CHALLENGES AND OPPORTUNITIES

Rural Communities Tend to Be More Willing to Work Together and to Innovate

BY TOM DEAN, MD

Providing high quality health care in rural areas has always been a challenge. Shortages of personnel, facilities in need of updating, limited access to specialized services, poorer and sicker patients, and the stereotype—in the minds of both consumers and policymakers—that small rural systems inevitably deliver a lesser quality of care have long challenged rural health care providers.

These challenges are real. Currently, rural areas have 20 percent of the U.S. population but only 11 percent of the physicians. Among rural residents, 28 percent describe their health status as fair or poor compared to 21 percent of urban residents. In rural areas, 14 percent of people have incomes below the poverty level, compared to 11 percent in urban settings. The average per capita income in rural areas is only 73 percent of that in urban communities.[1]

The fundamental problem is finding ways to deliver an increasingly complex and expensive service to a population that is older, sicker, more geographically dispersed, ever more ethnically diverse, and less economically secure than at any time in recent memory. While these problems are not exclusively rural, they are more prevalent and their impact is greater in rural communities.

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Community Character and Variability

Rural communities have always varied one from another. In many ways, however, these variations are increasing. Some communities, especially those within easy driving distance of metropolitan areas, are economically more secure and have both a larger population base and an easier time of maintaining a full range of health care services.

On the other hand, those communities that are truly rural, those that are economically dependent on agriculture, timber, or minerals, have seen major changes both in the structure of their industries and the viability of their communities. We have seen major improvements in transportation followed by the "Wal-Mart phenomenon," in which more and more rural residents travel outside their own communities for routine purchases. Mechanization has led to a need for fewer and fewer workers, with a steady decline in population in many rural areas. Capital demands and more corporate involvement have led to more frequent absentee ownership. There is less dependence on local communities for the provision of goods and services and, with that, less commitment to support local community infrastructure including health facilities.

These trends present a real threat to the basic viability of many communities. Even those that have in the past served as trade centers and important points of access for health services are less secure than they once were.[2]

The relationship between health services and community economic vitality is an important and a complex one. In communities both large and small, health care is a major employer. In small rural communities, health care facilities are frequently the largest employers and key contributors to community economic health. If these facilities go into decline the pure economic impact is substantial. Furthermore, a community's ability to

attract new residents and new business activity is severely impeded if it is unable to guarantee access to a reliable level of health services.

Quality Concerns

Delivering health care services in rural areas presents a number of unique challenges. Some of these relate to maintenance of infrastructure, some to recruiting appropriate personnel, and some of the most difficult relate to the public *perception* of the quality of the services available.

Concerns regarding the quality of care provided in rural facilities have long been a worry of both rural residents and those with interests in health system development (many seem to believe that "the small and familiar can't be as good as the big and distant"). Such apprehension has led some rural residents (especially those with mobility and more resources) to seek care—at least elective care—in urban centers, which in turn weakens rural systems.

It is certainly true that low-volume systems are at a disadvantage in some functions—especially when it comes to doing complex and technologically sophisticated procedures. At the same time, analyses of medical errors and lapses in quality indicate that the most prevalent problems are those related to complex systems—such things as misidentification of patients, breakdowns in communication, and failure of follow-through when responsibility for care is transferred from one segment of the system to another. Because of their smaller size, their less compartmentalized structures, and their closer contact and familiarity with their patients, rural systems should be in a better position to prevent such mistakes.

There are solid, if not extensive, data to support this view. In a recent study of quality of care provided to Medicare patients nine of the 10 top ranking states were rural states.[3] Studies of obstetric outcomes in Washington state demonstrated that when obstetric care was centralized in larger communities, costs went up, and, rather than improving, the outcomes actually got worse.[4]

This brings up the important and often overlooked relationship between access to care and quality of outcome. No matter how good the care is from a technical standpoint, outcomes will suffer if patients cannot get *to* the care. In rural areas, both financial barriers and geographic barriers limit access and are major contributors to poorer outcomes.

Even with all these impediments, however, the bulk of the evidence indicates that by carefully selecting the range of services they attempt to deliver and by matching those services with the needs of the population, rural health providers can deliver care that is as good as—and, in many cases, actually better—than that in urban centers.

It is ironic that physician autonomy remains strongest in rural communities—the places where physician recruiting is the most difficult.

Professional Recruiting

Attracting an adequate number of health care professionals to rural communities has always been, and continues to be, a major difficulty. In this regard we think primarily of physicians, but other professions are vital and the people who practice them are often hard to find. Much attention has been given recently to the nationwide nursing shortage, and this clearly is felt in many rural communities as well. Shortages are also seen in the areas of radiology and laboratory technology, physical therapy, mental health, and pharmacy. The decline of the small-town independent pharmacy is a phenomenon whose impact is just beginning to be felt and one which has deeply troubling implications for continued access to pharmaceutical services.[5]

With regard to physicians, numerous reasons have been given for the difficulties in recruiting. These include inadequate compensation, long hours, professional isolation, lack of appropriate training, spouse preferences, and shortage of cultural and entertainment opportunities. Certainly all of these factors are relevant to some degree, but their actual importance is often hard to define. One of the most significant problems is a simple lack of understanding on the part of recent graduates as to what rural practice is all about. Programs that provide meaningful exposure to rural practice for students and residents are much more successful in neutralizing the stereotypes which frequently cause young physicians to steer away from rural practice.[6]

Nationwide trends in physician specialty choice are especially worrisome. In the last few years there has been a steady decline in the number of medical school graduates choosing residency training in primary care specialties.[7] Since the majority of rural physicians are in primary care (54 percent versus 38 percent in urban) this decline threatens to make an already difficult situation even worse.

In a broader context, physician discontent is a national concern.[8] A major factor frequently cited as a cause of this discontent is a perceived loss of professional autonomy. It is ironic that the areas in which physician autonomy is most well-preserved are in small rural communities—and these are the places where physician recruiting is the most difficult.

Two public programs that have been helpful in getting professionals into rural communities are the National Health Service Corps (NHSC) and the J-1 visa waiver program. In the NHSC, the federal government provides scholarships and loan

repayment programs to medical, dental, pharmacy, and mental health professional students in return for agreements to work in underserved areas, many of which are rural. The program has had considerable success but is too small to begin to meet the needs of all shortage areas.

In the J-1 visa waiver program foreign medical graduates who have completed residency training in the U.S. are allowed to stay beyond their training period if they practice in a professional shortage area. After completion of a three-year period they can begin application for permanent residence. There have been some problems with turnover of personnel and, at times, a mismatch between the training of the physician (sometimes in subspecialty areas) and the needs of the community. Nonetheless, in many cases these physicians have provided extremely valuable service to needy communities. (For more about the visa issue, see Brian McCartie, "Recruiting Physicians for Rural Areas," p. 34.)

Insurance Coverage

Maintaining health insurance coverage has become an increasingly difficult problem throughout society. Residents of rural areas confront all the obstacles faced by the rest of society. In addition, they encounter several special situations that make things even more difficult. Overall rural incomes trail those in metropolitan areas, whereas the cost of insurance is usually equivalent. There are fewer large employers in rural areas, so access to good quality group insurance plans is much more limited. Those who are self-employed or in very small businesses have to try to find coverage on the individual market—a segment of the market which insurance companies avoid and one in which premiums are substantially higher. The net effect is that these people often have to settle for policies with high deductibles and more limited coverage—when they can get insurance at all.

Community Leadership

In any discussion, generalizations are dangerous. This is particularly true with regard to rural areas. They differ greatly, and within any set of rural communities and the health systems that serve them, one will inevitably find a range of successes and failures, enthusiasm and cynicism, care that is outstanding, and care that leaves much to be desired. It has been wisely stated that "if you've seen one small rural community, you've seen one small rural community." The challenges they face are similar but the responses they mobilize vary widely—some creative and visionary, some timid and less effective.

It is intriguing to try to understand the differences between those communities that succeed in health care, on one hand, and those that lag behind, on the other. In analyzing this issue—which is profoundly important and central to any overall rural health strategy—one might expect to find that communities with greater financial resources, better access to capital, and less isolated locations would automatically experience greater degrees of success. But the reality is not nearly so clear-cut. Although these factors clearly are important, they are by no means enough to explain the community differences that we observe. Observers who have examined these questions agree that, by far, the most important predictors of health system success are local leadership and the ability of communities to resolve potentially divisive disputes, thereby avoiding the development of opposing factions within the community. Communities that are able to realistically evaluate their needs and to face them directly have a much greater chance of developing and sustaining a successful system of health services.[9]

One or two energetic, creative people can often do remarkable things in rural settings.

National System Concerns

For all their unique challenges, however, the most significant problems that rural communities and their residents face are the fundamental defects in our overall health care system. Rapidly rising costs, fragmentation of care, inability to maintain dependable insurance coverage, and lack of consistent primary and preventive care are major problems for our society as a whole. All of these have deep impacts in rural areas—more so even than in urban localities. No moves to improve the state of rural health care can expect to have any real success unless these broad national problems are addressed.

The Pluses of Rural Care

Overall the picture of rural health care is indeed mixed. Rural communities and rural health care providers face an array of economic, demographic, and geographic challenges that are often intimidating and sometimes seem overwhelming.

At the same time, there exist within rural communities health care opportunities that are often not found in urban areas. Rural systems tend to be small, flexible, and adaptable—settings in which one or two energetic and creative individuals can do remarkable things. Rural residents tend to be realistic in their expectations and understand that there are limits—both medical and financial—to what a person can expect health care to deliver. Many rural systems have maintained a not-for-profit community orientation. With this comes a sense of community ownership and a greater willingness to undertake projects just

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because there is a need, whether or not the projects are likely to be profitable. Such willingness is increasingly absent in the commercially driven systems that have come to dominate urban communities.

All these rural characteristics provide a fertile environment for the kind of creative and humane innovation that our society so desperately needs. □

NOTES

1. Tim Size, "Rural Health Can Lead the Way," *Eye on Health*, August 22, 2002, p. 2, available at www.rwhc.com/eoh.02.pdf/EOHSeptember.pdf.
2. Timothy Egan, "Amid Dying Towns of Rural Plains, One Makes a Stand," *New York Times*, December 1, 2003, available at http://query.nytimes.com/gst/abstract.html?res=F20E15F93B5E0C728CDDAB0994DB404482.
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4. Tom Nesbitt, et al., "Local Access to Obstetric Care in Rural Areas: Effect on Perinatal Care, Birth Outcome and Cost," WWAMI Rural Health Research Center Working Paper, August 1993; the article also appeared in the *American Journal of Public Health*, vol. 80, no. 7, July 1990, pp. 814-818.
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6. Howard Rabinowitz, et al., "A Program to Increase the Number of Family Physicians in Rural and Underserved Areas," *JAMA*, vol. 281, no. 3, January 1999, pp. 255-260.
7. Dale Newton, et al., "Trends in Career Choice by U.S. Medical School Graduates," *JAMA*, vol. 290, no. 9, September 2003, pp. 1,179-1,182.
8. David Mechanic, "Physician Discontent," *JAMA*, vol. 290, no. 7, August 2003, pp. 941-946.
9. Bruce Amundson, "Myth and Reality of the Rural Health Service Crisis: Facing Up to Community Responsibilities," *Journal of Rural Health*, vol. 9, no. 3, Summer 1993, pp. 76-87; Heartland Center for Leadership Development, "20 Clues to Rural Community Survival," Lincoln, NE, available at www.heartlandcenter.info.

"ADAPT, IMPROVISE, OVERCOME!"

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Association or the state Office of Rural Health, or contacting legislators, or serving on local community boards. Serving on the local development corporation board is especially important because each of its members has an interest in the community's economic future. How many times have we heard someone say, "If the school and hospital go, so does the town." At facilities such as ECHS, we need to be able to recognize changing conditions and be proactive rather than reactive.

When you have a community the size of Eureka's, your staffing pool is not very deep and you thus become vulnerable when vacancies arise. Filling positions in medicine, management, radiology, laboratory, and nursing is not easy. Recruiting specialists for a community as small and isolated as ours can be a difficult proposition.

We at ECHS have worked with a number of area facilities and a local educational institution to provide a variety of classes using two-way videoconferencing equipment. The program was designed to help single parents (and others) who wanted to get additional education and further themselves but could not travel to attend classes. Through this program, over a period of three years, we were able to graduate quite a few registered nurses, licensed practical nurses, and medical technicians. However, as happens more times than not, we could not renew our funding for the program, and now it has been lost.

*Education through video conferenc*ing is one way rural health care can triumph over the challenges it faces. Don't get me wrong. I'm not saying, "The future is so bright that we have to wear sunglasses." But I do feel that we have a lot of energy and talent out there, and with it we will come up with ways to get past the hurdles before us.

Our community's ever-increasing number of elderly residents is just one of the problems we face on a daily basis. At ECHS, we chose not to ignore it but, rather, to research the needs of that segment of our population and adapt to meeting those needs. Among the services that our elderly need to receive in their own community: increased access to various specialists; physical and occupational therapists to help treat arthritic problems; assisted-living units to help fill the gap between acute care, on one hand, and nursing home care, on the other; and increased availability to home care, to mention just a few.

CREATIVITY WILL BE NEEDED

The first thing a facility like ours needs is an educated and progressive board of trustees that can help us meet these challenges. I am a strong believer in educating boards as much as possible so that they are aware of the barriers they face and can recognize what is coming down the road. The second critical item is keeping your staff informed about both the changes ahead and their role in those changes. And third (but not least) in importance is involving your medical staff in the growth process. You have to have a "buy-in" attitude in all of these groups.

ECHS has received national recognition for its ability to get this message across and move forward in filling our facility's needs. This recognition has created opportunities for us to present our case before a variety of state health care associations, hospital boards, and various other health care groups across the nation. Our goal continues to be education of board members, management, physicians, staff—and community residents as well. One year, for example, we launched a referendum for a local one-cent city sales tax with which we planned to retire a large federal loan. After hearing the specifics and our long-term plan, the community rallied behind us and approved the tax. In fact, the initiative got 85 percent of the vote!

Unfortunately, we do not expect our community's percentage of people over the age of 65 to grow smaller in the years to come. We need to continue to be proactive in our approach to health care services. If we can continue to take an aggressive approach to meeting continually changing service needs, we should be able to beat the odds and maintain our small rural community hospital for many years to come. □