where I had a role. Few people could enrich a discussion, a meeting, or a complex organizational task like Jim Bernstein.

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As Editor of this Journal, I am very grateful to Jim's good friend and colleague, Donald Madison, for writing in this issue an overview² of Jim's remarkable career and a description of how North Carolina's rural health program took shape and continues to have great influence in the field of rural health at a national level.

Contemporary Issues in Rural Healthcare

In our attempt to identify and clarify some of the more complex and demanding issues in rural health and healthcare with this issue of the Journal, we hope to honor Jim Bernstein in a way he would consider useful. It is our hope that publications like this one can help keep the initiatives he and others started in forward motion and help raise their visibility as public policy issues of our time.

Those who have examined the differential health indicators for both rural and urban communities in the United States have come to the conclusion that, when the effects of age, gender, and other covariates are "controlled" through statistical adjustments, the once clear disadvantage of rural areas in terms of both mortality and morbidity is no longer apparent.³ Disease and mortality differences between metropolitan and non-metropolitan areas in this country are more likely associated with racial and ethnic or socio-economic characteristics of populations than with the size or remote location of place. Yet, the accessibility of healthcare services for those with virtually any disease or disability is far less certain in rural areas of the United States. Moreover, rural residents consistently are more likely to describe their health as "poor" or "fair" than are residents of more urban areas.³ These observations, coupled with the urbanization of the population as a whole and the "aging" of United States rural populations in general, will make the task of assuring the availability and accessibility of quality healthcare services for rural populations an even greater challenge for future healthcare policy and program development.

Despite these seemingly paradoxical findings of non-differential urban-rural differences in critical health indicators (when other factors are taken into account) and the lack of access to basic healthcare services in rural areas, wide variations in health status indicators of the nation's rural areas exist. Geographic areas characterized by low socio-economic status or minority racial, and ethnic group concentrations are likely to have far worse health status indicators, as well as more restricted access to healthcare services.

These wide variations and the implications of limited access to basic healthcare services have caused most states to give special attention to these issues. In North Carolina, since the early 1970s, this effort has revolved around the work of the Office of Rural Health, or what is now known as the Office of Research, Demonstrations, and Rural Health Development, within the North Carolina Department of Health and Human Services. In this issue of the Journal, it is our intent to give special focus to a number of the key issues confronting this state and others in the first decade of the 21st century. For some of these issues, it will seem as though little or no progress has been made. For others, considerable forward movement has taken place.

One observation worth noting is that rural health policy, after several decades, is now a matter of significance in national health policy. Jeanne Lambrew, one of President Clinton's chief health policy advisors, describes the current political landscape and illustrates evidence of the how rural health constituencies have been influential in recent national policy development.⁴

In a broad brush examination of contemporary rural health issues, there are several issues that still seem to be the defining issues of the field. The first of these relates to the healthcare professional workforce and its distribution. Concerns regarding an adequate supply of healthcare professionals are perhaps as important now as they were three decades ago, especially with regard to certain professions (e.g., dentistry), and yet, these issues have become intertwined with others, such as reimbursement (payment) policies, practice act limitations on non-physician providers, and practice organization arrangements. There are still significant issues related to how we recruit and retain healthcare professionals in small and remote communities. Examples include considerations of how newly trained physicians, dentists,

nurses, pharmacists, and others are incentivized to consider practice locations in rural communities through educational loan repayment programs, scholarships, and other financial inducements. Donald Pathman⁵ offers a detailed discussion of ways in which these programs have had an impact and how lessons learned from past decades of experimentation with financial and obligated service placements can be used to further refine programs. Robert Seligson and Pam Highsmith⁶ of the North Carolina Medical Society Foundation provide a description of the Community Practitioner Program, which was developed under the Foundation with support from the Kate B. Reynolds Charitable Trust and the Society's own membership. The Program's purpose is to help rural communities acquire the medical personnel needed to sustain primary care services when recruitment and retention have proven to be a problem. This is an initiative that has worked "hand-in-glove" with the activities of the state Office of Rural Health and helps to explain why so many North Carolina communities, formerly without primary care services, have achieved success in starting and maintaining such programs in recent years.

A second major dimension of efforts to address the nation's rural health problems involves a complex set of factors that determine which rural communities will be able to address these issues most successfully. The North Carolina Office of Rural Health, under Jim Bernstein's leadership, put the majority of its emphasis on facilitating communities who had the leadership capacity to organize viable local efforts in response to these problems. As a result of decades of intense collaboration with local communities across North Carolina, there is now a body of knowledge and experience that has proven to be useful in assuring the success of local health services planning efforts. Torlen Wade and his colleagues⁷ provide an overview of the basic approach to the establishment of local community and state governmental partnerships in rural health program development that has characterized the modus operandi of the Office of Rural Health since its inception. Rita Salain,⁸ a person who has worked both in North Carolina and now in Georgia, adds to this discussion by illustrating in greater detail the various components of community development that have been shown to be essential and effective in making organized approaches to rural health issues possible.

In the discussion of the program development aspects of rural healthcare, practicing physicians play a critical role, both as direct providers of care and as leaders through the restructuring or development of local healthcare services to ensure greater effectiveness and long-term organizational and financial viability. Steve Crane⁹ provides a useful discussion of the potential role physicians may play as these discussions take place, building on the experience in three of the western-most counties of our state. Leadership of rural community development efforts and the skills involved in identifying appropriate and effective leaders for such efforts were among the most important aspects that many have identified as a central feature of the way Jim Bernstein and the Office of Rural Health were able to facilitate the development of so many separate rural health programs across our state. In this issue of the Journal, we are pleased that one of Jim's many colleagues, Tim Size¹⁰ from Wisconsin, offers a perspective on the importance of leadership and its development based on his many years of developing rural community-hospital networks in southern Wisconsin.

In every effort to bring greater coherence and organizational effectiveness to rural health services, a vital function is associated with local or regional hospitals. Jeff Spade, Executive Director of the North Carolina Hospital Association's Rural Health Center, and Serge Dihoff, Assistant Director for the North Carolina Office of Research, Demonstrations and Rural Health,¹¹ provide an overview of the way in which North Carolina hospitals have become closely involved with small rural communities in the effort to facilitate these developments.

A discussion of rural healthcare programs and priorities would not be complete without consideration of the difficulties these communities face in meeting the challenges of mental health and substance abuse services. Given the enormous impact of efforts to restructure mental health services in our state, there are many opportunities for persons with serious and persistent mental health problems to fall through the cracks and to have their needs go unmet. In this issue of the Journal, John Gale and David

Lambert¹² of the University of Southern Maine provide a discussion of the problems associated with assuring access to such services in rural communities. In addition, a sidebar illustration of a successful program offering mental health and substance abuse services in North Carolina has been contributed by Denise Levis.¹³ Levis describes how mental health and substance abuse services have been integrated with the Community Care of North Carolina (CCNC) Program, a set of networks across the state through which the care of Medicaid enrollees is managed in an effort to achieve both quality of care and cost-containment objectives.

The area of major concern to all who have focused their work in the rural health arena that is absent in any detail from these pages is the matter of financing rural healthcare services and programs. However, these issues are raised parenthetically throughout these discussions. It is clear that the patchwork of federal and state programs to cover the cost of particular rural health programs and needs does not reflect a comprehensive approach to meeting these national health challenges. It has, more often than not, been possible to address rural health needs through public financing only when specific rural-urban comparisons are made visible and raised to a level of importance that justifies specific targeting of new funds. Today, more funds are available to meet the broad spectrum of rural healthcare needs than were three decades ago. However, much work remains to be done to help rural residents benefit equally from the modern healthcare capacities that residents of more urban areas have.

We hope that these papers will be of interest and encouragement to those who have worked long and hard to address the fundamental problems of rural health. We also hope that our readers will find stimulation among these papers for further efforts toward the goals embraced by these authors and enunciated on so many occasions by Jim Bernstein, to whose memory this issue of the Journal is respectfully dedicated.

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