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Health Care in Rural America: The Congressional Perspective

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Hearing Before the Pepper Commission (Bipartisan Commission on Comprehensive Health Care), *Health Care in Rural America: The Frontier Perspective* (Washington: June 1989, S. Hrg. 101-969), 211 pp.

Hearing Before the Senate Subcommittee on Medicare and Long Term Care, *Rural Health Care* (Washington: May 1990, S. Hrg. 101-490), 102 pp.

Office of Technology Assessment, *Health Care in Rural America,* Summary (Washington: September 1990, OTA-H-435), 26 pp.

Office of Technology Assessment, *Rural Health Care, Defining "Rural" Areas: Impact on Health Care Policy and Research* (Washington: July 1989, OTA Staff Paper), 60 pp.; $3.25.

Office of Technology Assessment, Special Report, *Rural Emergency Medical Services* (Washington: November 1989, OTA-H-445) 104 pp.; $4.75.

A quiet crisis in rural health care has developed in recent years. Rural hospitals have been closing in increasing numbers, leaving small communities without medical facilities. Rural physicians and other health professionals are either retiring or leaving their rural practices without new replacements. An overall decline in the availability of health care for rural citizens has resulted with serious consequences. These problems in access to health care have attracted the attention of congressional leaders in health policy making. According to John H. Gibbons, Director of the Office of Technology Assessment (OTA), federal policies affecting rural health care have received renewed scrutiny (OTA, September 1990). The Senate Rural Health Caucus, a bi-partisan group of seventy-one senators whose aim is to increase awareness of rural health issues in Congress, is particularly concerned about the comparative disadvantage of rural areas in access to medical care (National Resource Center for Rural Elderly, 1991). Members of the Caucus requested the OTA, an organization that supplies up-to-date information on a large number of issues to congressional members and committees, to prepare an overall assessment of rural health care in America.

Prompted by similar concerns, congressional committees held hearings into the problems of rural health care in 1989 and 1990. Two hearings produced publications of expert testimony which are helpful in understanding the true nature of the apparent crisis in rural health care.

Negative Outcomes for the Health of Rural Citizens

Without intervention, rural hospitals continue to close in increasing numbers. The OTA Special Report, *Rural Emergency Medical Services* (November 1989), states that since 1981, over 550 rural hospitals have closed nationwide. The problem of access increases as each rural hospital closes and each health professional leaves a rural practice. In the Hearing Before the Senate Subcommittee on Medicare and Long Term Care (S. Hrg. 101-490, May 1990), Jeffrey Human, Director of the Office of Rural Health Policy, Department of Health and Human Services, stated that the largest problem in rural health care is access. He added that the problem of access was actually two fold: declining numbers of hospital facilities and shortages of health care professionals in rural areas.

The loss of access to health care in rural areas has taken its toll on the health of rural citizens, as illustrated in congressional testimony. On June 28, 1989, John B. Coombs, M.D., gave a statement on behalf of the American Academy of Family Physicians before the Pepper Commission (Bipartisan Commission on Comprehensive Health Care). In that statement, Dr. Coombs portrayed the largest problem in rural health to be the lack of access to health care and its adverse effects on the health of rural citizens. The most problematic area according to Dr. Coombs is obstetrical care. Physicians are observing alarmingly high infant mortality in rural areas. Dr. Coombs pointed out that in 1986, seven of the eleven states with the highest postneonatal (within 28 days of birth) mortality rates were rural (S. Hrg. 101-969). He attributes this phenomenon to the absence of prenatal care. In testimony, Dr. Coombs said "...we talk a lot about the AIDS crisis, and I don't want to downplay the importance of that, but when you look at infant mortality, it doesn't hold a candle to it in terms of the number of babies that die every day (because of) poor access to care" (S. Hrg. 101-969, p. 37).

The OTA report, *Health Care in America* (September 1990), shows infant mortality in rural areas as slightly higher than that of urban areas, with rates of 10.8 infant deaths per 1,000 live births in rural areas compared to 10.4 per 1,000 live births in urban areas. The same OTA report provides two other measures of the status of rural health: rates of injury- related mortality and chronic illness. Both are higher in rural areas, possibly attributable to the lack of health care facilities and physicians. Rates of injury-related mortality are .5 per 1,000 residents in rural areas and .4 per 1,000 residents in urban areas. According to the report, chronic illness and disability affect a larger proportion of rural than urban citizens with fourteen percent affected in rural populations as opposed to twelve percent in urban areas (OTA, September 1990). The latter difference is likely attributable to the higher proportion of elderly in the rural population. However, the higher rate of injury-related mortality in rural areas may correlate with limitations on access to health care.

New Burdens on Emergency Medical Services

According to the OTA Special Report, *Rural Emergency Medical Services* (November 1989), injuries occur at nearly equal frequency in

urban and rural areas but are more severe in rural areas, resulting in higher mortality. The explanation for higher mortality may be in the delay in detection and response to trauma injuries in rural areas. The report says that the treatment of trauma injuries is further disadvantaged by the compromised hospital access.

Declining health care services in rural areas shift responsibilities to emergency medical services (EMS) for both emergency care and urgent primary care, such as delivering babies. The report suggests that EMS providers in rural areas have difficulty providing services at such a heightened level of demand and in such a difficult environment in which to operate. The OTA Special Report points to several problems specific to rural emergency medical service. EMS systems must contend with sparse and dispersed populations accessible in some cases by poor roads or in some cases by no roads at all. They must also use antiquated communications equipment and inconsistent telephone service. Further hindering communications are radio "dead spots" in which some rural areas are outside the range of available radio equipment. The report also alludes to the problems of personnel shortages and often inadequate training for EMS personnel. Problems also exist in the hospitals to which such services transport. Many of the smaller community hospitals do not have twenty-four hour emergency or trauma centers. Also, there are few rural physicians trained to provide medial supervision of local EMS operations (OTA, November 1989). These disadvantages are compounded by the new responsibilities EMS systems must shoulder when rural hospitals close.

Who Is to Blame?

Congressional concern for rural health care is clearly appropriate. The general tone of both the hearing testimony and the OTA research is that many of the problems of the current situation are directly attributable to federal health policy. The Medicare Prospective Payment System, implemented in 1984, dramatically changed the method in which all hospitals receive payment for the care of Medicare-eligible patients. Rather than payment on a cost-per-patient basis, hospitals are eligible to receive a predetermined amount of money based on a formula derived form the patient's disease. Rural hospitals are paid consistently less under this system.

The Medicare Prospective Payment System penalizes rural hospitals. It fails to recognize that they operate in a more difficult environment. Rural hospitals face the problems of low occupancy rates and high proportions of Medicare and Medicaid patients. They must offer incentives to attract qualified physicians and health care professionals to less than attractive locations. They are hindered by the inability to acquire capital for marketing and improvements needed to stay competitive in the health care environment. Many rural hospitals find the financial pressures too great to remain solvent, and they close.

In *Health Care in America*, the Office of Technology Assessment (September 1990) examines the role of the federal government in rural health care. The OTA says that the states are dependent on the federal government for assistance in maintaining and enhancing rural health care resources. In fact, the report states that forty-four percent of their resources for rural health activities come from federal sources (p. 4). The largest proportion of this contribution comes from the federal health care financing programs, Medicare and Medicaid, which subsidize medical care for the elderly and indigent, respectively.

The decrease of federal funds for health programs is problematic for rural areas. Generally, rural areas have larger percentages of elderly in their populations, which implies a greater demand for medical care because the elderly are the most frequent users of medical care. A larger number of elderly in the rural population also indicates the greater sensitivity to funding changes in Medicare and Medicaid, two programs commonly relied upon by elderly citizens. According to the OTA report, *Defining "Rural" Areas: Impact on Health Care Policy and Research,* by Maria Hewitt (July 1989), the national percentage of individuals age sixty-five and older was 11.2 percent, the percentage for urban areas was 11.5 percent, and for rural areas, 14.1 percent. According to the OTA (September 1990), the federal government also provides three major block grants, which influence rural health care. These are the Maternal and Child Health block grant, Preventive Health and Health Services block grant and the Alcohol, Drug Abuse, and Mental Health block grant. These block grants address specific health care needs, not the general health problems of rural citizens.

The OTA report further states that the federal government has tried to improve rural health care through seven target programs. The National Health Service Corps, for example, exists to address the need for physicians and health professionals in rural areas. It provides scholarships and other incentives for professionals to practice in rural settings. Other federal programs attempt to enhance rural facilities through planning and linkages to other facilities. The federal government provides funded research in rural health topics through the Office of Rural Health Policy and the Agency for Health Care and Policy Research. In the current era of federal budget constraints, these programs do not receive high priority, while the problems the programs address worsen.

In *Health Care in Rural America* (September 1990), the OTA authors are quick to point out that federal policy is only partly responsible for the decline in rural health care. The primary culprit is the decline in rural population over recent decades, combined with the legacy of federally subsidized overbuilding of hospitals during the 1950s and 1960s. Rural America cannot support its present complement of hospitals. Declining populations mean low occupancy rates, creating problems of financial exigency for the smaller community hospitals. Often those financially distressed hospitals are the only health care facility in a rural community or county.

Smaller community hospitals also lose patients because they cannot compete with larger urban hospitals in technology or staff qualifications. The

result is low occupancy rates and financial loss. *Health Care in Rural America* implies that natural market forces play the largest role in much of the forced closings of rural hospitals. However, the hearing testimony of rural physicians indicates that the prospective payment system of Medicare is also largely culpable. Summing up such perceptions in a statement at the June 28, 1989 Hearing of the Pepper Commission, held in Missoula Montana, Senator Max Baucus (D–MT), made the following statement: "(In) rural states like Montana, our people and our caregiving institutions have special problems. People have to go great distances for care. Sometimes they don't get it. And hospitals and other caregiving institutions are not adequately reimbursed for the care they provide. Their costs are higher because they have to have and maintain high quality equipment and staff to care for fewer people than big-city hospitals. The law that Congress passed to reimburse hospitals didn't take into account the especially high overhead costs of rural hospitals. We have to fix that law" (S. Hrg. 101-969: p. 4).

Regardless of the cause of the problems, some rural citizens are no longer able to access health care in their communities. Diminishing health care availability in rural areas is apparently tied to the decline of rural economies. "Free market" solutions to access problems are unlikely. Deteriorating local economies, unable to attract investment in the forms of industry and medical facilities, continue to falter and lose population to out-migration. Local health care providers continue to flee the difficult economic environment.

Even if the federal government were willing to intervene to directly enhance rural economies or at least their health care, barriers exist to such involvement. The barriers are the type found in the application of any national policy in a federal system. State and local diversity work against cooperation and standardization. According to the OTA (September 1990), variance exists in the health care needs and problems of rural areas across the nation. These differences create a problem in identifying areas that require the focus of federal policies. The OTA concludes that such policies must have the involvement and cooperation of the states to identify crisis areas. Currently, no standardized criteria exist to designate areas without adequate health care. In fact, an OTA survey found that twenty-one of forty-four states that responded rely on their own designation criteria instead of, or in addition to, federal criteria for identifying areas deficient in available health care (OTA September 1990: p. 6). The large diversity in problems and needs for health care suggests the need for involvement of state governments to develop standardized criteria appropriate for federal policy. The cooperation of communities and health care providers is also needed. OTA (September 1990) cites the lack of community and provider will as a major barrier to the successful implementation of mitigating strategies.

Defining "Rural"

The OTA (September 1990) suggests that the major challenge in designing federal rural health policies is to identify those areas where residents' access to basic health care are most affected (p. 5). In some cases, there are definitional questions creating problems in designating rural areas. The OTA publication, *Defining "Rural" Areas: Impact on Health Care Policy and Research* (July 1989), illustrates this problem succinctly. The report points out the difficulty in quantifying rural health problems and making informed policy decisions without a clear definition of what and where "rural" areas are. Policy planners intuitively associate small population and sparse settlement with "rural." The problem is that these features exist on a continuum and that federal policies usually rely on dichotomous definitions (OTA, July 1989).

Most definitions of rural areas derive from one of two sources: the Office of Management and Budget (OMB) or the Bureau of the Census. There is no consistency in federal programs as to whose definition is best. The OMB uses county boundaries and Metropolitan Statistical Areas (MSAs) as the bases of its delineation of urban or rural. An MSA consists of one or more counties, determined on the basis of population size and density, and the area surrounding the urban counties that is affected by the economic integration as reflected in commuting patterns. Rural areas are defined by exclusion as those not captured in the MSAs. The Census Bureau defines the rural population as those individuals living in settlements with populations no larger than 2,500. Census determinations do not include county, city, or other locally determined borders, making them difficult to use.

The OTA (July 1989) indicates that both methods identify approximately twenty-five percent of the population as rural but that these populations are not identical. "For example, about 40 percent of the Census defined rural population lives within MSA's and 14 percent of the MSA population lives in Census defined rural areas" (p. 1). This inconsistency is visible in public policy. Under congressional direction, the Health Care Finance Administration (HCFA) uses the census definition to certify health facilities under the Rural Health Clinics Act. The same agency uses MSA designations for hospital reimbursement categories under Medicare.

The Health Care Finance Administration, using cost derived formulas, commonly pays rural hospitals less than urban hospitals. While cost differences exist, OTA (July 1989) suggests that the location of the hospital may be a correlate rather than a determinant of cost differences. Rural hospitals have complained about the shortfall of their reimbursement schedule since the implementation of the Medicare Prospective Payment System. Perhaps the problem lies in the method used to distinguish urban from rural hospitals and a failure to recognize the special disadvantages of rural hospitals.

Potential Solutions

In *Health Care in Rural America*, the OTA provides twenty-nine specific options for congressional action to

improve rural health care. Virtually all of these options rely upon increased funding for rural health care facilities, grants for training, or the provision of financial incentives to health care professionals. Such recommendations may go unheeded in an era of federal fiscal retrenchment. However financially unrealistic, the OTA recommendations would provide for sound policy in a different financial environment.

Policy makers should also be concerned with mitigating measures for the increased burden placed on rural Emergency Medical Service systems. State and local organizations usually operate EMS systems, making federal intervention inappropriate or impossible. However, the OTA Special Report, *Rural Emergency Medical Services* (November 1989), suggests that the federal policy makers should consider promoting the training of EMS providers and giving technical funding assistance to states. With such assistance, the state or local governments may then take the initiative to enhance the ability of their EMS systems to deal with the new demand.

Even with such aid, rural EMS systems still face adversity that cannot be improved by federal intervention. Problems such as widely dispersed populations are not easily addressed by policy. However, one technological advance shows promise in redressing the problems faced by rural EMS systems: the use of helicopter medevac programs in rural areas.

According to the OTA Special Report, in 1987 there were 231 helicopter ambulance services operating in 46 states and the District of Columbia. Of these, 156 were based in hospitals, 30 were public service systems, 33 were military and 12 were independent operations. The report notes that at least 19 more programs were to begin by 1988. The growth of these programs is a sign of the increased demand placed on such services by rural areas as well as changes in medical protocols regarding trauma and emergency care.

According to a national map provided in the OTA Special Report, helicopter services in 1987 concentrated in urban areas. Rural states had relatively few programs, for example: New Mexico and Alaska had one helicopter program each; Arizona, Nevada, North Dakota, South Dakota, Kansas, and Idaho had only two programs each. Expansion of helicopter evacuation programs into more rural areas would affect the disparity in injury- related mortality between urban and rural areas. Helicopter evacuation of injured patients to metropolitan hospitals might in part replace some of the access to care lost to closing rural hospitals and the loss of health care professionals.

The Need for Primary Care

Helicopter Medevac Programs do not represent a panacea for access problems in rural health care. Even though emergency treatment of trauma may mean a life or death outcome in a given situation, primary care is also necessary for health maintenance. Primary care is usually provided by a physician in an office, clinic, or small community hospital. It is the first line of medical intervention. According to Dr. John Coombs' testimony before the Pepper Commission (June 1989), rural health care is built on a primary care model that includes a mix of services and emphasizes comprehensiveness and continuity. Dr. Coombs told the Commission that in March 1988 there were nearly 2,000, mostly rural, primary care Health Manpower Shortage Areas as defined by the Department of Health and Human Services (S. Hrg. 101-969, p. 18). The fact that as many as twenty-five percent of all rural physicians will retire or leave their community within the next five years only makes the problem worse. Rural physicians are usually the providers of rural primary care. When communities lose their physicians, as well as their hospitals, primary care needs may remain unaddressed and develop into situations requiring critical care. Critical care is much more costly on a per patient basis than primary care.

The Future of Rural Health Care

The continued decline in the numbers of rural hospitals, physicians and other health care professionals seems irreversible under current policy. The publications discussed here help policy makers to grasp the depth and severity of the crisis in rural health care. Information provided by the Office of Technology Assessment and expert testimony in congressional hearings substantiate the existence of a crisis and point out the sad consequences of lost access to rural health care. There are no easy policy solutions to the crisis. Overlapping jurisdictions of federal, state, and local governments create barriers to a national policy approach. Further complicating the picture are the market forces at work in rural economies that represent basic changes in the national economy. An effective policy approach to such changes may not be possible in the current political environment.

The Role of Private Health Care

The influences of private health care providers and organizations are also important. Health care professionals and organizations are making rational economic choices about the provision of service to rural areas. Federal policies limiting health care subsidies may influence their decisions. However, the realities of declining rural economies also affect decisions made by health care providers and organizations. Policy to prevent providers or organizations from leaving rural areas would first have to address the economic decline of many rural areas. Rural economic decline is a much larger problem requiring a broad approach of economic support and subsidization. A natural, economic resurgence in rural areas is unlikely in the near future. In the short term, federal policy to address the rural health care shortage may be the only alternative. However, such a policy is unlikely in the current era of federal deficits and fiscal stress.

A Spirit of Self Reliance

The effects of federal policy and economic changes in rural areas diminish access to health care and place the health of rural citizens at risk. Dr. Coombs summed up the attitude of rural citizens in his congressional testimony: "From the general paucity of resources in rural areas has grown the spirit of innovation and self reliance that permeates all aspects of rural life" (S. Hrg. 101-969, p. 14). That attitude may explain why the crisis in rural health care has remained such a quiet crisis. Nevertheless, self reliance cannot replace medical or technical skill. The role of federal policy in facilitating the crisis may call to question whether or not the rights of federal citizenship (in effect purchased by the payment of federal taxes) have been abridged for rural citizens. Has there been preferential treatment of residents of urban areas in the development of federal health financing policies? Does such treatment constitute de facto discrimination? None of the discussions in the five publications reviewed address such questions.

Advocacy Organizations

Both public and private advocacy organizations are involved in improving the current situation in rural health care. The Senate Rural Health Caucus is one such group. As previously stated, this group commissioned the OTA report, *Health Care in Rural America* (September 1990). "The caucus provides in-service education to senators' staffs, makes recommendations on funding priorities, communicates with the Department of Health and Human Services on proposed or existing regulations, advocates for rural health initiatives in any relevant Senate committee and meets with representatives of national organizations addressing rural health issues" (National Resource Center for Rural Elderly: 1991, p. 1).

A similar organization exists in the House of Representatives. It is the House Rural Health Care Coalition, with 157 bipartisan members. This coalition sponsors annual packages of rural health care bills introduced by individual members. The focus of the coalition is on specific issues in rural health care such as hospital access, physician availability and nursing home problems.

Another public agency devoted to seeking solutions to rural health care problems is the Office of Rural Health Policy (ORHP), established in 1987 within the Public Health Service which is part of the Department of Health and Human Services (DHHS). This agency has several official functions such as coordinating all research on rural health care derived from the DHHS and administering the Rural Health Research Center grant program. Grants from that program are most often provided to universities for applied research. The ORHP also advises the secretary of DHHS regarding federal policy development affecting rural health care. Another major function of the ORHP is to sponsor the Rural Information Center Health Service as a clearinghouse for information on rural health care. The ORHP also provides public speakers who address issues of rural health care and sponsors educational activities in an effort to improve knowledge and interaction with other organizations involved in rural health care.

The National Rural Health Association (NRHA) is a private organization existing to address problems in rural health care. Established in 1978, the NRHA "defines itself as seeking to improve the health of rural Americans and to provide leadership on rural issues through advocacy, communications, education and research" (National Resource Center for Rural Elderly: 1991, p. 1). The organization's membership consists of health care professionals, administrators, and researchers totalling more than 1,800 members. The NRHA publishes the only national journal dedicated to rural health care issues, *The Journal of Rural Health*. The group also acts to promote concern about rural health care through conferences and activities to promote the rural health perspective in Congress.

The existence of these four groups and the breadth of their efforts are confirmation of the presence of a crisis in rural health care. Congressional leaders are well advised to continue investigating the status of rural health care. Unabated, the crisis in rural health care will become much larger on the political landscape. Congressional policy makers need timely, empirical and valid information such as provided in the five publications reviewed. Accurate information is essential for decision making that literally means life or death for a few rural citizens and the determination of a measure of the quality of life for many more.

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