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The Changing Face of Rural Health Care

Indiana Representative Terry Goodin, moderator, introduced the topic by commenting on the rate of absenteeism in schools in his area due to illness. “Kids can’t learn if they’re not well.”

Alan Morgan, Executive Director, National Rural Health Association, listed three ‘big bucket’ issues that are impacting health in rural areas:

1. Workforce shortages and how to attract physicians and clinicians. Medical students tend to come from upper income urban areas, are trained in urban areas where they may have also started families and incurred considerable debt. They are then placed in a rural clinic. We are dumfounded that they don’t want to stay there. Success is where state and federal partnerships encourage “grow their own” that encourage rural youth to enter healthcare professions.
2. How to keep hospitals. Since 2010, 93 rural hospitals have closed; only ten of those have re-opened. Lack of access to emergency care causes elderly to depart and families to avoid moving in. Telehealth technology and pricing is becoming an option. Broadband is still the big barrier. Its accessibility is a rural development issue.
3. Recent nationally declining life expectancies are due in part to outlier statistics such as opioid abuse and suicides. (Data showing longevity in very remote areas is probably due to the reality that you can’t stay alive there unless you are healthy.) Census data shows that rural populations and quality of life is stable and increasing next to urban areas. Younger generations are returning to rural areas for quality of life reasons.

Healthcare is a rural development issue. For most small towns the hospital is the second largest employer after the school system. Hospitals allow people to stay in the community and bring resources to it as well. Responding to the concern that telehealth is taking professionals out of the community, Morgan responded that those professionals were never there to begin with and house calls are not coming back.

Liability and scope of practice - such as medical assistants performing certain procedures where doctors are in short supply – becomes an insurance issue and a turf battle with lobbyists for various medical professions. NRHA’s position is that if there is documented evidence that a certain type of service can be performed safely and effectively, it should be provided.

Where is the loss of community hospitals headed? NRHA is partnering with an analytical firm to compare the financials of rural hospitals to those of all hospitals. Without some form of federal, state and/or local intervention, it is predicted that one third of the nation’s hospitals will close. Currently hospitals have to have in-patient beds to qualify. Proposals at the federal level are considering no beds, 24/7 ER service and highly utilized telehealth. Free-standing ERs are not a solution in rural areas because they require a steady stream of patients.

When a community hospital starts to fail, residents go elsewhere and clinical staff jump ship. It becomes a self-fulfilling prophecy. Obstetrics and gynecology is facing huge closures because they don’t have sufficient patient volume to afford liability insurance. Ditto for midwifery.

Helicopter emergency transport is a costly solution but Medicare/Medicaid is looking into it. In that respect, state lines are barriers to regional, multi-state economies and solutions.

National healthcare and single payer programs
Our culture defends and extends life. It has been successful at extending life, if not the quality, in a very expensive manner.
Ninety-two percent of farmers and ranchers have health insurance; seventy- two percent say it is inadequate and costs too much.

The Affordable Care Act didn't help rural but its elimination will close rural hospitals. The reimbursement rate for clinics is at half the cost. It will have to increase for clinics to stay open. The individual market collapsed last year. *Affordability* is the big issue. Deductibles and co-pays are too high at small hospitals. Patients are referred to bigger hospitals that bill the state for balance due. That is just bad debt that's sky rocketing and isn't being reported. Deductibles and premiums are astronomical.

Factors affecting health and longevity

In terms of general factors contributing to health and longevity, 30 percent of the pie chart is genetics, 10 percent is environment, 10% is health care and *40% is behavior. That's the low hanging fruit* for a reasonable approach with tools to check behavior.

Regarding a comment on smoking and poor diet as long-term intractable behavioral factors, Morgan responded that telemedicine is adopting consumer driven options where it's on a list of choices for when, why and where you go healthcare services. It is a challenge because people have been raised on a culture of third-party payer systems that, for example, sends them to urgent care for the flu, etc.

At the state level the Housing Assistance Council is taking on the Medicaid waiver process to establish programs that impact behavior. Some programs are starting to pay for *wellness exams and home visits* that are based on prevention rather than treatment.