Even in times of plenty, rural areas endure insufficient funding and personnel for health care services. Now with tougher economic times and shrinking resources, state and local officials are finding innovative ways to overcome the persistent challenges that rural health care in America faces.

That was the overriding message of a recent workshop on rural health policy sponsored by the User Liaison Program (ULP) of the Agency for Healthcare Research and Quality for state and local policy-makers in the summer of 2002. Policy-makers and national experts at the meeting discussed emerging challenges to providing rural health care in light of current budget realities. With the July 2002 release of the U.S. Department of Health and Human Services Rural Task Force report, “One Department Serving Rural America,” new weight is being given to the needs of rural health policy at both the federal and state levels (see sidebar).

### What makes rural America different

More than 20 percent of the American population lives in rural areas, yet most health care services are located in urban areas. Between 1990 and 2000, the population living in rural areas grew from 61 million to 65 million people, according to the U.S. Department of Agriculture’s Economic Research Service. However, most of this growth was concentrated in a small number of counties adjacent to urban areas. Geographic isolation and diffuse populations present unique challenges to policy-makers concerned with using scarce resources to meet the needs of rural residents.

The smaller, more dispersed population of rural areas in comparison to urban areas makes any service provision more expensive due to complex logistics and the difficulties of achieving economies of scale. Compounding this problem, rural communities tend to be poorer, are increasingly diverse ethnically, have a higher proportion of seniors and have limited economic opportunities. These factors all increase the need for health and social services.

In spite of the persistent stereotype that rural areas are dominated by agriculture, the truth is that rural America is increasingly dependent upon other sources of income. Health care is a significant portion of rural economies, making up as much as 20 percent of income and employment, according to the HHS Rural Task Force report. Rural leaders increasingly recognize that maintaining health care and other key services is critical for
attracting and maintaining economic opportunities in rural communities.

**Key issues in rural health policy**

State leaders identified a number of challenges for rural health care in their states. State Rep. Robert Cannell of Arizona sees lack of affordable health insurance as a particularly difficult problem for his state’s rural areas, where there is little or no access to managed care, drug coverage or Medicare HMOs. Arizona’s hospitals and other providers must also deal with a greater proportion of illegal immigrants and high levels of uncompensated care.

Dr. David Palm, program coordinator of Nebraska’s Health and Human Services System, said providing mental health services was a big challenge in Nebraska. “Of 535 communities, 90 percent have less than 2,500 people, and 70 percent have less than 1,000,” Palm said. “We don’t have a critical mass for services.”

Another priority for Nebraska is to build a comprehensive, coordinated public health system. Public health services, such as immunizations and infectious-disease surveillance, were previously contracted out to a variety of organizations with gaps in services in some areas and duplication of services in others. “Without the capacity to assess environmental risks, infectious disease outbreaks could be a nightmare,” said Palm.

Nancy Tyler, Counsel for West Virginia’s House of Delegates, finds workforce shortages and medical malpractice insurance costs to be the biggest threats to West Virginia’s rural health care system. “West Virginia is losing providers,” said Tyler. “And there are no specialists in major portions of the state.”

Russ McDaid, Deputy Director of the Governor’s Policy Office in Pennsylvania, echoed Tyler’s sentiments. “We have gone beyond a maldistribution to legitimate shortages in our rural areas,” said McDaid. Regarding the impact of the medical liability crisis in Pennsylvania, McDaid said, “One more malpractice claim for some providers and they are out of business, because they operate on razor thin margins.”

The Oklahoma Department of Health is unique in that it serves exclusively the non-urban areas of the state. Although the state coordinates efforts with city health departments in Tulsa and Oklahoma City, the urban areas manage their public health systems separately. From this vantage point, Stephen Ronck, Deputy Commissioner for the Oklahoma State Department of Health, sees personal health care services, especially prenatal care, as a key priority for his agency. “Processing plants in Oklahoma’s rural areas have attracted a lot of immigrant labor,” said Ronck. This reality has meant “higher infant mortality rates in the state and has put pressure on the public health system to respond.”

**Access, affordability and rising health care costs**

The job market and financial resources of rural communities often result in more uninsured and underinsured individuals, according to the HHS Rural Task Force report. “Financial access is a real concern, with health care costs on the rise,” said Nebraska’s David Palm. “The outlook does not look good financially and it is especially hard on rural areas.”

Rural workers are almost twice as likely to receive minimum wage as urban workers, according to the Rural Policy Research Institute. Greater rates of poverty and unemployment, a higher proportion of low-wage, less-skilled jobs, and smaller-sized businesses mean that employer-sponsored insurance is often not offered and reliance upon public health insurance is higher. Rural areas also have more seniors who cannot afford or do not have access to prescription drug coverage.

North Carolina has used its enhanced Medicaid managed care programs, Access II and III, to enhance access, control costs and improve care. Access II uses primary care case management with disease management and care coordination as added components. Access III also includes an integrated delivery system. Initial data from North Carolina show lower emergency room costs, lower increases in costs overall and better outcomes in Access II and III, than in the traditional primary care case management program, Access I.
Texas is seeking to increase access to Medicaid for telemedicine services, with enhanced reimbursement for Medicaid recipients in rural areas. In 2001, the Texas legislature passed three pieces of legislation (SB 789, SB 1536, and HB 1327) to expand the use of telemedicine in rural areas, which would be particularly beneficial to state employees and small businesses with the state paying the cost of reimbur- sement. 

Another challenge facing states is the financial viability of rural providers. “Rural hospitals have the same basic cost structure as their urban counterparts,” said McDaid. Yet, rural hospitals typically must spread fixed costs across fewer patients, resulting in much lower operating margins. In addition, Medicare pays 47 percent of rural hospital care compared to 36 percent for urban areas, according to the Medicare Payment Advisory Commission’s June 2001 report. Because Medicare payments generally do not allow for inefficiencies in ensuring minimum access to services, the higher volume of Medicare patients hurts rural providers disproportionately.

Medical malpractice costs are also problematic for rural hospitals in states like Pennsylvania, West Virginia, Nevada and Mississippi. A significant jump in malpractice insurance premiums can mean the difference between profitability and eventual bankruptcy.

The Balanced Budget Act of 1997 authorized the Medicare Rural Hospital Flexibility Program (Flex). This program encouraged statewide planning, allowed cost-based reimbursement to hospitals that meet Critical Access Hospital (CAH) criteria, encouraged the development of rural health networks, enhanced funding for emergency medical services and supported quality improvement programs in rural health systems.

The Flex program and particularly CAH designation have significantly improved the financial health of many rural hospitals. (See figure 1) But, even with the Flex program, rural hospitals still face tremendous financial challenges. “Decreases in federal funding mean that hospitals above critical access designation, but that are not tertiary, face more of a challenge to survive,” said Tyler.

Another avenue for strengthening rural hospitals is through rural networks. Networking helps smaller rural providers share resources and achieve economies of scale, thus lowering costs through increased volume or spreading of fixed costs across a larger group. Examples of rural networking include outsourcing of laundry services, housekeeping, billing and collections and other services; joint continuing medical education, training and credentialing of providers; and shared employee benefits and provider networks. “We have strong rural networks that share resources and our hospita-
Because of the chronic shortages of mental health workers in rural areas, most rural residents receive mental health services from their primary care providers. More than 90 percent of psychiatrists and psychologists work in urban areas, according to Dennis Mohatt of the Mental Health Program of the Western Interstate Commission for Higher Education.

States are looking at an array of options to deal with the workforce challenges in rural areas. Pennsylvania, like many other states, has a loan forgiveness/repayment program for physicians, nurses and other practitioners who practice in rural areas. McDaid stressed that the use of physician extenders – physician assistants, certified nurse practitioners and the like – are especially important in rural areas to alleviate the shortage in primary care providers. States may consider offering loan programs to other health professionals besides doctors.

Some states are using their Area Health Education Centers for recruitment and retention of health care workers, through health career programs and community-based clinical training. Scholarships and tax credits are other policy options for alleviating rural health worker shortages.

For mental health services, there is a mix of approaches. In Nebraska, the state and the Center for Rural Affairs have partnered to provide training on rural issues to hotline workers and mental health workers. Wyoming’s state hospital has developed a practice circuit for its staff psychiatrists to extend services around the state. Oregon has a telemedicine partnership with the Oregon Health Sciences Center, primary care clinics and mental health providers in remote areas of the state. In the Upper Peninsula region of Michigan, the approach integrated primary care and mental health services by relocating behavioral health staff from outpatient clinics to family practice clinics. This shift resulted in increased referrals and reduced costs for services as well as a reduction in the stigma associated with seeking mental health services.

**Facing budget challenges**

The current budget shortfall in many states has forced state officials to think outside the box when it comes to meeting rural health needs. “We are in wait-and-see mode,” said Ronck. “We are not adding anything new unless there is federal money to do it.” On the other hand, he added, “People in public health are the unsung heroes who strive to help people in their communities. They don’t worry too much about dollars and cents.”

Russ McDaid echoed Ronck’s sentiments. “Nothing stimulates the imagination as a difficult budget year,” said McDaid, “We need to be intellectually innovative.”

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